Doc. 256

IN THE COURT OF COMMON PLEAS

CUYAHOGA COUNTY, OHIO

HOWARD L. AXELROD, et al.,

Plaintiffs,

-vs-

JUDGE KZLCOYNE
CASE NO. 220922

MARK KRIWINSKY, D.D.S,
Defendant,

- - - -

Deposition of CLARENCE KREBS, D.D.S., taken as if upon cross-examination before Lynn A. Kanitsky, a Registered Professional Reporter and Notary Public within and for the State of Ohio, at the offices of Gallagher, Sharp, Fultin & Norman, Seventh Floor Bulkley Building, Cleveland, Ohio, at 2:50 p.m. On Tuesday, February 9, 1993, pursuant to notice and/or stipulations of counsel, on behalf of the Plaintiffs in this cause.

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On behalf of the Plaintiffs;

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On behalf of the Defendant.

CLARENCE KREBS, D.D.S., of lawful age, called by the Plaintiffs for the purpose of cross-examination, as provided by the Rules of Civil Procedure, being by me first duly sworn, as hereinafter certified, deposed and said as follows:

CROSS-EXAMINATION OF CLARENCE KREBS, D.D.S.

BY MS. TRICARICHI:

Q. Dr. Krebs, my name is Carla Tricarichi and I along with Tim Clements represent the plaintiff Howard Axelrod in this matter. I'm going to take your deposition.

I presume you're familiar with how a deposition goes and what the format is; is that a fair statement?

A. Yes.

Q. So I don't really need to go into much detail.

If you don't understand any of my questions I'll be happy to rephrase them. Otherwise I'll have understood you to have understood them and you will have answered them.

Doctor, can you state your name for the record?

A. Yes. My name is Clarence, middle name is George, Krebs, K-r-e-b-S, Jr.

Q. And can you tell us, first, your residence address?
A. My residence address is 30611 Timber Lane, Bay Village 44140.
Q. Can you give us your professional address?
A. My office address is 22255 Center Ridge Road, Rocky River, Ohio. The practice I'm associated with also has an office in Sandusky, Ohio, 1322 Milan Road, M-i-l-a-n, Sandusky, Ohio.
Q. That's a pop quiz.
A. Yes. And I am currently on leave of absence from that office, so my current professional address is Case Western Reserve University School of Dentistry.
Q. You are on leave for your practice entirely in either location?
A. Correct.
Q. Can you tell me what your occupation is?
A. My occupation has been as an endodontist,
Q. Until?
A. Until officially June, end of June of this year.
Q. Of '92?
A. Yes.
Q. Prior to that you have practiced with the group that is on your letterhead?

A. That's correct.
Q. Endodontic Associates?
A. Correct.
Q. How long had you practiced with that group?
A. 21 years.
Q. Had you practiced with anyone else prior to that?
A. Yes. I had practiced with Dr. Robert Fox in Chicago, for a year-and-a-half.
Previously by myself,
Q. When you practiced with Dr. Fox were you also practicing as an endodontist with Dr. Fox?
A. Yes.
Q. What's your current position at Case Western Reserve?
A. My current position is acting director of endodontics at Case Western Reserve.
Q. Tell me what that entails.

Q
A Those are individuals who have graduated from dental school, have a DDS degree, are going on for additional training that are qualified under

the American Dental Association guidelines.

Q. Sort of akinship to a fellowship in the medical field?

A. I'm not sure if that's a good analogy. The American Dental Association has set up rules for graduate training and people must meet these educational requirements to declare themselves a specialist.

Q. After you finish your four years of dental school, you graduate with a DDS; is that right?

A. From Case Western Reserve, yes.

Q. I'm talking about the institution, let's refer to the institution where you are.

Then there's a subsequent training available in endodontics?

A. Yes.

Q. Can you tell me how long that training is?

A. It's a two-year program.

Q. When you graduate from that training, what type of degree do you get or receive?

A. They receive a master of science degree and a certificate in endodontics.

Q. Then is there any kind of certification or national test that these grads take?

A. There's no required national testing.

Q. There's none whatsoever, it just doesn't exist?
A. They are not required. in any way to take any additional tests after that point in time. There may be state requirements for specialties and so forth.
Q. Are there any that exist?
A. There are tests that exist, both in terms of state government, some states have specialty board examinations.
Q. Is there a special board examination in endodontics?
A. Not in Ohio. There is, the American Association of Endodontists does have a board called a national board which also, as a volunteer, may be taken.
Q. Olay. Are you board certified by that board?
A. I am not.
Q. Can you give me your educational background, doctor?
A. Starting with college I would assume?
Q. College is fine.
A. T attended Western Michigan University for two years. 'Then I attended Case Western Reserve University. I have a bachelor's degree from Case Western Reserve University and doctor of

dental surgery from Case Western Reserve University.

The DDS was 1967.

The additional education I've had, I had graduate training in endodontics at the University of Illinois which was from 1969, 1971, two academic years

Q. In those two years were you in a hospital setting, doctor, primarily?

A. No. It's primarily in the university setting. It was a hospital component, but it was primarily in the university.

Q. Is that where you developed your specialization in endodontics?

A. Yes.

Q. I'm sorry, that was what university?

A. University of Illinois.

Q. Did you graduate then after that course of, that two-year course of study with --

A. Yes, With a certificate in endodontics.

Q. Okay. Thereafter, where did you go after 1971?

A. After 1971 then I began the, what developed into this group of Endodontic Associates. I started out by myself and subsequently took other individuals into the practice.

Q. Your work with Dr. Fox then was during the '69, '71 period?

You were not in private practice, you were a fellow or graduate student of some kind?

A. Yes.

Q. Is your leave indefinite with your practice?

A. Yes, at this point.

Q. So this is sort of a new profession for you now?

A. Yes, new in terms of doing it as a full time thing, yes --

MR. SMITH: *Go* ahead.

A. -- exclusive thing. I have taught at other times.

Q. Can you tell me about your teaching background?

A. My teaching background was in 1971 and 1972, academic year. I was a clinical instructor at Case Western Reserve on a two day a week basis in conjunction with starting my practice.

Subsequent to that, I have, over the years, given a number of lectures at Case Western Reserve, but only on an informal, or occasional basis.

Since July 1, I have been there exclusively directing the graduate program, July 1, 1992.

Q. So before 1992 you were working to be a lecturer of some type?
A. Yes.
Q. Did you have an academic appointment?
A. No academic appointment,
Q. Are you presently on the staff of any hospitals?
A. No.
Q. Can you tell me what professional societies you aie a member of?
A. I'm a member of the American Dental Association. The Ohio Dental Association. Greater Cleveland Dental Society. American Association of Endodontists, Ohio Association of Endodontists.

A number of other study clubs, local study clubs, et cetera, but those are the main, large groups.

Q. When you say local study clubs you don't have to detail them, but are they clubs in which you do any kind of research in endodontics?
A. No. They are not specifically endodontic groups.
Q. Can you tell me what they are?
A. They are groups that generally will have mixed group dentists with various specialties that will have a monthly meeting with a speaker. Most

of them do qualify for the Ohio State --
Q. Continuing?
A. Continuing education type things, yes, exactly.
Q. I understand. What professional publications do you subscribe to?
A. Journal of the American Dental Association and Journal of endodontics, Plus Oral Surgery. Oral Medicine, Oral Pathology.
Q. Are you published, doctor?
A. No.
Q. Now, other than the documents that you have shown to me, that is approximately three depositions; Dr. Kriwinsky, Dr. Krell, Mr. Axelrod, the original chart and your report, your retention letter from Mr. Smith, the continuance letter, the complaint, plaintiff's answers to interrogatories, production of documents, Kaiser Hospital records, St. Luke's Hospital records, Kaiser Hospital records, Drs. Berk and Grady, Smilovits, Flores. A Letter from Dr. Kriwinsky, a letter from Dr. Krell; is there anything else that you have reviewed in your preparation of this case?
A. I've reviewed some various textbooks specifically with regard to this case.

Q. Can you tell me the names of those textbooks?
A. I've reviewed two endodontic textbooks, Principle and Practice of Endodontics.
Q. Does it have an editor?
A. Dr. Walton and Torabinejad. If you ask me to spell it I'm going to look up on Mark's wall up there because he's got it.
MR. SMITH: The green one?
A. Next to the one that says Orthodontics, if she needs a correct spelling.
Q. It's worse than my name.
A. I also have reviewed some oral surgery texts.
Q. Can you give me the names of those texts?
A. One is Oral and Maxillofacial Surgery, Archer is the author. And I'm uncertain of the other names to give you an exact quote.
Q. You can't tell me what the other books are?
A. I can't give you an exact quote of the title.
Q. If you reviewed your records at your office, would you be able to tell me what those other quotes are?
A. Absolutely.
Q. Could you give that information to Mr. Smith so that he can provide it to me?
A. Yes.

Q. Doctor, do you consider the text that you've mentioned, along with whatever other texts you reviewed in your office, which you can't recall right now, to be authoritative in the area of endodontia; is that the correct term?
A. Yes, endodontics, Certainly the endodontics texts are very representative. There are numerous textbooks available. This is a highly respected textbook and it happens to be the one that you have in your hand is the basic --
Q. Principles and Practice --
A. -- text that I use in the graduate program,
That's not to say that any single textbook isn't an authority. The other textbooks are really respected, well known texts in oral surgery that are or have been used in oral surgery programs as reference texts.
Q. Can you tell me specifically in what capacity you used, for example, this Principle and Practice of Endodontics in your evaluation of this case?
A. Yes, I used it just to have a couple of references regarding the fact, for instance, that this type of an occurrence does occur.
Q. When you say this type of occurrence, what type

of occurrence are you talking about?

A. The type of occurrence we are discussing in this case, swelling and discomfort after endodontic treatment.

Q. Are you referring specifically to Ludwig's angina or the symptoms of swelling?

A. No. I'm referring to the fact that post-root canal treatment occasionally there is swelling and discomfort.

MR. SMITH: I want the record to reflect, despite the fact she's a Democrat, I'm letting Carla use my book, that I paid €or.

MS. TRICARICHI: That you paid for did you say?

MR. SMITH: Yes.

MS. TRICARICHI: I thank you, Mark, that's very generous of you.

MR, SMITH: Your welcome, It's my new spirit of cooperation.

MS. TRICARJCHI: That's very good.

MR. SMITH: Coming down from the mountain into the valley to help.

MS. TRICARICHI: In the valley, that's where I am, to help?

Q. Okay. Doctor, I think you used the word, did you say which occasionally occurs?
A. Yes.
Q. The swelling?
A. Yes. I would accept the word occasionally.
Q. Is that based on your clinical practice that you say that?
A. That's based on clinical observation and textbooks.
Q. Before I get into your practice, let me ask you a few more --
A. Certainly.
Q. - background questions,
Other than these texts, there's nothing else you reviewed, any other publications that you reviewed?
A. Not specifically for this case, no.
Q. You just have a normal reading --
A. yes
Q. -- of these --
A. Yes.
Q. -- publications?
A. There are a great number of publications and articles which may have some bearing, but were not reviewed specifically for this case.

Any particular articles you are referring to that have a bearing?

A. No not that I can think of right offhand.

Q. If any of them come to mind please provide Mr. Smith with them,

A. Yes.

Q. Have you only prepared one report in this case?

A. Yes, that is correct.

Q. And that is the report of August the 14th, 1992?

A. Yes.

Q. Can you tell me, doctor, have you ever served as an expert in other cases before?

A. Yes, I have.

Q. Can you give me an idea of how many cases in which you have served?

A. I would say five or six. I'm not certain of the exact number, but approximately that.

Q. Have you worked with Mr. Smith and his firm before?

A. I have worked with one member of his firm before, yes.

Q. Who would that be?

A. Mr. Auciello.

Q. Another Italian, Ernie Auciello.

Was that a dental malpractice case as well?

A. Yes.
Q. Can you tell me something about the facts of that case?
A. Well, let me think about that one.
Gosh, I'm hard pressed to give you details, to be very honest with you, it was about three years ago.
Q. Do you remember the name of the case?
A. No, 1 do not.
Q. Did you give a deposition in that case?
A. Yes.
Q. You don't remember the name of the defendant or the plaintiff?
A. No, I don't.
Q. Okay.
A. He may be able to find that out for you, Mr. Smith may be able to find that out for you.
Q. You testified. on behalf of the defendant in that case?
A. Yes.
Q. Did you also have testimony in court?
A. Yes.
Q. Would your records, whatever records you keep, indicate the caption of that case?
A. I'm uncertain if I have that.

Q. Well, again, I would ask you to search your records and see if you could find that for me. Was it in this county?
A. No, it was not.
Q. What county was it?
A. Geauga County.
Q. You said there were approximately five or six, can you tell me about some of the other cases?
A. One of the cases was a case in which I was retained as an expert for the plaintiff to give an opinion. Again, I cannot give you that name,
Q. Do you remember the name of the lawyer?
A. Yes, George which I wrote an opinion for him and as far as I know, it did not progress to --
Q. \in~didn't testify in that case?
A. T did not give a deposition, I merely wrote an opinion as an expert.

I also represented a plaintiff in an additional case in which Mr. Smith was sitting on the other side of the table. And I don't know that case either, but he may be able to help us.

Q. Who was the plaintiff's counsel in Lhat?

MR. SMITH: Dominic Finucchi.

A. Dominic Finucchi, you are right.

I'm currently involved in a case, I've been retained by Sam Butcher, and that is representing a plaintiff in a case.

Q. Sam Butcher is the lawyer?

A. Yes.

THE WITNESS: With Stewart and DeChant; is that right?

MR. SMITH: Yes.

A. Down the street.

Q. Now, the case in which Mr. Finucchi was involved, can you tell me anything about the facts of that case?

A. The facts were really totally unrelated to this case, it was involving a breakage of an endodontic instrument in a tooth.

Q. Did you testify in court in that case?

A, No, I believe that was settled.

Q. Did you testify in deposition?

A. I did give a deposition in that case, yes.

Q. Excuse me, and the case with Stewart and DeChant, have you testified at all in that case?

A. No, that's still in progress, but I have given a deposition in that case.

Q. Can you tell me what the subject matter of that case was?

A. The subject matter of that case is that I'm one of a group of experts who are testifying and the case involves a complete reconstruction of the patient's mouth and I'm testifying regarding the condition of the teeth at the time of reconstruction.

Q. The defendant, is it a general dentist?

A. Yes.

Q. Any other cases in which you have served as an expert?

A. Yes. I was involved in one other case and I was involved as an expert. Well, I'm not sure that I mould say I was involved as an expert, that may be inaccurate. I did testify in the case, it was as a witness for the defense in a malpractice suit, involving a patient that I had treated, but the testimony was really peripheral *to* the actual endodontic treatment.

Q. Is this a patient in which a general dentist was the defendant and the general dentist had referred the case to you?

A. Yes.

Q. Were you being sued or was the general dentist?

A. No, the general dentist was.

Q. So you served as, perhaps as a fact witness and

as an expert witness?

A. As a fact witness and certainly, I don't believe that my testimony would be considered as an expert witness. Again, that's a legal question that I don't answer.

But that was a situation in which I did testify during the trial.

Q. Okay.

A. That was in Common Pleas Court in Cuyahoga County.

Q. In Cuyahoga County?

Can you tell me again, do you know the name of the dentist?

A. The dentist was Nahigian. N-a-h -- oh, gosh. I g-i-a-n, or something of that nature, Nahigian. I don't remember the plaintiff's name.

Q. Any other cases?

A. That's all that come to mind right at the moment. That's five or six.

Q. Can you give me a little bit of background on that case?

A. The background of that case was that the plaintiff alleged some defective treatment involving restoration subsequent: to some

treatment that I had done. I was not a party to the suit.

Q. What type of restoration are you talking about?

A. As I remember, a full crown. This was a number of years ago, six or eight years ago, so I'm a little fuzzy and that's a pure guess, timewise.

Q. Any other cases that you can remember?

A. Not that I can think of right off the top of my head.

Q. Doctor, did you ever practice as a general dentist?

A. Yes.

Q. When was that?

A. From 1967 to 1969.

Q. Was that in Cleveland?

A. That was in Lorain County.

Q. Lorain County?

A. Yes.

Q. Do you do any advertising of the fact that you are willing to review cases for litigation purposes?

A. I have never done any advertising myself, with one possibility, I have a friend who happens to be a trial attorney and he -- I never ask him, but he may have put my name out, but I have not

done any myself.

Q. Not yourself?

A. No,

Q. Have you ever been sued for malpractice?

A. No,

Q. Have you ever had your dental. license revoked?

A. No.

Q. Or suspended or any kind of disciplinary action?

A. No, none at all.

Q. I have to ask you that question, it's a standard question.

A. I'm not offended, that's fine,

Q. Doctor, prior to your work with Case Western Reserve you worked as an endodontist for some time; is that right?

A. Yea;.

Q. Can you describe for us what types of procedures you performed in your practice?

A. We did everything that was within the scope of endodontics, which goes from conservative root canal treatment, surgical root canal treatments, treatments of traumas, retreatments of other work that's been done by dentists that had failed for one reason or another.

Q. Maybe you should, first of all, give me a

definition of what an endodontist is.

A. The official definition of an endodontist is that branch of dentistry that deals with the anatomy, physiology and pathology of the dental pulp and periapical tissues.

Q Now, you used the terminology conservative root canal, then there was another adjective.

A. Well, I probably should have used traditional as opposed to conservative.

Q. There were two of them.

A. Nonsurgical and surgical, if *you* will.

Q. What did you say, conservative and what was the other one you said?

A. Surgical.

Q. Explain the difference to me.

A. Regular or traditional root canal. treatment involves doing root canal treatment by making an opening through the tooth itself and addressing the problem from within the tooth.

Surgical treatment involves addressing a problem from the outside by making an incision in soft tissues, in effect working from the other end of the tooth.

Q. Externally?

A. Not external where you have your hand on your

face, but external in through the gum tissue through the supporting structures as opposed to through the tooth.

Q. Can you tell me when the surgical, a surgical. root canal is indicated?

A. Well, it would be impossible probably to list every single possibility, but it would include such things as, when the root canal treatment through the tooth was impossible or impractical; such as if the root canal had become calcified in its normal development process, it had gotten so small it's technically impossible to reach through the tooth.

It could also be practical in a situation in which a large, significant restoration was on the tooth that you would endanger that restoration by working through it, and that the alternative choice might be to work from the outside.

There are other types of problems that could develop which would preclude doing it through the tooth, either physically -- most cases are physically, you just can't reach it through that way. And then in which case, doing it surgically, by a direct approach, would allow

you to have a chance to resolve the problem.
Q. Would it be fair to say Mr. Axelrod had what you called a nonsurgical --
A. Yes.
Q. - or conservative root canal?
A. Yes, yes.
Q. Now, as an endodontist, can you tell me typically the source of your patients, where did they come from when you were in private practice?
A. When I was in private practice, a hundred percent of our patients were by referral from other dentists.
Q. Can you tell me what factors a general dentist would consider when deciding to refer a patient either to you or to an endodontist?
A. Well, I can only give you my opinion of what that is -- not being in that position -- but some of the factors that may be taken into consideration would be their desire or lack of desire to do root canal treatment. A large number of referrals were from people that just didn't want to be bothered. There may be situations in which there are cases that would be deemed by them, too difficult for their

ability.

Or there may be situations in which the patient requests being sent to a specialist, which happens in this day and age.

Those probably would cover the bulk of cases.

Q. Are general dentists qualified to perform all types of root canals?

A. They're legally allowed to provide anything, their state license does not limit the treatment that they can provide and it would depend upon their education.

Q. Well, in your opinion, are general dentists qualified to perform root canals?

A. Yes, as a general statement. I'm not sure that's a very clear statement for me to make. Numerically, general dentists probably do about 90 percent of the root canal procedures done in the country every year.

Q. Are there other factors, such as tooth location, that would go into a decision to refer?

A. Tooth location is generally not considered a factor in determining, but what it is, it would be more the individual case, the individual tooth, the individual patient.

Q. Well, can you tell me what about an individual Cooth might cause a general dentist to refer the case to you?

A. A case that I think should probably be referred to a specialist would be a tooth in which there was some alteration of normal anatomy, either through disease process or through dental treatment. Something that would make that a particularly difficult case to treat.

Or maybe a case in which normal developmental changes have occurred that would lead the dentist to believe that it might be beyond his capabilities of doing treatment.

Q. Tell me an instance,

A. An instance would be, there's a process that's very, very common in teeth called calcific metamorphosis and what. it is, is a situation in which the tooth -- that the nerve of the tooth, the pulp of the tooth, that we talked about, will lay down some additional hard tooth structure, in fact, try to close off that pathway. It's done in response to irritation, but it can occur naturally.

If we looked at an x-ray and saw a lot of this material, then we might feel that this is a

more difficult case and the individual would make the decision and if they have never treated a case like that, then they certainly should refer that case.

Q. You also talked about a disease process that the tooth might be undergoing as a reason for referring?

A. Yes, things like internal resorption and external resorption is probably something a general dentist is not experienced in.

Q. What do you mean?

A. Internal and external resorption is a process by which the dental pulp, in response to an injury, actually begins to dissolve and damage the hard tissue structure itself.

Q. When you say injury, what type of injury, traumatic injury?

A. It could be traumatic injury. It occurs frequently with traumatic injury, but it also could be decay.

Q. So it's your opinion that the tooth location has no bearing on the difficulty, the level of difficulty --

A. I don't think that the tooth location is, should be a factor, a specific factor in terms of

whether the general dentist should or should not do it.

You did ask me one reason I brought that text in, we can look in that textbook and find that stated very plainly.

Q. I'm asking you also --

A. And I'm giving you my opinion,

Q. -- based on your opinion,

A. I'm saying you had asked what things that I had used that book for and that brought one to mind.

Q. Okay. Right. Are there more canals involved in the treatment of molars, for example, than there would be in anterior teeth?

A, Generally, yes.

Q. Does that change the degree of difficulty?

A. Not inherently so, otherwise there are situations in which an anterior tooth could be much more difficult than a molar tooth. It would depend upon the individual case.

As a group it would be unfair to say that a general dentist should or should not treat a particular group of teeth.

Q. There were other situations, other than conservative root canal versus surgical root canal that you mentioned, I think they were in

which you were called upon as the endodontist to which other patients were referred.

Can you give us other circumstances?

A. Endodontists frequently will see people who have had traumatic injury to teeth, teeth which have suffered such things as root fractures or avulsions where the tooth was knocked out. Luxation, 1-u-x-a-t-i-o-n. Luxation means the tooth has been moved, physically moved.

Those types of situations require some specialized treatment. that many general dentists have not had experience with, but certainly if they have had experience, they are then qualified to do the work.

Q. Okay. Can you tell me, doctor, are there occasions in which you are referred a case in which the general dentist began the procedure, the root canal procedure, and then it was referred to you?

A. Yes.

Q. Can you tell me about those instances, why they are referred in those cases.

A. In the example that you gave where a case is started and then referred to us, there are times when the general dentist will feel that it's

within his capabilities, but as he begins treatment he discovers that, oops, this is not within my capability and at that point, instead of pressing forward he realizes that and chooses to refer.

Q. We talked about some of the factors that a general dentist would use in determining referral.

What about the medical condition of the patient, is that something that a general dentist would take into consideration?

A. I would be --

MR. SMITH: Just a minute, doctor. Let me enter an objection because I think the term medical condition of the patient is exceptionally broad,

MS. TRICARICHI: I can only say that he began to answer the question.

MR. SMITH: He's certainly permitted to answer, but --

A. I have no problem answering the question,

MR. SMITH: -- I object to form.

A. My answer to that would be that there are, in terms of absolute contraindications to endodontic treatment, very, very few, if any,

contraindications

Q. Now, explain that to me.

A. Meaning that I am hard pressed -- as I sit here, I'm not going to say that we couldn't come up with some, if we thought a while, come up with a situation in which the root canal treatment should not be done.

But if root canal. is needed, I think that there's no situation in which it could be done, in which we would not be justified in doing it.

The reason that I say that is, in general, when we get to the stage where a tooth requires root canal treatment the alternative is surgical extraction. That's pretty much where we are. And surgical extraction in the medically compromised patient is much more traumatic than endodontic treatment.

Q. Than a root canal'?

A. Yes, than certainly the nonsurgical root canal treatment.

Q. Well, I mean, I didn't say that, I didn't ask you whether it shouldn't be done, period.

I asked you whether the medically compromised patient, as you indicated, was a factor that a general dentist should consider in

determining whether to refer to an endodontist; or that's what I meant to ask, I guess.

A. I guess I misunderstood your question. I don't think that there's a great deal of justification for that.

I think that if the patient can be treated as an outpatient in the office, that there would be no difference.

If the patient required hospitalization, that might be different, except, as I told you, I don't have hospital privileges and quite honestly, I'm not aware of too many endodontists that do.

There probably could be a situation in which if a patient were extremely medically compromised that the treatment should be referred and could be done in a hospital.

Q. Well, doctor, the reason general dentists refer to you is because presumably they believe you have more expertise in doing root canals, specifically with reference to root canals than they do?

A. That's correct.

Q. Generally?

A. That's correct.

Q. That's what they are looking for when they refer to you?
A. Yes. I think --
Q. Is that right?
A. I think that's probably correct. In some cases there are, as I said, there are many people who don't want to do root canal treatment and refer a for that purpose.
Q. Doctor, let's say you were a general dentist -- y o practiced general dentistry?
A. Yes.
Q. A patient like Howard Axelrod presented to you a diet controlled diabetic,
A. Yes.
Q. Who had been told he had a heart murmur.

Can you tell me if he presented to you on May the -- I believe it's May the 4th, or prior to the beginning of this procedure, what would you have done?

MR. SMITH: Objection. But go ahead.

A. TC you are --
Q. As a general dentist.
A. If you are talking about his medical status, I don't believe that his medical status would be a

factor.

Q. You didn't think that was something that Dr. Kriwinsky should consider in his treatment of Mr. Axelrod?

A. I think regarding the diabetes, if a patient says, and we believe him -- again, Dr. Kriwinsky had had some previous experience with Mr. Axelrod that you haven't built into this hypothetical situation.

But if a patient comes in and says they control their diabetes with their diet, that's a sign they don't have a big problem,

If they have a big problem they are on, at least oral medication or insulin by injection. Those people we would be a little more concerned about.

Likewise, the situation with the heart murmur. Again, I didn't look real heavily at that with Mr. Axelrod, but many, many people have heart murmurs and they are treated by general dentists on a daily basis.

Q. Would it be significant to you to learn as the general dentist anything more about Mr. Axelrod's heart murmur?

A. If he had come to me and I had never seen him

before I would probably certainly question him about it.

Q. Can you tell me what the distinction is in your mind, in your treatment?

A. The distinction in my mind probably would be when he saw his last dentist. One of the things is -- I know you are leading to -- is the concern regarding potential heart problems. And my standard question is, has their physician told them anything and when they had their last dental appointment, have they had premedication.

If they have had other dental care and surgical procedures, then I would not be extremely alarmed by that.

Q. So you would base your treatment entirely on the fact that if they hadn't had previous premedication?

A. That would be a factor, that would certainly he a factor.

Q. Well, let's talk a little bit about antibiotic therapy and the €actors that you, that a general dentist would consider with reference to performing a root canal

What should a general dentist consider before the beginning of the treatment?

Again, I would ask you to clarify that, I'm not sure what you are -- with all the things that we have talked about -- I'm not sure what you are asking me.

Q. We were talking a little bit about antibiotic treatment.

A. For what purpose?

Q. For regarding a root canal.

A. Yes. My question is, are we talking about the heart murmur or are we talking about infection?

Q. Well, let's talk about Mr. Axelrod for a minute.

A. Okay.

Q. Is it your position or is it your opinion that when he first came to see Dr. Krell at the beginning of May --

A. Dr. Kriwinsky.

Q. Dr. Kriwinsky, I'm sorry. At the beginning of May, that he had an infection at that time?

A. I see no evidence of that.

There's nothing in the record that reflects that at any rate.

Q. You see no evidence of any disease processes?

A. I do see the evidence of some disease processes, yes.

Well, explain to me, I guess, the difference

between what I said and infection.
A. You said infection and infection and disease processes are not necessarily the same.
Q. Explain to me the difference.
A. Well, we are talking about Mr. Axelrod's case, but in general, you could have a cyst or you could have cancer or you can have an infection
Q. Okay.
A. There are different disease processes.
So do we see any sign? I see nothing in the record or anyplace that says that Mr. Axelrod on May 4th or whatever that date may have been, had an infection.
Q. Okay.
A. Assuming we are talking about dental decay not being an infection, it's a bacterial thing, but that's not what we normally refer to as an infection.
You have reviewed Dr. Krell's deposition; is that right?
A. Yes.
Q. So you've had an opportunity to read his opinion?
A. I did read that.
Q. Regarding the --

A. I didn't memorize it, but I did read it
Q. Regarding the x-rays that he saw?
A. Yes.
Q. And his opinion?
A. Yes.
Q. I don't want to misquote him, but he relied on the radiological data in his determination that there was disease process ongoing; would you disagree with that?
A. If he used the word some disease process, I would agree with him. I would need to review his actual deposition to see what he said to see whether I truly agree with him, but if he said that I would agree,
Q. Do you agree there was some disease process going on --
A. Yes.
Q. -- with Mr. Axelrod's molar back there?
A. Yes.
Q. Okay. And how would that disease process at the onset of the procedure when he came in, in the beginning of May, have affected your treatment of him considering his other medical complications?
A. I think the presence of the disease process is

why the treatment was done.

If your question is should he have been given an antibiotic because of that disease process before the root canal treatment was started, the answer is no.

Q. Tell me why you think that.

A. My question to you would be, why would you, because there's no indication that it's necessary.

Q. The fact that there's disease process ongoing when he walks in.

A. True.

Q. And --

A. If you're saying, is it the standard of care to give antibiotic treatment to everybody undergoing root canals because they all have a disease process, the answer is no, it's not clearly the standard of care. Most root canals are done without antibiotics.

Q. At any time, either as a precautionary measure beforehand or at any time?

A. A precautionary measure in a situation like this would be, quite frankly in my opinion, over-treatment

As a general rule, the vast majority *of*

root canals are done without antibiotic treatment and certainly in this case, because he had no swelling and no sign of infection at that time.

If he had had -- if the situation was different, then the answer would be different.

But in this situation if that tooth came into my mouth, in anybody's mouth, other than his, would I give them an antibiotic? The answer is no.

Q. When Mr. Axelrod returned -- strike that.

While we are talking about antibiotic therapy, can you tell me situations where antibiotic therapy would be indicated before the onset of the disease?

A. If a patient comes in and they have an active infection that we can determine is an active infection, that is they have swelling, pressure, et cetera, then it may he appropriate to have antibiotic therapy.

Q. I'm sorry, what did you say, disease process -- what did you say?

A. I said infection, signs of infection. I'm saying disease process, infection may be a disease process, but it's not the only disease

process.

Q. So if there had been an infection, Mr. Axelrod could have had an infection when he walked in on May 4th and it just didn't manifest itself?

A. There was no clinical evidence of that.

Q. Again, do you agree with Dr. Krell that there's some x-ray data to indicate that there was some disease process ongoing?

A. I would agree there's some disease process.

My recollection of the deposition of Dr. Krell was that he used the word infection which I would disagree with.

Q. Tell me why you would disagree with that.

A. It's impossible to *see* infection on an x-ray, it cannot be done.

Q. Okay. You would determine infection based on the subjective complaints of the patient?

A. That's the only way that we can, without doing any treatment, yes.

Q. *So* when we are using the word disease process it's a precursory to infection?

A. What we are saying on disease process, no, it's not necessarily precursive to infection. Disease process means some abnormal change. Some change away from the norm, which we do see on

the x-rays.

I believe he used the term that he can see areas of infection around the root and that's an inaccurate statement because x-rays don't show us bacteria or microorganisms which cause infections.

Q. Could Dr. Kriwinsky have determined whether that tooth was infected by his examination of it?

A. I don't believe so, with the information I have available to me.

Q. So he just didn't know one way or the other, Dr. Kriwinsky?

A. There was certainly no evidence that it was an infection.

Q. Well, he was -- there was no evidence?

A. In the absence of evidence, we have to assume it's not there.

Is there a way that anyone could say absolutely, positively? No, that doesn't exist in medicine or dentistry.

Q. Let's move to May the 15th, are you familiar with these dates, sort of, from the chart?

A" I think the copy I have is really horrible.

Q. Take Mr. Axelrod's case, when he had this condition performed, this root canal performed,

on, I think, it's May the 4th; am I right there?
A. There's an entry May 4th, yes.
Q. Okay. If you, as the treating general dentist, had performed a root canal on a molar, such as the molar that Mr. Axclrod had the root canal performed on, and you had then received word from Mr. Axelrod after he had come in to see you for the second time, after the 15th, that he was beginning to have swelling and pain; would it have been important for you to personally see the patient, doctor?

MR. SMITII: Let me object.

A, I think you have confused the date and the treatment here,

MR. SMITH: Let me note an objection. Doctor -- wait. I'm sorry.

Just so I can be heard. Let me note an objection to the form of the question, A, I do think it confuses the facts.

And, B, I don't think it has enough facts in it to be answerable; however, to the extent you understand it, answer it.

A. No, I can't answer that, because what you are giving me is not what it says here.
Q. Let's take the factual situation where Mr.

Axelrod has had the root canal performed by Dr. Kriwinsky on May the 4th.

A. Yes.

Q. He then returns for his second appointment on May the 15th. Okay?

A. Correct.

Q. Subsequent to that time and after he leaves Dr. Kriwinsky's office on the 15th he starts experiencing pain and swelling and he notifies the doctor of that.

A. Yes.

Q. If you were the treating dentist in that case, based on the symptoms that Mr. Axelrod was relating to you, would it have been important to you as a treating physician to see the patient?

MR. SMITH: Objection.

A. Yes.

MR. SMITH: Go on.

A. I probably would want to see him the next day. Well, he didn't call till that morning of the 16th, according to the records. I would have wanted to see him on the 16th.

Q. Okay. Would it have been important for you to observe the swelling and the amount of swelling, for example?

A, If he had swelling, I would, I personally would see the patient, yes. That would be part of the process.

Q. Would you have made a diagnosis over the phone based on his symptoms to you?

MR. SMITH: Objection.

Q. Complaints to you, I should say.

A. Would I make a diagnosis over the phone? I don't know that you can make a diagnosis over the phone.

As I'm reading the record it says, as I remember the deposition, he said that he phoned and gave him a prescription for a pain reliever.

If you are asking me if that's unusual or out of the norm, the answer is no, that's a fairly frequent occurrence.

Q. He did not prescribe antibiotics at that time?

A. He, according to this, he did not at the 8:30 morning appointment.

Q. And does the record indicate whether he saw Mr. Axelrod at that time?

A. It does not indicate. It says -- as I read this -- it says, pain and swelling number 18, something is crossed out, I guess it says tooth

does not hurt a lot,

Q. No, just does it indicate whether --

A. I don't know if it -- it indicates neither. This indicates neither that he did it by phone or that he saw him, so I do not know.

Q. Would your records -- if you had records on a patient like this, would your records indicate whether you had personally seen him in the office or whether you discussed it over the phone?

A. I probably would. I keep significantly more detailed records than we have in this case and I've indicated that I think that's a shortcoming, but that's what we had to work with.

Q. Can you tell me, can you describe for me the type of medication that Dr. Kriwinsky prescribed initially, the Tylox?

A. Tylox is a synthetic narcotic pain reliever purely for pain relief.

Q. If you had been treating Mr. Axelrod and you had been able to examine him personally at the time when he first complained about the swelling that morning, would you have been able to determine whether there was an infectious process?

A. I have no way of answering that question.

I didn't see him. I can conceive of situations in which the answer could be either side. I don't want to make one up for you.

Q. Okay. So you don't know?

A. I would have no way of knowing that. I have no way of giving you a real answer on that.

Q. Well, while we were talking about indications for antibiotic therapy before the process had begun, you talked about the fact that swelling might be an indication to you that there was an infection process going on. Is swelling an indication to you then at this juncture that an infection process might be going on?

A. It would depend on what the actual situation was. Is swelling always associated with infection, the answer is no.

Swelling is a normal cardinal sign of inflammation. You can have inflammation if we scratch your skin. If you take your fingernails and dray it across your skin you will yet what we call a wheal and it will actually he a little swelling. That's obviously not an infection, So there are different circumstances.

Without having seen the patient I would be

purely speculating and guessing arid I'm really unwilling to give you an answer.

Q. Well, having just undergone the second part of this treatment, the second sitting of this root canal, and then learning that Mr. Axelrod was experiencing some swelling, that's a little different than scraping your hand across your skin and creating any inflammation?

A. Not as remote as you would think. It still could be either from trauma, the trauma of the procedure or it could be from an infectious process. If I saw him I might be able to make that determination.

But if you are asking me to sit here two years later and make the decision, I just can't do that.

I see nothing in the record that lets me give you a real answer to that.

Q. Did it matter -- would it have mattered to you, had you been the treating physician, the treating general dentist, whether Mr. Axelrod was experiencing the swelling, the fact that he was a diabetic; would that have mattered to you?

MR. SMITH: I'm sorry, what?

Q. Would the fact that Mr. Axelrod was a diabetic

and was experiencing this swelling have mattered to you in your treatment?

MR. SMITH: Thank you,

A. I don't think I would have been significantly more concerned, assuming again, that he was accurate in his claim of control of diet. A controlled diabetic's healing is as good as a normal person's, if they are truly controlled.

Q. A controlled diabetic is no more compromised than someone who doesn't have diabetes?

A. If it's truly controlled I don't think there's a significant difference in how we would treat them.

Q. Doctor, what is the significance of a patient calling and saying -- like Mr. Axelrod did -- that he had swelling and then a few hours he was running a temperature; can you tell me what --

MR. SMITH: Objection. Again, I don't think there's enough facts.

MS. TRICARICHI: Well, the deposition of Mr. Axelrod indicates that.

MR. SMITH: I'm sorry?

MS. TRICARICHI: His deposition, that's what he indicates in his deposition.

MR. SMITH: I know, but swelling the size of a golf ball, a grapefruit? A temperature of 110 or 100?

I mean, you are asking him what the significance is of tenderness and swelling and a temperature, so what swelling and what temperature?

MS. TRICARICHL: I'm talking about

Mr. Axelrod's swelling.

MR. SMITH: What is that?

MS. TRICARICHI: Well, based on --

MR. SMITH: I don't have a photographic memory

A. That's my point again. If you are asking regarding Mr. Axelrod, I don't know what those numbers were.

Would I be concerned about it, would I want to find out what those were if I were the treating doctor? I would want to see him at that point.

Q. You would want to see him. Would you want to take his temperature and find out whether he was running a temperature?

A. That would be a possibility if he had taken it and told me, I would probably, assuming that I've never met Mr. Axelrod, but assuming he's a relatively normal, rational, reliable person and he said my temperature was 98-and-a-half or 99-and-a-half or whatever, maybe I would believe whatever he told me unless there were a reason to believe differently.

Q. Would those two things having heard from him in the morning of May the 15th -- May the 16th, I stand corrected, May the 16th, that he was experiencing swelling and running a fever cause you to think there was some kind of infection?

A. If those were the facts -- I don't know that those were the facts, it's not in here. But if those were the facts, the swelling with the fever would indicate that he probably is undergoing. an infectious process, yes.

Q. If you were the treating general. dentist in this case, what would that indicate to you in terms of treatment at that point?

A. If this were the case, if this hypothetical situation were in fact the case, then I would feel it was likely that he had at least a low grade infection at that point and I would

consider putting him on antibiotics at that point in time.

Q. Can you give me an example of one particular antibiotic you would have used at that particular juncture?

A, Most dentists will use either penicillin or erythromycin as a drug of first choice depending upon personal preference and the patient history and so forth.

Q. Did your records indicate on your patients what particular antibiotics you use?

A. Yes. My personal records, yes.

Q. Your records of your patients?

A. Yes.

Q. Would indicate that?

A. Yes.

Q. That would be good form to indicate that on your records?

A. Yes.

Q. Do you, doctor, keep records on patient's charts of any conversations that you have with other dentists or other -- it's hard, you would be talking to you -- as an endodontis ~ ,solely, you would have been talking to general dentists?

A. As an endodontist, I would probably do that,

yes.

Significant conversations, of course.

Q. Would it be good procedure to do that if you were a general dentist as well?

A. I think it would probably be reasonable, sure.

Q. Now, later on, on the 16th, Dr. Kriwinsky, I believe, Dr. Kriwinsky talks about an I&D?

A, I don't see it.

Q. Oh, no, it's on the 17th. I think it's on the 17th. His statement is, there's no where to I&D.

Can you explain to me what he meant by that?

A. What I think he meant? What he meant, you would have to ask him.

Normally when we are going Lo do an incision and drainage -- or I'm making the assumption that is what he's talking about here what we would do, if the patient said that there is swelling here, we would retract their cheek and look for an area that's what we call fluctuant. Fluctuant is an area that has a fluid-filled sac or fluid-filled balloon. Someplace where we can determine that there is something to drain, generally pus or infected

material. And if we can find that spot, then we would make the incision in that general area.

Q. Well, when you say there's something to drain, if there's a swelling there, doctor --

A. Uhm-hum.

Q. -- isn't there going to be something to drain?

A. No, not necessarily.

Q. Tell me why not necessarily.

A. Because you can have swellings that have absolutely no drainage, You can have swellings which may develop drainage but are too early a stage, they have not localized is the term that we use.

When the infection first starts it tends Lo be very generalized and the tissues are very firm and stretched, but there's not this pool of infected material with which we can locate and drain.

Q. Would you, as an endodontist, have been able to locate that pool more readily than a general dentist?

A. Again, I have no idea. Without seeing Mr. Axelrod, that. would be purely speculation on my part.

I've never met Mr. Axelrod.. I know quite

honestly when I talked with Dr. Kriwinsky he told me Mr. Axelrod and I have something in common, big, chubby cheeks.

I've worked on other people, not too many people bigger than I, but it's more difficult on large people,

Swelling on you, we would see right away. On me, you have to count chins to see if I have an extra one on the side.

So could I have seen it? I don't know. You're asking me to make a judgment I can't fairly make. I'm not going to say something more for or against your client or mine or Mr. Smith's at any rate, because I don't know that. I don't know that.

Q. Can you tell me when an I&D procedure is indicated?

A. An incision and drainage in this situation that we are talking about here, which is as I'm interpreting it, okay, from the record, I only have what's in front of me here, would be indicated only if he could find this area, an area in which he could feel this fluctuance and in which he knew that if he made an incision that he would get some drainage or some relief

from that particular area.
Q. Okay.
A. I€ he had a generalized hard swelling it would be inappropriate to do an incision and drainage, as I'm envisioning his problem.
Q. It would be inappropriate for any type of --
A. Yes.
Q. -- dental practitioner to do?
A. Yes. Yes.
Q. Well, how would you treat something like that that wasn't fluctuant?
A. Antibiotic therapy.
Q. Can you tell from the records what type of swelling Mr, Axelrod was experiencing?
A. With the information that he has here, let me read it and tell you.

MR. SMITH: Are you talking about just Dr. Kriwinsky's record or the hospital chart and everything else:

A. Well, as I'm looking at Dr. Kriwinsky's record --

MR. SMITH: Doctor, wait. I'm sorry. I want a clarification for the record.

You asked, Carla, can you tell from

the record what kind of swelling he had. I guess you are driving at whether or not I&D was possible, and using just Kriwinsky's records or all the records?

MS. TRICARICHI: Right now I'm asking him about Dr. Kriwinsky's comment about what he said, I&D, no where to drain. That's what started this whole thing.

Now, I'm talking about the information that's contained in Dr. Kriwinsky's records.

MR.. SMITH: Thank you.

A. Looking at Dr. Kriwinsky's record on the 17th he starts -- if I can describe it a little bit more -- he says he has some swelling under the tongue on the anterior lateral or left side and submandibular region Then he refers to the incision and drainage problem.

So what do I see? I see nothing in the record that indicates anything different than what we have been talking about,

He apparently looked to see if he could find an area that we described where he could make this incision and drainage and apparently

didn't find it.
Q. So he didn't find this fluctuant area that you were talking about?
A, Yes.
Q. Or he describes as a soft area, I think?
A, Yes, same thing.
Q. In your review of the Kaiser hospital records, when he was brought in originally --
A, Uhm-hum.
Q. -- into the emergency room, do you recall any further description of the swelling that would indicate a different consistency or did it indicate the same consistency in swelling?
A, No. As I read it, I saw nothing which indicated a difference. I think quite clearly, no difference.
Q. So under no circumstances could Dr. Kriwinsky have performed an incision and drainage in the office?
A. He could have, but I don't think he should have.
Q. He should not have done that?
A. Yes, I believe that, at that point.
Q. Is there any -- could any other type of dental practitioner, i.e., an endodontist, or -- well, let's just say an endodontist, could that type

of person have performed an I&D at that time, that juncture?

A. Again, could they have or should they have?

Q. Well, should they have.

A. Again, I did not see him. Arid another endodontist did on the 17th, as I read the record and his professional. opinion at that time would answer the question, no.

In other words, Dr. Katz, ne was referred to Dr. Katz and Dr, Katz did not elect or did not feel an incision and drainage was necessary --

Q. Well --

A. -- from the record. That's all I have, again, I didn't see Mr. Axelrod.

Q. What record from Dr. Kriwinsky's record?

A. From the record and/or the deposition, I'm not sure where this comes from, but either in the deposition or the record I remember seeing that he talked with Dr, Katz on the phone and Dr. Katz said, do an incision and drainage at that point. As I remember it, Dr. Kriwinsky said I can't find the place to do it; The discussion we just had.

In which case, then Dr. Katz said I would

see him. And I believe that the record shows -- and I don't believe there's any dispute -- that Mr. Axelrod saw Dr. Katz on the 17th.

At that appointment Dr. Katz obviously examined him and elected not to do an incision and drainage.

So I have to make the assumption, and I'm making an assumption, that my feeling would have been the same. I see nothing that says it would have been different had I been there.

But I did not see the circumstances, so I'm going only by what I'm hearing.

Q Doctor, is it possible that Dr. Katz instead of your perception of what Dr. Katz' nonperformance of the I&D was, that he didn't think it was appropriate at that time?

A. Yes, that's a judgment I'm making.

Q. That's the judgment. Isn't it possible, based on the records that you have, which is essentially Dr. Kriwinsky's version of what Dr. Katz did or did not do, I mean, that's what your opinion is based on?

MR. SMITH: Well, I mean he's --

A. I think there's no -- as I read both Dr. Kriwinsky's deposition and Mr. Axelrod's

deposition, I saw no disagreement on the facts of this relationship with Dr. Katz.

Q. Well --

A. I didn't see anything in there that Mr. Axelrod was saying this didn't happen. That he went there and he saw him and he said, take a different antibiotic and we'll see how it goes in the next 24 hours is basically what happened.

So I didn't think that there was -- I don't remember that there was any disagreement about this with plaintiff or defendant.

Q. Dr. Katz didn't treat him at all?

A. I don't believe that he did. I believe he looked at him and determined at that point in time, treatment, which would have been incision and drainage, was inappropriate based on his professional judgment. I don't know why --

MR. SMITH: For the record, just so the record is clear, the first thing you did, Carla, I think was establish that among the things that Dr. Krebs reviewed were Dr. Katz' records. We are talking as if he has not seen those records and I think he has.

MS. TRICARICHI: I'm talking about

what he bases his opinion on as he speaks here today. If he wants to talk about --

A. I'm basing my opinion on --

MR. SMITH: Wait a minute, doctor. You keep adding these factual statements in the front of your question Chat implies that the only thing he's looked at are Dr. Kriwinsky's record and that's going to create a confusing deposition.

He's seen other records. He's seen Dr. Kriwinsky's record. He's seen Dr. Katz' records, x, y and z records, everything you established in the first part of the depo.

I just want the deposition to be clear on Kaiser records.

MS. TRICARICHI: I asked him what he was basing the opinion on.

A. I think I told you. I hope I told you.

Q. If a general dentist once refers you to, or refers a patient to an endodontist and then tlie endodontist is presumably treating the patient for that particular condition, would it be normal procedure for the dentist then, the general dentist, to continue to treat that

patient for that problem?
A. I would think that the normal course would be for the general dentist to drop treatment and allow the specialist to take over at that point:.
Q. That didn't happen in this case, isn't that right?
A. I don't think either of them did anything after the fact. I think, as I read the record, after he saw Dr. Ratz sometime on the 17th, I'm not sure of the time, the next thing we know is that Mr. Axelrod took it upon himself to present to the medical people, as I read the record.
Q. Would it have made any difference if Dr. Kriwinsky had referred him to Dr. Katz on the 16th?
MR. SMITH: Objection. Go ahead.
A. No. I think the answer is, to the best of my professional opinion is, no, it would not have made a difference.
Q. It wouldn't have made a difference?
A. No.
Q. You testified that you had not seen the patient as an endodontist and you didn't see how, based on this information, an I&D, whether it would have been appropriate or not?

A. Correct.
Q. What about, would it have made any difference if Mr. Axelrod had seen an oral surgeon with reference *to* their ability or their inability to do an I&D?
A. In a normal situation? What day are we talking about, I guess --
Q. On the 16th.
A. On the 16th, would it have made a difference? I really doubt it.

Again, anything is possible. I know where you're going, because I read Dr. Krell's deposition.

But in my opinion, if he saw the average oral surgeon on the 16th, less than 24 hours after this problem began, that average oral surgeon would not do an incision and drainage at that point in time.

Q. Why is that?
A, Because I've seen hundreds of these cases and I've never seen anybody do it. I don't think it's reasonable. I think it would be over-treatment,
Q. You have never seen someone do -- you mean it's premature, is that what you are saying?

A. Yes. I'm saying it's premature. The vast majority of these cases are resolved by antibiotic therapy without this external incision and drainage that Mr. Axelrod had. It's a very unusual procedure, It's not done on a daily basis in people that have these infections on a daily basis.

Q. So what you are saying is it could have been treated totally by antibiotic therapy?

A, I think it could have and it may have been. It despites another treatment on top of it. We don't know.

Q. I don't understand what you mean by that comment.

A. What I'm saying is that the preferred treatment in these types of :infections is to do antibiotic therapy first and give it an opportunity to *see* if it will resolve

Q. Is time of the essence regarding antibiotic therapy in this type of situation?

MR. SMITH: Objection.

A. I think time is -- I'm riot sure what the term "of the essence" means in the legal vernacular, but I would say certainly, we shouldn't wait days without prescribing it, but as I look at

the record it appears that Mr. Axelrod received some antibiotic approximately noontime the day that he called, so I don't have any great problem with that.

Would it have been nice -- as I told Mr. Smith -- if he gave it to him at 6 in the morning; it would have been nice, but I doubt it would have changed the outcome.

Q. It would have been better?

A. It would have been.

But I think when we see now, with hindsight that progress of the infection, I don't think it would have helped.

Q. Why is that?

A. Well, because we saw that 24 hours later he had no significant improvement and time -- I'm not sure that what we are really talking about here is a four-hour time difference and it would have made a significant differeiice. I'm hard pressed to imagine that would have changed this case.

Q. You think an incision and drainage on the 16th would have been too aggressive of a --

A. Absolutely.

Q. -- procedure?

A. Absolutely.

Q. -- to perform?
A. Absolutely.
Q. Well, doctor, is it your opinion that Mr. Axelrod's development of Ludwig's angina which was --
A. Wait a minute. It's my opinion he did not develop Ludwig's angina.

The definition of Ludwig's angina, in any surgery or oral infection textbook defines it as a bilateral infection.

And Mr. Axelrod had only unilateral involvement.

Q. So you disagree with the diagnosis arid the people at Kaiser who treated him?
A. No. I like their diagnosis because they got it right, then someone in pencil wrote it in , Ludwig's angina. There's something called false Ludwig's angina. It's a term which unfortunately is thrown around a lot, but does not meet the classic definition, it's unilateral. In fact if you will read the textbook I quoted you before Dr. Archer, the maxillofacial surgeon, he flat out states if it's not bilateral it is not Ludwig's angina, so we would disagree with the diagnosis, yes.

Q. Well, tell me if there's a difference in whether we call it Ludwig's -- so you are saying it has to be bilateral in order to be a true Ludwig's angina?

A. I'm not saying that, the textbook says that.

Q. But that's your clinical opinion as well?

A, Yes, absolutely.

Q. Have you treated patients with Ludwig's?

A. No, not with -- I've treated patients with this type of situation. But I've newer seen a case.

In the recent times I've never read of a ease, Ludwig's angina, I don't know if it exists, I mean, it does in theory. This was a problem pre antibiotics with a serious life-threatening problem pre-antibiotics. But I'm not aware of any cases.

There probably are some, but I'm not aware of any cases in the recent literature that say it exists,

Q. But you have treated patients with conditions like this on one side?

A. Yes, yes.

Q. How many such patients have you treated?

A. Oh, I would guess over the years, depending upon degree, now, I don't know the degree. Patients

with significant swelling that you could see below here, I would guess over the years, and I'm purely guessing. Maybe in the range of 50.

Q. And can you tell me were these patients, I know it's hard to generalize, but in some of these patients, were these patients in which you had performed the root canal from the beginning?

A. I know that there have been at least a patient or two that fit that category where that may have happened. I don't know at. what point during treatment, but it has happened during the course of treatment, yes.

Q. One or two. And the others that you have treated?

A. May have come in that way before we saw them.

Q. So from another, from a referring --

A. Yes.

Q. -- general dentist?

A. Yes,

Q. What was the type of treatment, if you can generalize?

A. The treatment is, if, for instance, if the patient were referred to me and had not had root canal, would be to institute root canal treatment and place him on antibiotic therapy.

Q. What if they had root canal?
A. If they had the treatment, then the treatment is to still place them on antibiotic therapy and follow them closely.
Q. Of those 48 some patients approximately, did you perform an incision and drainage?
A. In none *of* them.
Q. In none *of* them?
A. Never.
Q. So in all of those cases their problem was resolved solely by antibiotic therapy?
A. Yes.
Q. And were any of them hospitalized?
A. I've never had a patient hospitalized.

In our practice with the people that we have had we have one patient that had to be hospitalized. It was not a patient I was treating, but we had one patient that was hospitalized.

Q. For this type of condition?
A. Yes, for the procedure we are talking about.
Q. Well, tell me, if that's the case, doctor, tell me what, if you had been the general dentist seeing Mr. Axelrod on May the 17th, how would you have had him proceed from there?

A. I would have --

MR. SMITH: Objection. Go ahead.

A. I would have referred him to a specialist if I felt -- as I think Dr. Kerwinslcy states, that he didn't, didn't understand how to treat the situation, he realized that this had now passed. from what he was capable of handling. I would have referred him to an endodontist, most likely, if I were the general dentist.

Q. At that point?

A. Or it's possible an oral surgeon as Dr. Krell would like us to do. I would not disagree that that's at least a possibility.

Q. An oral surgeon would be capable of treating this --

A. I think either person could.

Q. -- condition, Either an endodontist --

A. Yes.

Q. -- or and oral surgeon?

A. Yes, certainly.

Q. They are both qualified?

A. Absolutely.

Q. Is it your opinion that this, let's call it one-sided Ludwig's angina, or whatever you call it, mocks --

A. False Ludwig's angina.

MR. SMITH: One-sided Ludwig's angina is a dental. oxymoron.

A. It's a submandibular cellulitis is probably a more correct term.

Q. Is it your opinion that was directly related to the endodontic procedure performed by Dr. --

A. The timing is such I would have to say it certainly appears to be.

Everything is consistent with that.

You know, could you say, is there any other -- Mr. Smith asked me -- is there any other remote possibility? Yes, but it's remote. I think it was related to this.

Q. So --

A. Everything I see says it is.

Q. So is it your opinion that earlier antibiotic treatment before the procedure began, that is, precautionary or prophylactic antibiotic treatment, would not have made any difference?

A. Well, as I said, prophylactic antibiotics to prevent this problem, is not the normal treatment, It's not the standard of care,

If you are asking me now that we have 20/20 hindsight, might it have made a difference? If

we were lucky enough to know this was going to happen and pick an antibiotic that the microorganism was sensitive to, perhaps. But it's not the norm to premedicate with an antibiotic Lo avoid this type of a problem.

I think we addressed that earlier, the vast: majority of people would not get an antibiotic.

Q. But had he been given the antibiotic on a precautionary basis?

A. We don't know if that would have been effective. You can make a case it might have been, but we have no way of knowing because we don't know what the organism was sensitive to.

Q. You said on the 17th Dr. Kerwinslcy clearly feels it's out of his range of capability and he refers to Dr. Katz; is that a fair statement?

MR. SMITH: Objection.

A. Are we allowed to review?

Q. Sure, you are allowed to review anything.

A. Let me see Dr. Kerwinsky's deposition and I can quote what he said. I don't want to put words in his mouth

MR. SMITH: I thought what he said, Carla, if I'm correct in assuming Dr. Kerwinsky said --

MS. TRICARICHI: No. I'm talking about what Dr. Krebs said about his opinion of what Dr. Kerwinsky said.

A. That was the impression that I got and I would like to not put words into his mouth and see if we can find a --

MR. SMITH: Well, doctor, I'm going to step out for one minute while you are just talking about anything except the case.

- -

(Off the record.)

- - - -

MR. SMITH: Carla, please proceed.

Q. Doctor, go ahead.

A. Well, I guess what 1 was thinking of I may have misquoted him. I'm just reading a question that you asked him regarding this and he says "because the only conditions under which he would have drained it because it was within my realm of capability," so I'm assuming -- I guess I made the assumption incorrectly. I don't see that he said it. But my feeling was at this point, or my opinion was at some point he realized it was time to refer Mr. Axelrod to Dr.

Katz, which he obviously did. So at some point in there he made the decision, at least in his mind, that he would require some help from a specialist.

Q. Would it have made any difference if he had referred him a day before?

A. I think it probably would have been inappropriate. I doubt that it would have -- I think you asked me before, if it had would have made any difference and the answer is still no.

Q. You think it would have been inappropriate?

A. It may not have been inappropriate, but it would not have had any significance. I think at the 16th it would not have been inappropriate -- that's not a correct statement.

On the 16th it would have been appropriate to refer, if he had thought he had a reason to do that. I see nothing in the iccord that says it was imperative at that point Lhat he should have referred. 'That was purely a clinical judgment on his part on the 16th.

On the 17th we are getting to the stage where I think he realizes that referral is appropriate and I think rightly so.

MR. SMITH: Doctor, I want to

interject here, because I don't want to confuse the words appropriate with mandatory or the standard of care.

MS. TRICARICHI: You know, it's a plain meaning of the word. We can look it up in the dictionary.

MR. SMITH: Doctor, I want you to --

MS. TRICARICHI: This isn't your deposition. What he says speaks for himself. If he wants to explain himself on direct examination, that's fine.

A. I hope that was clear. Do I think he violated the standard of care by not referring on the 16th? Obviously, very clearly, no, he did not violate the standard of care, if that's what you are asking.

Q. No, I asked what I asked.

MS. TRICARICHI: And I would object to Mr. Smith's testifying on behalf of this witness here.

MR. SMITH: What was that?

MS. TRICARICHI: If your witness doesn't understand --

MR. SMITH: Trying Lo slander

me?

MS. TRICARICKI: .. doesn't understand what I have to say, I think I'm perfectly approachable and he can ask me to rephrase the question so he understands it.

MR. SMITH: I'm searching through for the truth here.

MS. TRICARICHI: You're always searching for the truth, like all insurance companies.

Q. I want to ask you some questions about some notations that you made on your copy of Mr. Axelrod's deposition. It was a little cumbersome. Let me lean over, we only have one copy with your notations.

At page 23 beginning at line, I believe, five, I can't see -- five and going to line twelve, you make a notation with a question mark, can you tell me what the significance *of* that is?

A. Well, my question mark was, I think, my concern was that he said when he went in for the very first time, and that was some significant period *of* time before the interval that we were talking about. And then the question becomes well, was

he talking May 4th and later on he did; so as I was reading that I put a question mark there because my question was, had he done it in 1985 or had he done it in 1990.

Q. Had he done what, told him about: his medical condition?

A. Yes, yes.

Q. Okay.

A. Yes.

Q. How frequently should a general dentist update his medical information that he has on his patients?

A. I think that there's no absolute standard, but I think certainly at least annually the patient should be asked if there are any changes and it may be, are there any changes in your medical history.

Q. Would those notations be noted on the chart?

A. If there were any changes, I would say it would be appropriate, at least in our office.

Q. If there were no changes it wouldn't be noted that that question had been asked or that there had been no changes?

A. It may or may not be.

Q. What's the procedure in your office?

A. Well, we don't see patients on a return basis very often so that's kind of a hypothetical question.
Q. Or at least you hope not?
A. I see them and they leave, so I can't answer that question to be honest with you.
Q. Well, when you are teaching your students?
A, Virtually the same situation there. We see people for a very short period of time, they leave and they do not come back, as a general rule, except some extended period of time then the university then requires they go through the process all over again. If they had a root canal treatment and were in the graduate department, if they were sent back to the undergraduate department and wandered back in, would they ask the question? I would hope they would ask the question, but it would depend on timing.
Q. Do you counsel your students to consult with the treating physicians of patients when they have, when they are medically compromised?
A. If it's a significant problem.
Q. Okay.
A. I don't think that in a situation like this,

they would call a physician.
Q. For either of the underlying conditions we talked about?
A. No, probably nor;.
Q. The diabetes?
A. Probably not,
Q. In your practice, did you have occasion to call treating physicians?
A. Very rarely.
Q. That would riot have been good procedure to check with --
A. I don't think it's a standard procedure in dentistry. I'm sorry, I closed the page up for you.
Q. That's a11 right. At page 25 of Mr. Axelrod's deposition you also make a notation, but can you first decipher and explain it?
A. It says, not a time of treatment oral medication for oral diabetes, but not '90. He was testifying that he took Micronase, but that was after the situation we are talking about. He was not taking Micronase, according to him, at the time this procedure was done,

He had indicated lie was controlling it with diet. Micronase is an oral medication for

diabetes.
Q. Is it like insulin?
A. It's an oral, Yeah, oral type.
Q. Okay.
A. I'm not intimately familiar with it. I know it exists, we do not prescribe it, but I know it exists, it's an insulin substitute.
Q. At the bottom of page 39 of Mr. Axelrod's deposition there's a notation in your hand. Can you tell us what that says?
A. Yes. It says Dr. Record shows payment and the question was, a receipt for treatment and this was a situation which was, as I recall it, there was a question of what the payment was for and the doctor's testimony and the record indicated it was for another family member, I believe Mrs.
Q. This had to do with how frequently they had seen him or something?
A. Yes, it was something of that nature. And there was a ledger card which may be in the record here, which basically came along with that.
Q. And at page 43 of Mr. Axelrod's deposition, line 19 -- line 14, I'm sorry?
A. Yes, the question which you're addressing, Mr. Axelrod testifies he always mentioned heart

murmur and once he found out that he mentioned he had diabetes, too he's saying it at every appointment,

My check mark was, it says check Dr. Grady because he had surgical treatment with Dr. Grady sometime earlier and my question for Mr. Smith was, it might be appropriate to ask Dr. Grady, can he confirm that the patient came in and told him this information; attempting to determine if in fact, this occurred at every appointment,

Q. At page 48 approximately line 6, I don't know what the notation is.

A. It says he had anesthesia, question mark.

I'll have to go back a little bit and see where we are. Okay. This was on 5/10 that it says he finished work put a temporary filling in, et cetera. Asked him about prescriptions and so forth, wondered whether he should have a pain killer.

My question was, did he have anesthesia for the root canal? Otherwise why was he asking for a pain reliever. I never had that question subsequently answered by Mr. Axelrod.

Q. I don't understand.

A. Otherwise, what I'm saying is, if you finish up

a dental appointment and you say I'm going to need something for pain. Wait. She's numb. Wow does she know she has pain? I questioned that in my own mind.

Q. In other words, whether there had been a history of having problems?

A. Yes. There's nothing in the record that says he had pain at that point in time, I looked. This is when I read through, I write these notes to myself to see if I can answer this question, Sometimes I resolve it and find it goes away and didn't erase them. I'm not trying to tell you I didn't give that some thought.

My question was, I go back. in the record it doesn't tell me he was anesthetized at this. This is at the end of the appointment he wants to know.

Q. At the end?

A. This is at the end of the 15th, partially. The way I'm reading that. But he said, he finished the work. So I could be -- but it was at one appointment or the other at any rate. That's why I had that in there, at any rate.

Q. I'm just trying to understand your thought process in these notations, that's all.

A. These are things that I thought might be a factor, they may or may not be.
Q. At page 49 of his deposition you underlined the comment by Howard that the tooth was tender until his return on the 15th.
A. That was so that I would check it against the record and I don't see that substantiated in the record. 'That's his testimony and I was unable to substantiate that,
Q. In other words, as we talked about --
A. My question is or what I did was, I try to, when I have a case, I try to compare plaintiff and defendant and see what areas we don't agree on. Because if they both agree you are not going to ask me the question, I hope.
Q. It's your testimony that Dr. Kerwinsky is not as complete as he could be in his record keeping?
A. I think he would have served himself much better with more detailed records, no question.

And then you skipped over the other part here, if you will. Were you experiencing any swelling? He says no.

Q. Between the first and the second?
A. The second visit he had no swelling, that's what- I based my answer to you before, should he have

had antibiotic. If the answer to that was yes, then I would have given you a different answer. But this is a plaintiff's comment, he had no swelling.

Q. So if he had come in on the 15th for this --

A. And said I have swelling, we have a whole new ball game. But when he comes in on the 15th and says, no, I have no swelling I wouldn't have given him an antibiotic.

Q. But the fact he had said he has mere tenderness --

A. Not in terms of an antibiotic, no. It says adjust occlusion.

He had placed a temporary, he placed filling material in. These arc not -- I realize you are looking for significant comments, but they are not all significant.

Q. It's your thought processes?

A. Yes, exactly. Tylox is oxycodone. O-x-y-c-o-d-o-n-e, and acetaminophen.

Tylox is oxycodone and acetaminophen. Then as you can see I was labeling the day so I could get the chronology correct.

Q. Okay. Again, on page 54, you underlined--

A. Those are just points that I thought were

important to consider.

Q. 7, 13 and 16.

A. Yes.

Q. His symptoms?

A. Yes. The significant signs that I was going to base my judgment upon,

Q. At page 55, what's your notation?

A, Mine is that he's confused regarding the time and date of prescriptions. There are a couple of times in his deposition where he was uncertain of when the prescript-ions were given so I have to rely upon the doctor's record for that.

Q. Oh, this just had to go with his confusion on page 56?

A. Yes. Again, same question. Obviously, he's a little unclear, he says I'm unclear now whether 1 got it at 4:00, Tuesday afternoon or if I got it the next morning.

Q. Let me see. There's a statement by Mr. Axelrod. at page 62, and he's relating what Dr. Kerwinsky said to him and that is, the tooth was okay, I think?

A. Yes. Tooth was fine.

Q. And this?

A. Why did I underline that? I underlined that to confirm what we knew, the tooth was fine. The area around the tooth, that wasn't too fine, we are not saying he didn't have a problem, but there seemed to be a great deal in the deposition, a great deal of emphasis on whether the tooth was sore or not and that's not a big factor.

Q. That's not?

A, There's a great deal of information in Dr. Krell's also. Day two, day three, I was trying to get the Liming correct.

Q. Is there significance on page 66 at line 13 when he talks about his tongue is swelling up?

A, No. I was just trying to get the chronology of these things since he was confused about time.

I was trying to get the chronology so I could identify what sequence these things happened in so I could answer the questions fairly intelligently.

Q. As an endodontist treating a patient who complained of his tongue swelling up --

A. I think there's no question that happened on day two, Dr. Kerwinsky says that. I don't think that's up for debate.

Q. Is it a significant finding as a treating physician?
A. Certainly when that happens, which Dr. Kerwinsky has in here, that's an indication that we are probably dealing with infection and he should be placed on an antibiotic which he was, on the 16th. The record indicates he was on the 16th. Yes, if he has swelling under the tongue my answer is yes, that's significant
Q. Why is that a significant complication?
A. I think at that point we believe we are now dealing with an infectious process and he should receive an antibiotic. The records indicate that Dr. Kerwinsky gave him erythromycin on 5/16, which was day two.
Q. That's the first time he gave him any antibiotic?
A. According to the record, yes.
Q. What's your notation up here?
A. This says a record shows this was on third day.
Q. I'm sorry, hold on just a second. Go ahead, doctor.
A. Mr. Axelrod, we are reading here, says that he would have had a 1:00 visit on Wednesday. But in fact he was confused as to the day. It appears

that that was Thursday. The third day rather than the second day.

Q. You are just focusing on the facts and times?

A. I'm trying to get chronology together that's what most of this underlining is.

Q. Is it your position it wasn't necessary for Mr. Axelrod to see a physician by the 17th?

A. No, I would say normally that would not be done.

Q. It was not necessary for him to see a physician?

A. Well, he chose to go there. I'm not convinced I don't know.

As the case ran its course, we don't know. I would be willing to say that I think he could have avoided the hospitalization. It was at least possible, but we will never know.

Dr. Krell. felt he could have avoided the hospitalization.

Q. But I think your basis for avoiding the hospitalization, if I understand it, is different. Your position is he could have avoided the hospitalization, if what?

A" If he had not elected to go there on the 17th. In other words he --

Q. If he had continued on the antibiotic?

A. If he continued the antibiotic and returned for

this 1:00 visit, then I believe that there was a good chance he would have avoided the hospitalization.

Q. You believe he would have avoided the I&D procedure?

A. That I'm not sure of at this point. He may have had the I&D done as an outpatient. That's a possibility again. You are asking me to predict the future.

All I know is that there were at least three professional who saw him who didn't feel tlie I&D was necessary. The only person who's saying it is, is an expert who never saw him.

Q. Who are the three professionals?

A. Dr. Kerwinsky, Dr. Katz and Dr. Flores who was at St. Luke's, did not elect tu do incision and drainage till the 21st. So I, from that, I can only assume, and tlie record T think reflects that Dr. Flores also agrees with us that it was inappropriate to do an incision and drainage at an earlier date.

MR. CLEMENTS: Excuse me, I have an appointment at 5:30 I have to attend to.

MR. SMITH: Doctor, do you need a break?

THE WITNESS: No, I'm fine, thank you.

Q. Excuse me, while you talked about the fact that Dr. Flores waited some few days to do the I&D procedure in the hospital --

A. Correct.

Q. -- and you attributed that to the fact that he must not have felt it was necessary when Mr. Axelrod first came in?

A. Yes.

Q. Is it possible that, this is the first time Dr. Flores had ever set eyes on Mr. Axelrod and as a new patient in the hospital he wanted to become familiarized with Mr. Axelrod's condition and his medical management?

A. I would think that would not be a reasonable explanation for the delay.

Q. You don't think so?

A. No. I think a surgeon, whoever he may be in the hospital, if you have an appendicitis and he's never seen you before, he's operating twenty minutes after you get there. He doesn't wait to get to know you, if it's needed he would have done the treatment.

Q. In this case it was eventually needed and

antibiotic --

A. Eventually it was done.

Q. But you don't believe it was necessary?

A. I question it, I questioned it because of Dr. Flores' notes. He indicates it was resolving, It just wasn't going fast enough for him. Incision and drainage was done, according to the record, as I read it because Dr. Flores was interested in having it resolved faster than it was. His notations are it was getting better on the 21st.

Q. Is it your position that Dr. Flores' treatment in performing the I&D was below the standard of care?

A. No. I think it's certainly one of the professional choices that he has to make. I certainly would not say it's below the standard of care. He may have been considering that it would give Mr. Axelrod the opportunity to leave the hospital at a quicker pace since he was already admitted and they weren't going to let him go until it resolved until a certain point, so I think that's certainly within the realm of the standard of care. I don't think there's only one absolute treatment that would be within

the standard of care.

I wouldn't criticize him at all. It's only a question in my mind, he's the only one that could answer why he elected to do the incision and drainage at that date.

Q. There are a couple of other depositions.

A. That could be.

Q. Oh, that's it.

A. Are you through with this one?

Q. Yes.

A. It's here anyway if you need it.

Q. I'm almost finished, doctor.

I found a notation that you made on Dr. Krell's deposition at page twenty, line twelve, do you disagree with his statement about canals on anterior teeth?

A. Yes.

Q. Tell me why.

A. Well, very rarely is a -- he says very rarely will you find more than one canal in an anterior tooth and it continues on. That's not a true statement.

Q. It's not unusual to find multiple canals?

A. Is 40 percent: unusual?

Q. That's based on your clinical experience?

A. Based on clinical experience arid we can pick up the textbook there that Mark just put away.

MR. SMITH: Not mine.

A. Lower anterior teeth 35, 40 percent of teeth have canals, very common. It relates to the difficulty question you asked earlier regarding, are back teeth necessarily more difficult than the front teeth, the answer I said is not bigger.

Q. The proximity to the submandibular cavity is not significant either to the molars as opposed to the anterior teeth?

A. No.

Q. With regard *to* infection?

A. With regard to possible infectious process, yes.

Q. Yes what?

A. The process is different in each area of the mouth.

This type of a problem that Mr. Axelrod had could not have developed from a -- would almost never happen from a lower anterior tooth. It wouldn't happen from an upper tooth, so, yes, it makes a little difference. It's not a determining factor in whether or not root canal treatment should be done by the general dentist.

Q. It's not a determining factor?

A. Yes, it makes a little bit of difference,

Q. There's a notation here on page 34 and 35 in Dr. Krell's deposition regarding the organisms of infection.

A. Uhm-hum.

Q. Okay.

A. Well, I would disagree, he and I if we were sitting here together, would understand what he was saying. I take exception to the way it was produced here for nonprofessionals, in that he states there was no pus. That is correct. This was not a subrogated pus-producing infection, that's correct.

Then he says there's pus producing organisms and organisms that do riot produce pus.

I would take great exception with that sentence. Pus is white blood cells and serous fluids, and there are no bacteria organisms that produce that. There are some organisms in response to which the body produces pus more readily than others.

But the organisms themselves do not produce

pus. So I was taking exception on a scientific basis.

Q. On the technicality of his speech?

A. I didn't want anyone to misinterpret what that meant.

Q. The same with this?

A. Well, the problem here, in this section, it starts on the previous page.

Q. Right. Page 35?

A. He is talking about anaerobic bacteria which are bacteria that live in an environment where there's no oxygen.

And thea on the next page he indicates that opening these fascial spaces and venting the area -- which he's talking about the process of doing the incision -- you get oxygenation and that solves the problem. And it's an interesting theory, in fact, one I've never heard of before. So I'm taking exception to that

First of all, for two reasons, one, that's not the reason we do incision and drainage.

And secondly, I think it's a moot question, we shouldn't waste a lot of time, because medical records say there were no anaerobic

bacteria found in the lesion. So we are talking --

Q. What's the reason we do incision and drainage?

A. The reason we do incision and drainage, in most cases in non-Ludwig's, non, true Ludwig's, is Lo remove the purulent material, remove irritating materials. Establish drainage. It's called incision and drainage and we want to get drainage, get that nasty stuff out of there. And a true Ludwig's case it's done and in this case the main help, it may happen from an incision, is to relieve tension on the tissues.

In a true Ludwig's case, if you would find a picture, if you could find a picture, there's some in the textbooks, but it's so rare it's going to be from 1940, they end up making a very large incision across the whole Lower jaw from side to side and the reason is not to let air in, the reason is to prevent choking.

Q. Because of the swelling of the tongue?

A. Because of the swelling. Before antibiotics, Ludwig's angina was almost invariably fatal, it strangled patients. Their airway was compromised.

Clearly not the case here, all the medical

records state very clearly that Mr. Axelrod's airway was not compromised at all..

Q. Rut you are not suggesting that- as a layperson, Mr, Axelrod feeling that his tongue was swelling, and that the whole side of his cheek was swelling --

A. No. I have ~ioproblem with Mr. Axelrod at all.

Q. You seem to have a problem with him seeking medical treatment on the 17th.

A. No, I have no problem with that. But what I'm saying is that if he had not sought medical care then I think the problem would have been resolved by the dental route. It was a situation and Mr. Axelrod was uncomfortable with the situation and if the patient is uncomfortable I have no problem with him seeking medical care,

Q. It's understandable why someone would feel uncomfortable, isn't it?

A. I have no problem with that, absolutely. I'm saying the tendency to try to blame that on Dr. Kerwinsky, that's where I'm trying to draw the line,

Q. You disagree with Dr. Krell on page 40 of his deposition that this was the type of root canal

that Dr. Kerwinsky was incapable of?
A. I think it was certainly a case that was well within his capabilities. I think the final product of the actual technical coot canal treatment bears it out, that he did a beautiful job notwithstanding the infection. But the root canal procedure, he did an excel-lent job. Did an excellent job.
Q. The tooth itself?
A. Yes.
Q. I think Dr. Krell doesn't disagree with you on that.

With reference to Krell's statement on 45, we discussed that already you believe that --
A. I believe -- well, yeah, I feel it's a rather egotistical or arrogant statement. I mean, you know, he's the only one who can do it?

MS. TRICARICHI: Mark, I don't mean to be rude, but off the record.

- - -

(Off the record.)

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Q. Dr. Krell talks at page 65 about the leakage on the tooth which he talks about in conjunction with the infection.

A. Yes, he did and I underlined that because earlier in the testimony in his deposition he said what I thought was exact opposite of that.

I don't know if I can find Lhat quickly for you.

Q. Could you explain what he meant, what you understood what he meant by leaking and whether that has any significance at all?

A. I think that he was attempting to find a source of the problem of infection.

Virtually the source of all infections are the oral cavity, to some degree, and so in this case, he's making a criticism saying that he thought this was the situation.

But it's the exact opposite of what he says in his deposition in which he says, I've concluded the tooth was sealed and by that I mean there was a water-type cement placed inside the tooth so there was no leakage of fluid into the center of the tooth.

Q. That's after the first visit, isn't it?

A. So yes, certainly we are talking about the same thing. I don't think the restoration got changed, the restoration in the x-rays looked the same. So I didn't see that, at any rate.

Q. The leakage Lhat you are talking about would have allowed bacteria to develop is that the theory?
A. I think that's what he is saying there.
Q. Doctor, in your report dated August 14th, 1992 at C, you talk about the consultation and referral was clone in a timely manner. I believe you're referring to Kerwinsky's referral to Katz?
A. Dr. Katz, correct.
Q. Can you explain your statement here with the additional agreement that a medical opinion was advisable?
A, I was basing that upon the record. that Dr. Kerwinsky had, I believe, in which on 5/17 he has written in his record, sent Mr. Axelrod over to Dr. Katz.
Q. That's the best copy?
A. It says something, I'm not certain of what the next word is, maybe agree to check and he says he will see his internist.
Q. So in that instance you thought it was prudent for --
A. Well, I'm just stating in the iccord what it was. I said in my note that the consultation

and referral. was done in a timely manner with the additional agreement because, certainly, I would never tell a patient, such as Mr. Axelrod, who had some concern -- you asked me about his throat, who had some concern, I would never say no, you can't see your physician. I would say fine, see him and get his assurance. Instead, he went to the emergency room.

When you go to the emergency room, as I told Mr. Smith, when you are a hammer everything looks like a nail. If you come to the emergency room, you are going to yet treatment and maybe put in. That's fine. I don't object.

Q. It can be a release in an emergency room?

A. Sometimes, but with this situation, no.

When you come in with a substantial swelling, now they are worried about being on the opposite side of the table from you and they are going to keep him.

That's the way it works. You know, if you have a cut or something, that may be different. But I have no real problem with Mr. Axelrod seeking medical care, if it made him feel better.

Was it absolutely necessary? That's where

we are going to have a disagreement.

Q. Your position is it was not or you don't know?

A. My position is that it's almost certainly it was not. But I'm in agreement with your expert, he doesn't feel hospitalization was unavoided. He has testified that he thinks that treatment was avoidable.

Q. We can quibble about that one.

A. I think he states that very clearly. All we quibble about is timing.

MS, TRICARICHI: I don't have any further questions. Doctor, you know the schtick.

THE WITNESS: I think she's done a great job and I'll waive signature.

(Signature waived,)

C E R T I F I C A T E

The State of Ohio, ) SS:
County of Cuyahoga.)

I, Lynn A. Konitsky, a Notary Public within and for the State of Ohio, authorized to administer oaths and to take arid certify depositions, do hereby certify that the above-named CHARLES KREBS, D.D.S. Was by me, before the giving of their deposition, first duly sworn to testify the truth, the whole truth, and nothing but the truth; that the deposition as above-set forth was reduced to writing by me by means of stenotypy, and was later transcribed into typewriting under my direction; that this is a true record of the testimony given by the witness, and the reading and signing of the deposition was expressly waived by the witness and by stipulation of counsel; that said deposition was taken at the aforementioned time, date and place, pursuant to notice or stipulation of counsel; and that I am not a relative or employee or attorney of any of the parties, or a relative or employee of such attorney, or financially interested in this action.

IN WITNESS WHEREOF, I have hereunto set my hand and seal of office, at Cleveland, Ohio, this 18th day of October A.D. 19 93.

Lynn A. Konitsky

Lynn A. Konitsky, Notary Public, State of Ohio
1750 Midland Building, Cleveland, Ohio 44115
My commission expires February 8, 1995