IN THE COURT OF COMMON PLEAS

CUYAHOGA COUNTY, OHIO

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KIMBERLY ECHOLS,

Plaintiff,

vs.

MITCHELL BARNEY, D.D.S., and AMERICAN DENTAL CENTERS,

Defendants.

CASE NO. 288236

ORIGINAL

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Deposition of MITCHELL V. BARNEY, D.D.S., a Defendant herein, called by the Plaintiff for Cross-Examination, pursuant to the Rules of Civil Procedure, taken before me, the undersigned, Carina L. Cecconi, a Registered Professional Reporter and Notary Public in and for the State of Ohio, at the offices of Reminger & Reminger, The 113 St. Clair Building, Cleveland, Ohio, on Tuesday, the 26th day of September, 1995, at 10:05 a.m.

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APPEARANCES:

On Behalf of the Plaintiff:

BY: Mark W. Ruf, Attorney at Law
Hoyt Block, Suite 300
700 West St. Clair Avenue
Cleveland, Ohio 44113-1230

On Behalf of the Defendants:

Messrs. Reminger & Reminger Co., LPA

BY: Roy A. Hulme, Attorney at Law
The 113 St. Clair Building
Cleveland, Ohio 44114

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DEPOSITION EXHIBITS:

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of lawful age, a Defendant herein, having been first duly sworn, as hereinafter certified, deposed and said as follows:

(Thereupon, Plaintiff's Exhibit 4 of the Barney Deposition was marked for purposes of identification.)

CROSS-EXAMINATION

BY MR. RUF:

Q. Dr. Barney, my name is Mark Ruf. I'm representing Kimberly Echols in a dental malpractice suit which she's brought against you. If at any time I ask you a question and you don't understand my question, then, please tell me. If you give me an answer to a question, then, I'll assume that you've understood my question, okay?

A. Yes, sir.

Q. Could you state your name, please?

A. My name is Mitchell Vernell Barney.

Q. Where do you reside?

A. 18412 Winslow Road.

Q. Is that in Cleveland?

A. That's in Shaker Heights, Ohio.

Q. What's the zip code there?

A. 44112.
Q. Where are you currently working?
A. American Dental Centers at Euclid Square Mall.
Q. What's the address there?
A. I believe it's 206 Euclid Square Mall.
Q. Do you know what the zip code is there?
A. 44132, I believe it is.
Q. Is that the only office you're practicing out of?
A. Yes, sir.
Q. And how long have you been there?
A. Almost three years.
Q. Before we talk about American Dental Centers, I want to get into some of your background. Could you tell me a little bit about your education?
A. I graduated from Adelphi University in 1977, with a bachelor's of science degree in biology and minor degree in chemistry.
Q. Did you have any kind of academic awards?
A. No, sir.
Q. Okay. Please continue.
A. I graduated from Meharry Medical College in Nashville, Tennessee, 1982.
Q. And is that where you went to dental school?
A. That's correct.
Q. Did you receive any awards from the dental school?

A. No, sir.
Q. Did you do any education post dental school, or did you start practicing afterwards?
A. Excuse me? Are you referring to post grad?
Q. Yes.
A. No post grad work, but I have continuing education courses after, continuously.
Q. Okay. By the way, how many continuing education hours do you need to keep your license as a dentist?
A. Twenty credit -- 20 credit hours per year.
Q. Okay. Over the past three years, have you attended any continuing education seminars on tooth extraction?
A. No, I haven't.
Q. Were there any seminars that discussed the topic of tooth extraction?
A. In the past three years, sir?
Q. Yes.
A. No, I haven't.
Q. I am going to show you what's been marked as Plaintiff's Exhibit A; could you take a look at that?
A. (Witness complies with request.)
MR. HULME: That's Exhibit 4. Deposition Exhibit 4.
MR. RUF: Okay. Sorry.

MR. HULME: That's okay.

BY MR. RUF:

Q. It threw me off there.

I'm sorry. I'm showing you what's been marked as Exhibit 4.

A. Yes.

Q. Is that a true and accurate copy of your curriculum vitae?

A. Yes.

Q. And is this current?

A. No.

Q. What needs to be added to this?

A. American Dental Centers, when I started practicing there, to present.

Q. Do you know the exact date you started practicing? Was it '92?

A. Approximately three years ago, which would be about '92. November of '92.

Q. Okay. While you were in dental school, did you study any particular field of dentistry, or was it just a general study of dentistry?

A. General study of dentistry.

Q. Okay. How many years have you been licensed to practice dentistry?

A. Since 1983.

Q. So that's 12 years?
A. That's correct.
Q. During that time, have you ever had your license revoked?
A. No.
Q. Have you ever been disciplined?
A. No.
Q. Did you start with Benjamin Schechter straight out of dental school?
A. No.
Q. What did you do prior to working with Dr. Schechter?
A. I was practicing dentistry at Glenville Health Association.
Q. Okay. And where is -- I'm sorry.
A. Excuse me. I started practice there in 1983.
Q. Okay. So you practiced there two years?
A. Four years.
Q. Four years?
A. Yes.
Q. You started in '83?
A. Yes.
Q. Well, under "Work Experience" you have "March of '85."
A. It could have been '86. '85, '86.

Q. Okay. Are you sure you worked for four years for -- what did you say, Glenview?
A. Glenville Health Association.
Q. Glenville?
A. Yes, sir, because I was in the National Health Service Corps, U.S. Public Health.
Q. While you were with Glenville, what kinds of dentistry did you practice?
A. All phases of dentistry except orthodontics.
Q. Could you tell me a little bit about how dentistry is set up? Are there different areas of practice in dentistry?
A. There are specialities in dentistry, yes, but general practitioners can practice any field they feel capable. There's no limitation.
Q. Okay. And what are the areas of specialization?
A. Often, general endodontics, pedodontics, oral surgery, prosthodontics, restorative dentistry, preventative dentistry, management of dentistry.
Q. Do you have either any specialized education or training in any of those areas?
A. I have taken courses, after I graduated, in all phases of those.
Q. And that's the continuing education credit?
A. That's correct.

Q. Well, have you been educated in any of those specialty areas?
A. Yes.
Q. Do you need to have a degree to practice -- a special degree, to practice in any of those specialty areas?
A. No, just your general practitioner.
Q. Well, how do you get involved in practicing in a specialty area?
A. You go -- I don't understand the question, excuse me.
Q. Well, do you just get a general dentistry degree and just start practicing in a specialty area?
A. No. When you're trained in dental school, you're trained in all of those.
Q. Do you have to get certification, board certification to practice in a specialty area?
A. No.
Q. Do you know how many tooth extractions you did when you worked for Glenville?
A. There were quite a few, more than what I'm performing now, because that was a welfare practice, and predominantly, we performed nothing but extractions and restorative and prosthetics.
Q. Approximately how many would you do per week?

A. That was a long time ago.
Q. I'm not asking you to guess. If you don't remember, just tell me.
A. I don't recall.
Q. What kinds of dentistry did you perform with Dr. Schechter?
A. All phases of dentistry except for orthodontics.
Q. I'm sorry. I didn't go in order here.
After Glenville, you worked for -- as a general practitioner, for Convenient Dental Centers?
A. I was a general practitioner at Convenient Dental Centers. That was part-time.
Q. What is Convenient Dental Centers?
A. That was a group of independent doctors practicing for a company specializing in dentistry.
Q. Is this a corporation, Convenient Dental Centers?
A. Yes. It no longer exists, though.
Q. Okay. Do you know when they went out of business?
A. I believe it was approximately '92. I left before they actually went bankrupt.
Q. What types of dentistry did you practice at Convenient Dental Centers?
A. All phases of dentistry except for orthodontics.
Q. Including the specialty areas we've discussed?
A. Yes.

Q. Okay. Do you know how many tooth extractions you would do per week when you worked at Convenient Dental Centers?

A. More than I'm performing right now, but I do not recall the exact figure, sir.

Q. And how many extractions are you performing a week now?

A. I usually perform at least five a day.

Q. What about with Dr. Schechter, what areas of dentistry did you practice?

A. All phases except for orthodontics.

Q. And again, that includes the specialty areas we discussed?

A. Yes, sir.

Q. Do you know how many extractions you were doing when you worked with Dr. Schechter?

A. No, I don't remember.

Q. Okay. Did you do a lot of extractions when you worked with him?

A. I performed extractions every day.

Q. Why don't you tell me, when do you perform an extraction? What are the indications for doing that?

A. If the patient is in pain, if the tooth is loose, if the patient prefers not to have endodon treatment, they would like to have that tooth out. If the tooth is

going to interfere with the design of a prosthesis, if a baby -- deciduous tooth is causing an adult to become impacted, we have to remove that tooth. If an orthodontist refers a patient to me requesting a particular tooth be extracted for that design, as he's going to move the teeth. If the tooth is infected, impacted.

Q. Okay. Anything else you can think of?

A. There are probably a few others, but I can't recall this morning.

Q. What types of extractions are there? Are there different procedures for performing extractions?

A. There are different extractions. Basically, the procedures are the same, just a little difficulty with the extractions. Where you have your routine extractions, your soft-tissue impaction extractions, your partial bony extractions, your complete bony impaction extractions.

Q. Why don't you tell me how those extractions differ. Why don't you start with routine extractions.

A. Routine extractions involve teeth that are periodontally involved, where you have lost a --

Q. I'm sorry? I didn't --

MR. HULME: Periodontally involved.

THE WITNESS: Periodontally involved.

BY MR. RUF:

Q. Okay.

A. Then there are deciduous teeth that have to be removed, and those are with, basically, the 28 regular teeth, we call them, the second molars of the upper and lower arch to the anterior teeth. Where we get into difficulties with the wisdom teeth where it causes the position, anatomy of the teeth. The structure of the roots, where they become difficult, where they are positioned in the oral cavity in the jaw, and that's where we get to our definition of soft tissue, where they are partially erupted and they're covered by just the gingiva, certain portions of the tooth. Where we get into our partial bony where they're impacted to -- with the adjacent teeth, to where we have a complete bony impaction where they're imbedded in the jawbone and they have not erupted into the oral cavity at all, and this can occur in the upper and lower arch.

Q. Now, for those four types of extractions, how does the procedure vary as far as extracting the tooth?

A. With the majority of the soft-tissue extractions -- I can say with all soft-tissue extractions, you may have to perform intravenous

sedation to extract the tooth.

When you go into your surgical extractions, you're going to have to use a high-speed instrument with a surgical burr. So you may have to section the tooth or make a groove in the area so you can have position where you can use your dental instruments to elevate that tooth into where you can remove it.

With your partial bony extractions, you have to be concerned with the adjacent teeth, because sometimes you may have destruction of the root underneath or the clinical crown of the adjacent tooth by that tooth, or there may be a large abscess involved, which you have to get involved with, and they're also a lot closer to the nerves that we consider.

With complete bony impactions, there are several positions that the impacted tooth can be in. We call them horizontal, vertical, or it can be reverse, in the opposite direction completely.

Q. Do you perform surgical extractions?

A. Yes. Surgical extractions can involve the normal 28 teeth because of the extent of the decay. So we do perform those. That's the step after the regular extractions, or an endodontically treated tooth would be brittle and then breaks away, we have to surgically remove that.

Q. Now, we went over four types of extractions, and then you mentioned surgical extractions?

A. That's the one I forgot about.

Q. So is that a fifth type, or --

A. That fifth type can involve older teeth. There are 32 teeth in adult teeth.

Q. Okay.

MR. HULME: Mark, I think you're trying to have him create, sort of, categories that don't necessarily exist in dentistry. I think he is trying to help educate you.

MR. RUF: Right.

MR. HULME: I think he said the routine ones, he groups under the deciduous teeth, baby teeth extractions, and periodontally involved teeth, which mostly involve the 28 nonwisdom teeth.

MR. RUF: Right.

MR. HULME: Then when he is talking about the wisdom teeth, they can be soft-tissue impacted, partially bony impacted or complete bony impacted. So I don't know how you want to break those down, but that's what I heard.

BY MR. RUF:

Q. Well, as far as a surgical extraction goes, that can be used for either soft tissue, bony impaction or

complete bony impaction?

A. No. No.

Q. When do you use surgical extraction?

A. Basically, with the 28 teeth, except when you have a third molar that has extensive decay and the tooth fractures when you're removing the tooth; then you have to go in with a high-speed burr, surgical burr, split the tooth and remove the root.

Q. So if you split a tooth while trying to remove it, you need to do a surgical extraction?

A. It would be considered a surgical extraction.

Q. Okay.

A. But, generally, not with wisdom teeth.

Q. You said a surgical extraction you use a high-speed burr?

A. Sometimes. It depends on the expertise of the individual. That's a judgment call as you're extracting.

Q. What else would you use beside a high-speed burr during a surgical extraction?

A. You normally use your elevators, forceps; those are two procedures. When you cannot -- when the tooth is not -- when you're not able to move those teeth, then you have to go in there and create a section so you can move it.

Q. Okay. When you perform a soft-tissue extraction, do you use the same technique every time?

A. Basically, yes, elevator and forceps.

Q. Could you describe that technique in detail for me, please?

A. Well, it depends on the coverage of the soft tissue on the tooth. You may have to use a scalpel to make an incision to allow the tooth to elevate up into the oral cavity.

First, you anesthetize the patient for that particular area, relieve the tooth of the periodontal attachment, then you elevate that tooth with several elevators, depending on the adaptation you get to that tooth, and either the tooth will come up with the elevator or you will use forceps to remove it completely.

Q. Following the elevation of the tooth, what do you do?

A. It may come up on its own, or you may have to use forceps for that tooth. Not every case is the same.

Q. All right. So once you elevate the tooth, then what do you do?

MR. HULME: You mean if it doesn't come out?

THE WITNESS: If it doesn't

come out, you use the forceps. Sometimes it comes up without the forceps.

BY MR. RUF:

Q. Okay. Is there anything that differs in a soft-tissue extraction from what you've just described? Are there any variations in that procedure?

just the position of the teeth, what teeth are involved, even for regular extractions.

Q. How do you remove the periodontal attachment?

A. You use elevators just to separate, detach it. Some doctors use scalpels, some use elevators.

Q. When you describe "periodontal attachment," what does that mean?

A. The tooth is suspended in the socket, and there are tissues called periodontal ligaments that suspend the tooth in the socket.

Q. Now, is that the soft tissue around the tooth, or is it --

A. Slightly underneath. It's in a sulcus.

Q. When you elevate the tooth, you use what kind of equipment, an elevator?

A. An elevator. There are several types of elevators, and --

Q. What types of elevators are there and when do use

each one?

A. There are various shapes for the straight elevators, you have root tip elevators, you have what we call the east/west elevator.

Q. When do you use each of those?

A. When they're indicated. You may not have to use any of them except for maybe the small elevators, but these are just available to us, and we determine that at the time of extraction.

Q. All right. When are they indicated with each elevator?

A. We usually just bring them out routinely. We use, basically, just a straight elevator. It all depends on the doctor's preference, which instruments he can use better. That's all. There's no set rule on that.

Q. Now, when you elevate a tooth, where do you put the elevator in the mouth?

A. It is actually inserted between the adjacent tooth and the tooth you're going to extract.

Q. Okay. And how do you use the tool?

A. You have to insert it at an angle where you can apply pressure. Sometimes you can't. It all depends if you can get that space in between the two teeth.

Q. What if you can't get the space in between the two teeth?

A. Then you have to perform a surgical extraction. You have to section the tooth.

Q. Would you agree that one of the goals during the extraction is to be as atraumatic as possible to the teeth?

A. To the patient?

Q. Yes.

A. Yes.

Q. You've been working for American Dental Centers for three years now?

A. Approximately three years, yes.

Q. Do you have a specific title with American Dental Centers?

A. General practitioner.

Q. Well, do you know how many extractions you do per year with American Dental Centers?

A. It varies between 1,000 and 1,500.

Q. How many days do you work a week?

A. Six days a week.

Q. How many hours a day?

A. Some days I work 12 hours a day, some Sundays I work from 12 to 5, and the other days 1 work from 3 to 9.

Q. So your hours vary?

A. Yes.

Q. How many hours do you work per week, generally?
A. Between 50, 60 hours.
Q. How are you paid by American Dental Centers?
A. On commission basis for services I render.
Q. So you're paid by a percentage of the collections?
A. Yes.
Q. And is that only on the procedures you perform?
A. Only on procedures I perform, yes.
Q. So if you refer it to another dentist at American Dental Centers, you don't get paid?
A. For that particular procedure, yes, that's correct.
Q. What types of dental providers do they have on staff at American Dental Centers?
A. We have a hygienist, we have oral surgeons, we have pedodontists available, orthodontists. We have a periodontist that's available also.
Q. Is there an oral surgeon on staff at all times during business hours?
A. No. He usually comes in once or maybe twice a week.
Q. How often would you say you refer cases to the oral surgeon in the office?
A. It varies on the patient. It's difficult to say. When I see something, I diagnose it, usually we have to

wait for approval, and then the patient determines if they would like to have that procedure performed. So it varies. It's difficult to say.

Q. Is it once a week, once a month?

A. It varies.

Q. Okay. You can't say?

A. I can't say.

Q. What types of dental conditions do you refer to an oral surgeon?

A. Mainly procedures I just don't feel I can perform He usually handles the partial bony, complete bony, osteoplasty, you know, if there's trimming of ridges.

Q. Do you ever refer soft-tissue extractions to the oral surgeon?

A. Yes.

Q. What types of soft-tissue extractions would you refer?

A. When a patient requests that they would like to see the oral surgeon for a soft-tissue extraction, I refer them to him.

Q. Does the oral surgeon have any additional education or training than you do?

A. He's board certified, yes.

Q. Okay. Do you ever refer patients out of American Dental Centers, or are all the referrals inside?

A. I refer them out also.

Q. Okay. Who do you make referrals to?

A. Usually, to the hospitals for -- because of medical problems or whatever, if it's too extensive for the office, and that's usually to Mt. Sinai, University Hospitals. If they do not feel like waiting for our oral surgeon to be seen, I'll refer them to Dr. Paul Smith. Sometimes endodontically treated teeth, we'll refer them to some endodontists.

Q. Does Dr. Paul Smith practice in some specialty area?

A. He's an oral surgeon, board certified.

Q. So complicated surgical cases you refer out?

A. No. The patient may just like to have the procedure performed by an oral surgeon.

Q. If you wanted to make a referral to the oral surgeon at American Dental, how would you do that?

A. Make a notation in the chart and notify the front desk. The patient will go to the front desk and say they would like to have this procedure done by an oral surgeon, with the assistant -- dental assistant taking --

Q. If you're having a problem during a procedure and you realize that you need an oral surgeon, what would you do?

A. I would discontinue my treatment and give the patient some medication to give them some relief until we can get them to see the oral surgeon.

Q. Okay. Do you have more than one oral surgeon on staff at American Dental at your office location?

A. We have one at our office, but there's another oral surgeon, who I do not know the name of, that's on the west side.

Q. What's the name of the oral surgeon at your office?

A. Dr. Murko.

Q. Could you spell his last name?

A. M-U-R-K-O.

Q. Do you have a good working relationship with Dr. Murko?

A. Yes.

Q. If you ever had a dental condition that's beyond your level of expertise, have you ever had a problem referring a case to Dr. Murko?

A. No.

Q. Do you remember Kimberly Echols?

A. No, I don't.

Q. You can't tell me what she looks like?

A. No, I can't.

(Thereupon, Plaintiff's Exhibit 5

of the Barney Deposition was marked for purposes of identification.)

BY MR. RUF:

Q. I'm handing you what's been marked as Exhibit 5. It's the records of American Dental Centers. Could you take a look at those, please?

A. (Witness complies with request.)

Q. Let's start with the first page. What's this first page? Does that have a title to it? Is that an intake sheet?

A. This involves the patient's history -- medical history, dental history, and information on the patient that we use.

Q. Based on this form, what can you tell me about Kimberly Echols' dental history?

A. She's single, she's female, she's born September 18, 1969, her employer is Hahn, Loeder & Parks, she does not have any dental insurance.

MR. HULME: Wait a second. "Is patient covered by dental insurance?"

THE WITNESS: "Yes." Excuse me. That's correct.

BY MR. RUF:

Q. Is that part of her dental history?

A. It's part of her history, information that we need; who is responsible for her payments, if she has any type of insurance, if she feels like using it?

Q. Okay.

A. She's not allergic to any medication that she's aware of, she's on birth control pills, she was pregnant June '92. At the time she filled out this history form, she was having discomfort. Last dental visit was unknown. At that point in time, when she did visit the dentist, she did not have any dental services rendered. She had X-rays taken. She does not visit on a regular basis because she writes down her last dental visit was unknown, and it states, "Have you lost any teeth," she said no. Her gums bleed due to gum infection, the extent of we don't know because she hasn't had an oral exam.

Q. Do you know who fills out this first page?

A. The patient does.

Q. They fill that out on their own?

A. Yes, and we review this with them.

Q. I forgot, did you call this first page anything in particular? Is there a name for this first page?

A. I guess you would call it a medical history form.

Q. Okay. Let's go to the next page.

A. (Witness complies with request.)

Q. It says, "Doctor's Checklist." What form is this?
A. This is a form that we fill out with the routine oral examinations.
Q. Okay. Who fills this out?
A. The doctor and the assistant
Q. Do you fill this out in the presence of the patient?
A. When we give the examination, yes. We go through the examination, we follow this as a guideline.
Q. Now, let's start at the top. There's a chart at the top. What are those entries for?
A. Oh, this is if -- this indicates to the doctor if they have medical insurance, what the percentages are that she's covered for insurance so we can discuss this with the patient, because the patient usually has to pay a deductible for certain procedures.
Q. I'm sorry. I was talking about below that. It says, "Exam, X-rays"; what is that for?
MR. HULME: That's what it is.
BY MR. RUF:
Q. I see. That chart relates to the insurance?
A. That's correct, because every insurance does not cover exams 100 percent, or X-rays. So we have to look up the insurance.

Q. So all the way down to the bold line, that's all it has to deal with, is insurance?

A. Where it says "crown" and "surgery," yes, that will deal with that portion.

Q. Okay. Now, below that, what is that form for?

MR. HULME: Where it says "medica1 history update"?

BY MR. RUF:

Q. Yes.

A. This is where we'll indicate when we review the medical history -- updated during examination with the patient. We will ask them is it current on the first page, or have there been any changes, because sometimes the patient, during the six months between examinations, may have taken some type of medication for some type of systemic problem, or they may have developed an allergic reaction to some medication, or they may have had some surgery we need to be aware of.

Q. The next line down says, "Thorough intraoral exam"; what is that for?

A. We evaluate the tissues of the head and neck, nose, eyes, ears, oral mucosa, hard and soft palate, the frenula, the tongue, et cetera.

Q. When do you do that?

A. When we give the patient the oral examination.

Q. Is that with each patient?

A. No, when -- for patients that desire to have an oral examination, this is what we go through.

Q. Do you know if any of those things were checked on Kimberly Echols?

A. No, she did not have an oral examination.

Q. Okay. What's the purpose of an oral examination?

A. To diagnose and see if there's any type of problem, and lets the patient know if there's any type of problem, and would they like to have that problem treated. It's just a record form between each examination.

Q. What is the importance of dental documentation?

A. To keep a record of what we're performing, and also *to* keep an update on the patient's history.

Q. So you would agree if anything is done dentally to a patient, it should be documented in the chart?

A. Yes.

Q. Now, what about on the rest of this page, is there anything that applies to Kimberly Echols on the lower part of the first column?

MR. HULME: You mean if she had had an --

THE WITNESS: -- examination?

MR. HULME: Yes.

THE WITNESS: This all applies to the patient if she had an examination

BY MR. RUF:

Q. So the remaining part of the first column all applies to oral examination?

A. The entire page applies to oral examination.

Q. Since she didn't have an oral examination, that's why there's nothing on this page?

A. That's correct.

Q. Okay. Do you know why an oral examination was not performed on her?

A. I'm assuming she did not want to have one.

Q. Do you only perform an oral examination if the patient requests it?

A. No. We instruct the patient that they need an oral exam and would they like to have one, and they have the option to have one done or delay until another day, or not having one at all.

Q. If a patient declines an oral exam, is that noted in the chart?

A. No.

Q. Do you always perform an oral exam unless the patient rejects the oral exam?

A. If you're referring to a complete oral examination, which this chart is for, we recommend oral

examination on all patients and we -- if they accept it, then we perform it.

Q. Would you agree that it's important to do an oral examination prior to doing a tooth extraction?

A. No.

Q. Why not?

A. Because certain patients come in requesting only you look at one particular area, and that's all they would like to have done. With the oral examination, there is a fee, and the patient has to decide whether they want to have -- pay that fee or not, but we do recommend oral examinations on all patients sometime, you know, in the near future if they refuse.

Q. Is that your routine, to recommend an oral exam with each patient?

A. I like to recommend oral examinations because there could be some other problem within the mouth that the patient needs to be aware of.

Q. Let's go to the next page.

A. (Witness complies with request.)

Q. At the top it says, "Treatment Plan." What is this page for?

A. This is the page that we use for charting what needs to be done in the mouth.

Q. The first entry is February 24, 1993. Do you

remember seeing Kimberly Echols prior to that date?

A. February 24, 1993?

Q. Yes.

A. No, I didn't know she was in the office that day.

Q. Do you remember seeing her prior to that time?

A. No.

Q. Do you ever see patients at the front desk and tell them to come back and make an appointment?

A. Excuse me? Can you explain the question?

MR. HULME: Mark, just so you're not confused. He didn't see her on February 24, 1993. That's not him.

BY MR. RUF:

Q. Do you know whose initials these are?

A. That's Dr. Raiffe.

Q. Is he still at American Dental Centers?

A. No, he's not.

Q. Do you know why she went to American Dental Centers on February 24, '93, from the chart?

A. It indicates she had a toothache on a wisdom tooth on the lower left side, tooth No. 17, and indicated it was abscessed.

Q. And what was done to the tooth?

A. She was administered some antibiotics and referred to the oral surgeon for extraction.

Q. Do you know what oral surgeon she was referred to?
A. According to this record it was Dr. Murko.
Q. And he's with American Dental?
A. Yes.
Q. Do you know, according to this record, was the extraction performed?
A. There is no indication on this record that the extraction was performed by the oral surgeon.
Q. Do you know what this notation is on 3/2/93?
A. "Patient rescheduled."
Q. And do you think that relates to the tooth extraction?
A. I don't know.
Q. Okay. Let's go to the entry August 30, '94. Under doctor number it says "BEG"?
A. "BE6." That's me.
Q. "BE6."
You have a number with American Dental Centers?
A. Yes.
Q. And that's how they determine what your collections are?
A. That's just a code for all services I perform.
Q. Do you remember seeing Kimberly Echols prior to August 30, 1994?
A. No, I don't.

Q. Okay. Do you remember seeing her out at the front desk?

A. No, I don't.

Q. Have you read over her deposition?

A. No, I haven't.

Q. According to your notation, what was her condition when you first saw her on August 30, 1994?

A. She came in as an emergency and she wanted to have this tooth treated. It was tooth No. 32, wisdom tooth.

Q. Do you know what the condition of the tooth was?

A. It was a soft-tissue impaction.

Q. Do you know what her complaints were?

A. She was in pain from that tooth. It was infected.

Q. Is there a notation in the chart to that effect?

A. No. The chart is just used for services that are rendered, basically, and anything unusual.

Q. Well, do you document patients' complaints in the chart?

A. No, not necessarily.

Q. So based on this chart, you can't tell me what her complaints were?

A. Yes, I can.

Q. How can you tell me what her complaints were?

A. From the service that was rendered. There was only one X-ray taken. There wasn't an oral examination,

and we removed tooth No. 32.

Q. Well, are a patient's complaints always the same with a soft-tissue extraction --

A. No.

Q. -- of No. 32?

A. No.

Q. How do the patient's complaints vary?

A. They can be gum infection, they can be routine checkup, it can be just a consultation.

Q. What about the patient's complaints, though?

MR. HULME: Could you --

MR. RUF: Do they always complain of pain and is it the same type of pain?

MR. HULME: You mean if the tooth is extracted?

BY MR. RUF:

Q. Right, if there's a problem with the soft-tissue impaction.

A. Excuse me? I don't understand your question.

Q. Okay. If a soft-tissue extraction is required, are the patient's complaints always the same?

A. No.

Q. How do their complaints vary?

A. Sometimes it could be a soft-tissue impaction and there may not be any symptoms, can be complete bony

impaction and not be any symptoms. A patient comes in, they discuss with us what they would like to have done that day, basically.

Q. Can you tell me, from your notation of August 30, 1994, what Kimberly Echols' complaints were on that day?

A. Tooth No. 32.

Q. Was she complaining of pain?

A. Yes, sir.

Q. How can you tell me that?

A. Because she came in for a particular procedure. If there was anything else, I would have notated it.

Q. If a soft-tissue extraction is required, other than pain, what would a patient complain about?

A. It would be a number of complaints. A patient could come in and complain about the services of another doctor, about the way the teeth are positioned

Q. I mean physical complaints.

A. You're referring to physical complaints? I don't understand.

Q. Is there anything other than pain that patients complain about?

A. Yes, but there's a number of them. I just can't recall them offhand.

Q. Okay. Why don't you tell me what you remember offhand.

MR. HULME: Mark, what are you trying -- I don't understand what your question is or what you're trying to ask. Are you asking what things can lead to the extraction of a wisdom tooth?

MR. RUF: Right.

MR. HULME: Like what things might --

BY MR. RUF:

Q. When a patient comes in, you discuss the patient's condition with the patient; is that correct?

A. The patient comes in and informs us what they would like to have done.

Q. You don't decide what needs to be done as a dentist?

A. We advise the patient. The patient makes the decision of what they would like to have done.

Q. Well, a patient may come in, they may say they're having throbbing pain in a tooth, they may say they're having fever, they may say they're having some other types of problems. Do you document those types of problems in the record?

A. With the oral examination, yes, if they decide to have that.

Q. If they don't have an oral examination, then you don't document those types of problems?

A. We take care of that particular problem for them. It's a limited oral examination, we call them, because the patient doesn't want anything else done but to take care of that particular problem.

Q. Do you know if on August 30, 1994, Kimberly Echols was complaining of a fever?

A. No, I don't recall that.

Q. Do you know what type of pain she was having? Was it throbbing pain, a dull ache?

A. I can't recall that.

Q. Do you know, was she having pain in any other teeth, or was it only No. 32?

A. From my notes, there is only an indication it was No. 32, area No. 32.

Q. Do you know where -- according to your records, were there any particular problems with tooth No. 32?

A. It was a soft-tissue impaction.

Q. Any other problems?

MR. HULME: You mean other than she was complaining of pain?

BY MR. RUF:

Q. Right. Any other problems?

A. I don't recall any other problems.

Q. According to your notes, was there anything about the condition of the tooth that would make it unusually

difficult for a soft-tissue extraction?

A. No.

Q. What are the remaining notations for August 30, 1994?

MR. HULME: Why don't you just start at the top and go through them, because I don't know what the remaining ones would be.

BY MR. RUF:

Q. Why don't we start from the beginning. We have the date, then your doctor number, then the tooth number, and then what follows that?

A. She rescheduled --

MR. HULME: No. August 30, 1994.

THE WITNESS: Okay. We took an X-ray of the tooth.

MR. HULME: Okay.

THE WITNESS: We extracted tooth No. 32, which was a soft-tissue extraction. We gave medication and some antibiotics for pain and infection. Then we scheduled her for -- or suggested that she get an oral examination and prophy, cleaning of the teeth.

BY MR. RUF:

Q. What did she say in response to that suggestion?

A. I don't recall.
Q. Did you just take one X-ray, or more than one X-ray?
A. I just took one X-ray for that day.
Q. I'd like to hand you the X-rays that have been produced for me. Why don't you take a look at those?
A. (Witness complies with request.)
Okay.
Q. Are any of those the X-ray that was performed on August 30, 1994?
A. The lower X-ray, right here is tooth No. 32. (Indicating.)
Q. Why don't we mark that as Exhibit 6?
(Thereupon, Plaintiff's Exhibit 6 of the Barney Deposition was marked for purposes of identification.)
BY MR. RUF:
Q. You're telling me the X-ray that was taken on August 30th is the lower X-ray on Exhibit 6?
A. That's correct.
Q. Do you know what the upper X-ray is?
A. This is a postop X-ray taken after I saw her by another doctor.
Q. Was the only X-ray that was done on August 30th

the lower X-ray on Exhibit 6?

A. That's correct.

Q. What view is that? Is that a certain view?

A. PA X-ray.

Q. What does "PA X-ray" mean?

A. Periapical X-ray.

Q. Are there other types of radiographs?

A. Bite-wings, periapical X-rays, panorex.

Q. When do you use each of those radiographs?

A. Panorex we usually perform when we give oral examinations.

Q. Which type of X-ray?

A. Panorex.

MR. HULME: This, Mark.

BY MR. RUF:

Q. Okay.

A. Bite-wings are used basically to -- during oral examinations, to determine if there are any interproximal cavities, and periapicals are used to determine if -- we can see the entire tooth in its entirety and the bone structure around there.

Q. Can you see wisdom teeth with panorex, bite-wing and periapical?

A. Not with bite-wing, but with panorex we can see wisdom teeth.

MR. HULME: You can see the upper part of the wisdom teeth with bite-wing.

THE WITNESS: Yes, upper part, but sometimes -- all depends on the position, because sometimes we cannot include the wisdom teeth in the bite-wings.

MR. RUF: When you perform a radiograph, what do you look for in the radiograph?

MR. HULME: Like for what?

MR. RUF: What types of things are you evaluating from a radiograph?

MR. HULME: For what purpose are you taking it? I mean, he mentioned that usually this is for the routine exam. Are you talking about taking a radiograph when you're going to do an extraction?

BY MR. RUF:

Q. Do you look for aclusions?

A. You don't look for aclusions with X-rays.

Q. Okay. What do you look for with X-rays?

A. Any type of abnormality.

Q. What types of abnormalities will appear on X-rays?

A. What type of abnormality?

Q. Right.

A. You're looking for decay, abscesses at the apex of

the teeth.

Q. Anything else?

MR. HULME: Are you talking about the big picture?

BY MR. RUF:

Q. Right.

A. We look for, you know, the mandibular nerve. Orthodontists use it to see where the maxilla -- max jaw bones are, how they're positioned. They use them as measurements.

Q. When you are going to perform a tooth extraction, what types of things are important to look for in a radiograph?

A. Everything that you can see that can be a problem

Q. What types of things can be a problem?

A. Position of the tooth, extent of decay. If there is a large abscess, you may want to refer to that to make sure you get out all the abscesses, or refer --

Q. What types of problems do you have with the position of the tooth?

A. You have to determine how close it is to the nerve, where the position is to the adjacent tooth; you determine if you will be able to get a good adaptation to the tooth.

Q. So you agree that when you're performing an

extraction, it's important to evaluate whether there's going to be interference with the nerve or not?

A. Yes.

Q. And how do you do that on a radiograph? Can you show me on Exhibit 6 where the nerve is in relation to the tooth?

MR. HULME: Where a nerve is? I mean, there are a lot of nerves.

THE WITNESS: The nerve is right here. Right there. It's that dark line. (Indicating.)

BY MR. RUF:

Q. It's the dark area below the tooth?

A. Yes. That's the major nerve, mandibular nerve.

Q. Now, is the dark area actually the nerve, or is that just the cavity that the nerve is in?

A. That's the cavity the nerve is in.

Q. And what is that cavity called?

A. Inferior alveolar nerve.

Q. Is that a canal? Is there a name for that canal?

A. No, sir.

Q. Okay. Are there any other nerves in that area of the No. 32 tooth other than the nerve you've described?

A. There are nerves attached to all of the teeth. There are nerves to the teeth, to the cheek.

Q. I was asking specifically about tooth No. 32. Are there any other nerves?

MR. HULME: He just said there are, and he was outlining the ones that were.

BY MR. RUF:

Q. I thought he said there are nerves to each tooth.

A. They transfer from the inferior alveolar nerve. They're all connected to that.

Q. Where does that nerve supply come from?

A. The mandible goes straight up this way to the brain.

Q. What's the name of the nerve that runs down along the mandible?

A. The facial nerve.

Q. Is there any other name for that nerve?

A. No, but the facial nerve has branches. That's the main branch. You're referring to having the main nerve, and then the branches from that nerve go to certain sections of the head and neck.

Q. Starting from here, running down along the mandible, can you describe the nerves that run down along that area?

A. From the facial nerve?

Q. Yes.

A. You have the inferior alveolar nerve, you have the

buccal nerve. Those are the two main branches.

Q. What area does the inferior alveolar nerve supply?

A. The mandible and the tongue.

Q. Does it supply the molars in the back of the mouth?

A. It supplies all of the teeth in the mouth.

Q. Okay. What about the --

A. On the lower arch, that is.

Q. What about the buccal nerve, what does that supply?

A. The lip, the buccal mucosa, predominantly.

Q. Does the inferior alveolar nerve run along the complete area of the mouth up to the lip? I'm sorry. Strike that.

Does the inferior alveolar nerve run along the whole side of the face up to the lip?

MR. HULME: Are you talking about anatomically --

MR. RUF: Yes.

MR. HULME: -- where is it positioned?

THE WITNESS: The inferior alveolar nerve is in the mandible. There are two. You have a left one, you have a right one. It supplies the sensation, basically, up to probably about the first

bicuspid where you can numb that area efficiently, but a lot of times we may have to numb the teeth individually in the front to be sure, okay? So we usually know we have profound anesthesia up to the canine. The buccal nerve supplies the sensation to the lower lip up to about the midline and the inner cheeks and the buccal mucosa of the soft tissue gums.

BY MR. RUF:

Q. Does the inferior alveolar nerve run into the lip?

A. No.

Q. Okay. Where does that nerve end?

A. Around the midline, right here. (Indicating.)

Q. Okay.

A. The inferior alveolar nerve is in the jawbone, is the main branch for the lower arch that supplies all the sensation. The buccal nerve is the secondary nerve that gives particular sensation for this area, particularly around the lip, the buccal mucosa. (Indicating.)

Q. If I give you a blank piece of paper, would you be able to draw what you're describing to me?

A. I'll try.

Q. Okay.

A. (Witness complies with request.)

Excuse my artwork. I haven't done this in a while.

Q. That's fine.

A. It usually runs in this pattern. (Indicating.)

Q. Now, what have you drawn for me? Is that the mandible?

A. That's the lower mandible, and the inferior alveolar nerve is inside here, okay? (Indicating.)

Q. Okay. And that runs --

A. It's usually on the tongue side, the inferior alveolar. We have what you call "mental nerves" in the bicuspid area here where we can numb the tooth, bicuspid. The buccal nerve is usually in this area right here, around the third molar region, and that's the cheeks, this area here. (Indicating.)

Q. Why don't you write down "buccal nerve" where the buccal nerve is?

A. (Witness complies with request.)

This is on the outside of the mandible. It's not on the inside.

Q. Okay.

MR. HULME: He's trying to describe three dimensions on a two dimension piece of paper.

BY MR. RUF:

Q. I understand.

When you extract tooth No. 32, which nerves do you

have to worry about?

A. The inferior alveolar nerve.

Q. Are there any other nerves you have to worry about?

MR. HULME: From the extraction itself?

MR. RUF: Yes.

THE WITNESS: Predominantly, it's the inferior alveolar nerve.

BY MR. RUF:

Q. Okay. Would you agree that when performing an extraction of tooth No. 32, you want to cause as minimal trauma as possible to the inferior alveolar nerve?

A. Correct.

Q. Do you believe that it's appropriate dental care to use brute force to extract a tooth?

MR. HULME: Objection to the phrase "brute force." Are you asking if that's a dental term of art?

BY MR. RUF:

Q. Do you know? Do you understand my question?

A. Some doctors use brute force. I don't.

Q. Okay. Why don't you use brute force?

A. Because if I can't get it out with normal technique, then I have to refer it to the oral surgeon.

I don't believe in brute force.

Q. What kinds of problems can result from using too much force to extract a tooth?

A. The ultimate, for this particular procedure, would be the fracture of the mandible.

Q. What other kinds of problems are a potential?

A. Bruising of the soft tissue.

Q. Is damage to the nerve a potential problem?

A. Not with brute force, no. Brute force is just mild pressure being applied to the tooth.

Q. Well, how can damage to the nerve result from extracting a tooth?

A. It all depends on where the roots are on that tooth in position to the nerve, where you can impinge pressure on there, or the tooth can be -- the nerve can be severed or damaged.

Q. How is the nerve severed? How would you do that?

A. Usually?

Q. Yes.

A. Usually, the nerve is severed maybe with a high-speed instrument, or if the roots are wrapped around that nerve, it can be damaged.

Q. How would the root be damaged during an extraction as opposed to being severed?

A. I don't understand the question.

Q. Is there a way to damage the nerve other than severing it?
A. Basically, yes.
Q. And what type of damage could result to a nerve?
A. Paresthesia of that area where there are sensations from the nerve.
Q. Well, how could paresthesia result from a tooth extraction?
A. Nerve being severed or damaged. Sometimes -- there are various degrees of paresthesia.
Q. You used two terms. You used "severing," and then you used "damaged." What do you mean by the term "damaged"? Is the nerve bruised, is it nicked, what?
A. There are several levels of paresthesia. Sometimes you will get a sensation where it may last a couple of days, couple of weeks, couple of months, then it turns back to normal. Then "severed" is where it's permanent, where you don't have any more sensation. It's just permanent damage.
Q. Let's get back to August 30, 1994. Based on the chart, what did you recommend to Kimberly Echols?
A. Oral examination -- complete oral examination and cleaning.
Q. What did you recommend as far as the tooth extraction?

A. I don't recall.
Q. Do you remember any discussions you had with Kimberly Echols?
A. No, I don't.
Q. Do you remember whether you discussed potential risks and complications with her?
A. I went over the consent form with her, yes, and my assistant.
Q. You specifically remember doing that?
A. I do that with all of my extractions. That's just routine with me.
Q. Do you specifically remember doing that with Kimberly Echols, or are you telling me that that's your routine practice?
A. It's my routine practice to go over every consent form with the patient prior to extraction.
Q. Do you specifically remember doing that with Kimberly Echols?
A. No, I don't.
Q. You're just telling me that that's something you do with every patient?
A. I do that before I extract the teeth.
Q. Why do you do that?
A. So the patient is aware that if there are any complications or any problems to get in contact with me

immediately so we can resolve that problem.

Q. What are the potential risks or complications from extracting tooth No. 32?

A. Paresthesia, that's the ultimate problem. Can be some bleeding. Infection can develop in the area.

MR. HULME: Do you want to go through those?

MR. RUF: If you'd like, you can look at the consent form.

MR. HULME: Then I am going to object, because it speaks for itself. The client acknowledged having it, signing it, going over it. Do you want him to read it? Personally, 1 don't think it's necessary, but do you want him to read it?

MR. RUF: He said he goes over risks and complications with the patient --

MR. HULME: Right.

BY MR. RUF:

Q. -- orally, and I just want to know what he discusses. Maybe it's not specifically what's in the consent form.

A. Well, what we have the patient do, with all extractions, is that the patient reads the consent form, the assistant goes over the consent form with that patient, and then I come in before the extraction and go

over that consent form again with the patient to see if they have any questions concerning the dental procedure that we're about to perform.

Q. Do you think the consent form relieves you of the obligation to perform your dental care in an appropriate manner?

A. What the dental form -- consent form does is makes the patient aware of what type of procedure is going on, in general, and, if there are any problems, what they need to do, to come back to me so we can relieve it. With any dental procedure, you are taking a risk with an extraction, and you need to try and make the patient aware of it prior to the treatment.

Q. Do you think by signing this consent form that relieves you of any obligation toward the patient?

A. No. It helps with the treatment of the patient.

Q. Okay. So you would agree that even if the patient signs the consent form you still have an obligation to perform your dental care in an appropriate manner?

A. That's what this states.

Q. Well, the consent form states the potential complications from a procedure, correct?

A. That's informing the patient so that they have a good understanding of what they're going to get into. You can't predict what's going to happen during an

extraction.

Q. Would you agree that some complications that develop during dental procedures are avoidable?

MR. HULME: Are what?

BY MR. RUF:

Q. Are avoidable.

A. Some are and some aren't. It depends on, you know, the case. We handle each on an individual basis.

Q. Do you think this consent form relieves you of damage which occurs from an avoidable complication?

MR. HULME: Objection to the form of the question, in particular if you're asking for legal conclusions. I'm not exactly sure what you're asking.

BY MR. RUF:

Q. I'm asking, as a professional, what does he think this consent form means?

A. The consent form makes the patient aware that problems and complications can occur, and what we can do about them if they occur.

Q. But it doesn't relieve you of any professional obligation that you have toward the patient?

A. No.

Q. Given the condition of Kimberly Echols' tooth on August 30, 1994, can you tell me what risks were most

probable with that tooth?
A. I don't recall.
Q. Based on the X-ray you showed me in Exhibit 6, what can you tell me about the proximity of the nerve to tooth No. 32?
A. It's very close to the apex of tooth No. 32.
Q. And the apex is what part of the tooth?
A. The root tip.
Q. So was there a danger of damaging the nerve by extracting tooth 32?
A. If you didn't know what you were doing, yes.
Q. If you did know what you were doing, you should have been able to remove tooth No. 32 without damaging the nerve?
A. I felt I could have, yes.
Q. Do you know, was that tooth fully erupted?
A. No. It was a soft-tissue impaction. It wasn't fully erupted. It was still partially covered by the gingiva.
Q. Was it partially erupted?
A. Yes.
Q. Did you consider surgical extraction of that tooth?
A. No.
Q. Why not?

A. It wasn't indicated.
Q. Based on the radiographs, is there anything about that tooth that you think posed a special problem?
A. Uh-uh.
MR. HULME: You have to say yes or no.
THE WITNESS: No.
BY MR. RUF:
Q. Do you think the extraction of tooth No. 32 should have been a routine procedure?
A. No, it wasn't a routine procedure. It was a soft-tissue extraction. It's more than a routine procedure.
Q. Would you say it was a routine soft-tissue extraction?
A. It was a soft-tissue extraction.
Q. There wasn't anything abnormally difficult about extracting tooth No. 32 from Kimberly Echols, was there, based on the radiograph and your examination of the tooth?
A. Not anything extremely difficult compared to other soft-tissue extractions I've done, no.
Q. You've done soft-tissue extractions that were more difficult than the extraction of tooth No. 32 on Kimberly Echols; is that correct?
A. That's correct.

Q. You've done those without complications?
A. That's right.
Q. Based on your chart, were there any problems with extracting tooth No. 32 on August 30, 1994?
A. No.
Q. Do you specifically remember doing the extraction?
A. No, I don't.
Q. Did you examine the area in which the extraction occurred following the procedure?
A. I usually do. I don't recall, specifically, this case.
Q. What's the purpose of inspecting the area?
A. To evaluate the area.
Q. Would you agree that one thing you want to look for is whether the root tip is broken off?
A. Yes.
Q. And why do you want to do that?
A. To determine if you'd like to remove it or leave it and observe it.
Q. What are potential problems that can result from a broken root tip being left in the mouth?
A. Either you have a systemic condition or asystemic condition, one or the other. Only time will determine that.
Q. What are systemic and asystemic conditions?

A. Systemic is no problem at all, the patient -- asystemic is no problem at all, patient just goes about their normal routine, no problem. Systemic is where the patient will experience pain, and then you may have to consider going in there and removing it or referring to an oral surgeon to have it done.

Q. Based on your education and experience, are you capable of removing a root tip which is broken off in a patient's mouth?

A. Most I can, but there are certain ones where I would refer to an oral surgeon.

Q. What types would you refer to an oral surgeon?

A. Some that are deeply imbedded next to a nerve.

Q. If a root tip breaks off, is there a certain sound that's made when the tooth --

A. Not necessarily.

Q. Is there a snapping or a popping?

A. Sometimes, but not all the time.

Q. Well, you would be able to tell from examining the part of the tooth that had been extracted whether the tip broke off, wouldn't you?

A. In most cases, yes.

Q. When would you not be able to do that?

A. Well, the problem we have with third molars is that the morphology of their molars are different.

Sometimes you have fused roots; sometimes you have a fourth root that may not show up on the X-ray. So it's difficult to determine in certain cases.

Q. Well, if there's a substantial portion of a root tip left in the mouth, you should be able to tell?

A. Yes.

Q. Would you agree that one of the risks of leaving a root tip in the mouth is infection?

A. Yes.

Q. Will you be able to see a broken root tip on an X-ray?

A. Yes.

Q. Would you agree that if there is a broken root tip in a patient's mouth, that it's important to inform the patient that the tooth is broken off and there's a root left in the mouth?

A. Most times we do, yes.

Q. When would you not inform the patient?

A. Depending on the patient. Sometimes you do, sometimes you don't. It's difficult to say.

Q. How do you decide whether or not to inform the patient that a root tip is left in their mouth?

A. Just evaluate patient by patient basis.

Q. What method do you use for retrieving a broken root tip?

A. For me in particular, I use what we call an "east/west elevator" to remove a root tip.
Q. If you can't get it out with the east/west elevator, what would you do?
A. Refer to an oral surgeon.
Q. Do you know how they would remove the root tip?
A. I never watched them work. So I couldn't comment on it. Everybody has their own techniques.
Q. What is "paresthesia"?
A. Numbness or tingling sensation, loss of control of muscles, loss of taste sensation in that particular area.
Q. That results from damage to a nerve?
A. Severing of a nerve.
Q. Is there anything other than severing of a nerve which can occur to a nerve which can result in paresthesia?
A. Just damaging. Then you have the tingling sensation, and usually that disappears in a couple of days, couple of weeks, couple of months. It's difficult to say.
Q. What are the causes of paresthesia?
A. Severing of the nerve.
Q. Well, how can that result? From trauma? Would you agree that trauma can cause paresthesia?

A. Trauma will cause numbness, but if you are talking about paresthesia, then, you're talking about severing.
Q. Can trauma cause damage to a nerve?
A. Yes.
Q. What other kinds of things can cause damage to a nerve?
A. Like I said before, severing. You know, if you use a high-speed instrument, you sever the nerve, that can happen.
Q. Well, that's encompassed by the term "trauma," isn't it?
A. Yeah, but you asked me what other techniques.
Q. Is there anything other than trauma you can think of that could damage a nerve?

MR. HULME: Are you talking about generally, like degeneration, or medications?

BY MR. RUF:

Q. I just want to know -- I mean, if there's anything other than trauma that can cause damage to a nerve.
A. Yes.
Q. What types of things?
A. Anesthetic. If you insert the needle and you're very extremely close to a nerve, that can cause trauma to the nerve.
Q. Well, again, though, that's trauma?

A. Yeah.

MR. HULME: That's my question. I think you guys are -- you have in your mind, Mark, what trauma means to you, and he may have a different -- it's a definition thing.

BY MR. RUF:

Q. When we use the term "trauma," what does that term mean *to* you?

A. Trauma means bruising. Trauma is something that's temporary, not permanent.

Q. Then what term would you use for a permanent --

A. Paresthesia.

Q. -- condition?

Would you agree that if an extraction is performed improperly, that it can result in paresthesia to the patient?

A. Probably.

Q. If paresthesia results to a patient, how is that treatable, if it is?

A. I just refer it to an oral surgeon. An oral surgeon, you know, uses his skills and techniques.

Q. So would you agree, based on your education and experience, you're unable to evaluate whether there's treatment for paresthesia --

A. No.

Q. -- in a patient?
A. Paresthesia basically resolves itself. It may take even a couple of years, but we diagnose and then we refer to the appropriate individuals to treat that condition
Q. What are the potential treatments for paresthesia?
A. You have to ask an oral surgeon.
Q. So you can't tell me what the potential treatments are?
A. No.
Q. Would you agree that paresthesia can be permanent?
A. Yes.
Q. Do you know if the nerves that run along the mandible can regenerate?
A. No. To my knowledge, they don't.
Q. If a person is to regain feeling and they're suffering from paresthesia, generally, over what time period does it take for the paresthesia to resolve?
A. Depends on the case. You can't predict that.
Q. Would you agree that if someone has had paresthesia for more than a year, that's a permanent condition?
A. Depends on the case. You have to evaluate the damage.
Q. Would you say that it's more probable than that

that it's a permanent condition?

A. No. Sometimes it comes back after a year or two.

Q. Let's go back to the chart.

A. Okay.

Q. Let's look at the entry of September 1, 1994. Do you know under "doctor number" who that is?

A. That's Dr. VonBerger.

MR. HULME: Do you know how to spell it?

THE WITNESS: V-O-N-B-E-R-G-E-R.

BY MR. RUF:

Q. And based on the record, he evaluated tooth No. 32?

A. Yes.

Q. And that was the tooth you extracted?

A. Yes.

Q. Do you know, did he perform an X-ray?

A. Yes.

Q. And is that shown on Exhibit 6?

A. Yes.

Q. And is that --

MR. HULME: One of them.

THE WITNESS: That's the top X-ray, yes.

BY MR. RUF:

Q. Top X-ray?

A. Yes.

Q. Why don't you take a look at the top part of Exhibit 6?

A. (Witness complies with request.)

Q. What can you tell me from looking at that radiograph, as far as tooth No. 32?

A. There is a root tip left.

Q. Would you say that it's a substantial part of a root tip?

A. Yes.

Q. And with a root tip that's left of that size, when you're performing an extraction, you should realize that that root tip was left in the mouth?

A. Yes.

Q. Do you remember whether you realized that a root tip was left in Kimberly Echols' mouth?

A. No.

Q. Do you ever perform radiographs following a tooth extraction?

A. No.

MR. HULME: You mean in an asymptomatic tooth?

BY MR. RUF:

Q. I'm asking do you ever perform radiographs following a tooth extraction?
A. Sometimes, yes.
Q. When would you do that?
A. When we determine if we removed the entire tooth, looking for the abscess, things of that nature, see what damage is on the adjacent tooth.
Q. If you think a root tip is broken off, do you perform radiographs?
A. No, not necessarily. It's a judgment. A lot of times you may want to sit back and observe it and see if there's an asymptomatic problem; if there's not, you just observe until that problem comes.
Q. Can you tell from your records whether Kimberly Echols was asymptomatic on August 30, 1994 following the extraction?
A. No. She would have still been numb when I did that. She wouldn't have any problems until after the numbness wears off.
Q. You couldn't tell whether or not she was asymptomatic during the office visit?
A. I wouldn't be able to remove the tooth if she was asymptomatic. She would have to be numb.
Q. Okay. Since she was numb, she wouldn't be able to feel anything around that area of the tooth, would she?

A. That's correct.
Q. And what area would be numbered to perform the extraction?
A. The right side of the mandible.
Q. So would it be the whole side of the face?
A. Not the whole side of the face.
Q. Okay.
A. Sometimes it can be a tingling sensation up to the ear, but nothing would affect the eyes, just the lower portion.
Q. Why don't you draw -- let's mark this Defendant's Exhibit 7.

(Thereupon, Plaintiff's Exhibit 7 of the Barney Deposition was marked for purposes of identification.)

BY MR. RUF:
Q. Why don't you draw on Exhibit 7 the area you would have numbed on Kimberly Echols.
A. I'll use a dotted line. Generally, that area. (Indicating.)
Q. So it would be in between the dotted lines that you've drawn on Exhibit 7?
A. Yes.
Q. Would you agree that if she suffered damage to the

nerve during the extraction, she would not have been able to feel that because the area had been numb?

A. Yes.

Q. Let's go back to the record, the entry for September 1st. Why don't we go over what the note says? Could you read the note out loud, please?

A. "Patient has right mesial root left where No. 32 was extracted; refer to oral surgeon. Prescription for Darvocet plus times 20, and Amoxicillin 500 milligrams times 20. Panorex, two PA's, next visit remove root tip."

Q. Do you know why Kimberly was referred to an oral surgeon?

A. No. I mean, I wasn't there during the time. No, I can't, you know --

MR. HULME: You mean other than to remove the root tip?

BY MR. RUF:

Q. Right. Would it be to have the root tip removed?

A. Yes.

Q. You said a prescription for Darvocet?

A. Yes.

Q. What's that for?

A. Pain medication.

Q. And then what is the other -- Amoxicillin?

A. That's an antibiotic.
Q. And that's to prevent infection?
A. Yes.
Q. Were any other medications prescribed at that time?
A. Just those two I see on that day.
Q. I'm sorry?
A. Just those two medications I see on that day.
Q. Then, on the last line, what does that say?
A. "Sent infor. to BW."
Q. What does that mean?
A. I don't know what "BW" means.
Q. Do you know who made the entry of 10/21/94?
A. The office manager at Euclid Square Mall, Sheila Calvetta.
Q. Which doctor did you say made the entry of September 1, '94?
A. That was Dr. VonBerger.
Q. Do you have any criticisms of what Dr. VonBerger recommended?
A. No.
Q. Do you believe that's an appropriate recommendation, to refer her to an oral surgeon to remove the root tip?
A. If he couldn't do it, yes, he referred to an oral

surgeon.

Q. Did you consider sectioning tooth No. 32 on Kimberly Echols?

A. No.

Q. Why not?

A. The tooth wasn't damaged.

Q. Is that the only time you section a tooth to remove it, is when it's damaged?

A. Most of the time, yes. If there's an extensive amount of decay or if the tooth is endodontically treated, we know it's going to break up, we section it.

Q. Do you ever section a tooth if the tooth is in close proximity to the nerve?

A. No.

Q. Why wouldn't you do that?

A. I just don't, because I don't want to sever the nerve with a high-speed instrument. You never know how far you're going to go down there with it. So I'd rather do it the normal way of elevating it, removing the pressure off the nerve.

Q. Is there any way to section a tooth without using a high-speed instrument?

MR. HULME: Hammer and chisel.

THE WITNESS: I don't know

what they used to perform with without a high speed, but that's the way I was taught.

BY MR. RUF:

Q. So you don't know of any other way besides using a high-speed instrument?

A. For surgical extraction?

Q. Right, to section a tooth.

A. That's what everybody uses for surgical extraction, a high-speed instrument

Q. Okay. If a molar is in close proximity to the nerve, what would you do to reduce the potential of trauma to the nerve?

A. Elevate the tooth.

Q. Anything else?

A. That's what you would normally do, elevate the tooth.

Q. Let's go over these other X-rays.

A. Okay.

Q. Why don't you mark those, too, as well?

MR. HULME: I believe they are the same.

THE WITNESS: Yes, that's correct.

MR. RUF: Let's just mark

the better copy

(Thereupon, Plaintiff's Exhibit 8 of the Barney Deposition was marked for purposes of identification.)

BY MR. RUF:

Q. Could you take a look at Plaintiff's Exhibit 8?

A. (Witness complies with request.)

Okay.

Q. First of all, what view is that?

A. This is a panorex film, whole mouth X-ray.

Q. That shows all the teeth in the mouth?

A. Yes.

Q. Is there anything significant about that X-ray?

A. Just a root tip in the area of 32.

Q. Anything else?

A. Tooth No. 17 is missing.

Q. Anything else?

A. Just amalgam restorations.

Q. Anything else you notice about that?

A. That's it.

(Whereupon, Attorney Hulme pointed to something on the document.)

THE WITNESS: That's from development, I think.

BY MR. RUF:

Q. What are you referring to?

A. This right here, that's just from development. (Indicating.)

Q. That's a defect in the radiograph?

A. Yes.

Fingerprints here on the side. (Indicating.)

MR. HULME: Probably from copying.

BY MR. RUF:

Q. Do you know when that X-ray was taken?

A. I assume this is the X-ray -- the panorex that Dr. VonBerger took, because there's no other indication before that a panorex was taken.

Q. So it appears that Dr. VonBerger took both a periapical view and a panorex?

A. Yes.

MR. HULME: He testified there were two periapicals and one panorex dated September 1, '94.

THE WITNESS: Yes.

BY MR. RUF:

Q. There were two periapicals taken?

A. Yes.

Q. Do you know where the other periapical is?

A. No, I don't.
Q. Let's go to the last entry on the chart, November 21, '94.
A. Mm-hmm.
Q. Do you know what that notation is?
A. "Sent pano to BW." Same entry as 10/21/94 by the office manager.
Q. Do you know if these are the complete records of American Dental Centers?
A. To my knowledge, yes.
Q. If a patient is experiencing paresthesia of the lip, what nerve would be involved with that?
A. Buccal nerve.
Q. That would not involve the inferior alveolar nerve?
A. Yes, it would, but with damage to the inferior alveolar nerve, you also have numbness to the tongue -- that whole side, the lip, the tongue, the buccal mucosa.
Q. So in order for the inferior alveolar nerve to be involved, you also have to have numbness to the tongue and then the mucosa?
A. (Witness nodding head up and down.)
And the lower lip on that side.
Q. Is it possible to have damage to the inferior alveolar nerve and only have it affect a patient's lip?

A. To my knowledge, no.

Q. According to your drawing, the buccal nerve is not anywhere near tooth No. 32, is it?

A. Yes.

Q. Okay.

MR. HULME: Let's get -- make sure -- "is it near," it comes out yes or no. That's one of those negative questions. "Is the buccal nerve near tooth No. 32?"

BY MR. RUF:

Q. Okay. Is the buccal nerve near tooth No. 32?

A. Yes.

Q. Let's look at Exhibit 6, the lower radiograph.

A. (Witness complies with request.)

Q. The dark cavity area that we discussed that houses the nerve supply, does that encompass the buccal nerve and the inferior alveolar nerve?

A. No.

Q. It only encompasses the inferior alveolar nerve?

A. That's correct.

Q. Can you tell by looking at Exhibit 6 whether the buccal nerve is in close proximity to tooth No. 32?

A. No.

Q. How would you do that? Can you do that from a radiograph?

A. No.

Q. How would you evaluate the proximity of the buccal nerve to tooth No. 32?

A. Unless you make a flap and remove the soft tissue and you see where the orifice is, but it doesn't show up on the PA's.

Q. So you would have to do that surgically and then by oral examination?

A. No, you can't see it orally.

MR. HULME: Surgically open up the flap and then look?

THE WITNESS: Oh, yes.

BY MR. RUF:

Q. You would have to use a surgical procedure first, and then --

A. That's correct.

Q. -- and then observe it visually?

A. You wouldn't be able to see it visually. You would see the orifice, but you wouldn't see where the nerves are.

Q. So you just look where the orifice is and make your evaluation based on that?

A. Right. Same thing with the mental nerve.

Q. If the buccal nerve was in close proximity with the tooth, do you believe that it would be appropriate

to remove the tooth?

A. Yes.

Q. And should you be able to remove the tooth without damaging the nerve?

A. Yes.

Q. And that's even if the nerve is in close proximity to the tooth?

A. Yes.

MR. HULME: Are you almost done, Mark?

MR. RUF: I only have a little bit.

MR. HULME: Take your time. I have a 12 o'clock meeting and I am going to find out where it is and send people on their way.

(Thereupon, a discussion was held off the record.)

BY MR. RUF:

Q. Back on the record.

If a patient has numbness and tingling from their ear to the center of the jaw, what nerve would be affected?

A. Inferior alveolar nerve.

Q. Have you read the report of Judith Wheeler?

A. Yes.

Q. Is there anything you disagree with in her report?
A. Yes.
Q. Do you want to see a copy of her report?
A. Yes.
Q. Why don't you read over the report and tell me what you disagree with and why.
MR. HULME: Do your best.
THE WITNESS: One of the reasons is that she said that Doctor -- that Ms. Echols returned the next day. It was actually two days afterward. That's incorrect.

She states here that the difficulty in paresthesia is with the right inferior alveolar nerve.

BY MR. RUF:
Q. Why do you think that is inaccurate?
A. Well, actually, if it's the inferior alveolar nerve, the tongue, lip, cheeks, everything is going to be numb over there. If it's just the lip, it's the buccal nerve.
Q. Okay.
A. "Failure to adequately, completely and atraumatically extract tooth No. 32."
Q. Why do you disagree with that?
A. Simply because when I do soft tissues, there's generally no trauma there. If I am going to have a

complication, I am going to refer to an oral surgeon.

Q. So you would agree that with a soft-tissue extraction there shouldn't be any trauma to the nerve?

A. Generally, no. If there is, then I make that decision before I even do it, and I refer to an oral surgeon.

MR. HULME: So you feel you did adequately, completely and atraumatically extract No. 32 to the extent that --

THE WITNESS: Right.

MR. HULME: -- the structure --

THE WITNESS: We were going to have her come in for follow-up.

BY MR. RUF:

Q. If there's a potential of trauma --

A. Then I'll --

Q. -- from extracting the tooth, then you would refer that to an oral surgeon?

A. Right.

Q. Let's continue. Any other areas in which you differ in your opinion?

A. "Failure to advise Ms. Echols of the nature of the incomplete extraction and the need for additional treatment." That's what we went over prior to.

"Failure --"

Q. So you're saying that you went over the potential for that complication prior to the procedure?

A. She read it. We went over it twice with her.

"Failure to adequately treat --"

Q. Excuse me. Let me ask you another question. I'm sorry. Did you discuss with Ms. Echols that there was a root tip left in her mouth following the extraction?

A. I don't recall exactly, but I probably did. So --

Q. But you have no specific recollection?

A. No, because this procedure probably only lasts about 15 minutes.

"Failure to adequately treat or timely refer the postoperative complications." That's incorrect. She was referred to an oral surgeon two days afterwards, and she was --

Q. I'm sorry.

A. And she was given medication both times by me and Dr. VonBerger.

Q. But she was referred postop by another dentist?

A. Of our office, yes. She didn't see me at the time.

Q. Okay. Generally, how long does a soft-tissue extraction take?

A. Up to 15 minutes. It all depends on the position

of the, you know, tooth and the morphology of the tooth, where it's positioned, adjacent to.

Q. Has it ever taken you an hour to do a tooth extraction?

A. No. If I can't remove it in 15 minutes, 20 minutes, I refer.

Q. So based on your dental opinion, if you can't remove a tooth in 15 or 20 minutes, then you need to refer it to an oral surgeon?

A. No, normally I do, because that's an indication it's more involved, and I'd rather have an oral surgeon take care of that, because this is what he does routinely.

Q. Have you reviewed the records of Case Western Reserve?

A. Yes, I have.

Q. Do you want to take a look at the records? I want to ask you a couple of questions.

A. Okay.

Q. First of all, I want to ask you if there's anything you disagree with about Case Western Reserve's records?

A. It's difficult to read.

Q. It is for me, too.

A. That's about it.

Q. Are you able to read what the record says?
A. I'm able to make out some of this, yes
Q. What do you think the first notation says?
A. "Twenty-nine-year-old had impacted tooth extracted, No. 32, at American Dental Centers by Dr. Barney." Looks like, "Referred to oral surgeon -- refer to oral surgeon," something like that.
What else do you want to know?
Q. Is there anything else there you can read?
A. "Nos. 1 and 16 fully impacted." I think it's "general anesthesia. No. 32 removal of root tip, mesial. Patient was given Amoxicillin prescription."
Q. So based on the dentist's or oral surgeon's note, they removed the root tip for tooth No. 32?
A. Yes, surgical extraction of root tip.
Q. Is there any notation in there about nerve damage or damage to the nerve during the procedure?
A. On 8/2, no -- 9/2, no. The only time I see damage here is on 9/13 where chief complaint of patient is the tissue healing well. Slight paresthesia on right mandibula.
Q. Where would the location of that be according to the record?
A. On the date 9/13/94, when the oral surgeon extracted 1, 16 and 32.

Q. Where would the paresthesia be according to the record?
A. She says of the lip.
Q. Okay.
A. And informed patient of that, and said she was going to observe it, see if any problems develop. At the bottom.
Q. Were there any of American Dental Centers' employees present during your extraction on August 30, 1994?
A. Yes.
Q. Who was present besides you?
A. Anthony Morris
Q. And who is he?
A. He was the dental assistant that was employed by us.
Q. Is he still employed by American Dental Centers?
A. He is in the service right now.
Q. Do you know where he is?
A. He's in the Navy.
Q. So he probably wouldn't be available, would he?
A. (Witness shrugging shoulders up and down.)
Q. Anyone else present other than Anthony Morris?
A. That's the only one indicated on my record.
Q. Is it routine practice to have somebody other than

the dental assistant present during an extraction?

A. No, just the dental assistant.

Q. Do you remember whether you had any social plans on August 30, 1994?

A. No.

Q. Do you know if Kimberly Echols' appointment was the last appointment of the day?

A. No. From the record, she was a walk-in, from my understanding.

MR. RUF: That's all I have.

MR. HULME: You have the right to read it, if it's typed up, or you can waive that right. Forget it. We're not going to waive it.

(Whereupon, the deposition was concluded at 12:09 p.m.)

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C E R T I F I C A T E

STATE OF OHIO,)
) *SS:*
SUMMIT COUNTY,)

I, Carina L. Cecconi, a Registered Professional Reporter and Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within named witness, MITCHELL V. BARNEY, D.D.S., was by me first duly sworn to testify the truth, the whole truth and nothing but the truth in the cause aforesaid; that the testimony then given by him was by me reduced to Stenotypy in the presence of said witness, afterwards prepared and produced by means of Computer-Aided Transcription and that the foregoing is a true and correct transcription of the testimony so given by him as aforesaid.

I do further certify that this deposition was taken at the time and place in the foregoing caption specified, and was completed without adjournment.

I do further certify that I am not a relative, counsel or attorney of either party, or otherwise interested in the event of this action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Akron, Ohio on this 4th day of October, 1995.

Carina L. Cecconi

Carina L. Cecconi
Registered Professional
Reporter and Notary Public in
and for the State of Ohio

My commission expires February 28, 1999

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