DE-IDENTIFIED DEPOSITION OF AN ORAL SURGEON PERFORMING DENTAL IMPLANTS

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF

and

Plaintiffs,

-against-

, D.D.S., and D.D.S., P.C.,

Defendants.

February 27, 2008
11:20 a.m.
89-00 Sutphin Boulevard
Jamaica, New York

EXAMINATION BEFORE TRIAL
of , the Defendant herein, held at the above-noted time and place before Josephine Winter, Certified Shorthand Reporter and a Notary Public of the State of New York, pursuant to Court Order, the Provisions of the C.P.L.R. pertaining thereto and stipulations between counsel.

0002

* * *

A P P E A R A N C E S:

LAW OFFICES OF GERALD M. OGINSKI, L.L.C.
Attorneys for Plaintiffs
25 Great Neck Road
Great Neck, New York 11021
BY: GERALD M. OGINSKI, ESQ.

, P.C.
Attorneys for Defendants
New York, New York 10005
BY: , ESQ.

* * *

16
17
18
19
20
21
22
23
24
25
0003
1
2 IT IS HEREBY STIPULATED AND
3 AGREED by and between counsel for the
4 respective parties hereto that all rights
5 provided by the C.P.L.R., and Part 221 of
6 the Uniform Rules for the Conduct of
7 Depositions, including the right to object
8 to any question, except as to the form, or
9 to move to strike any testimony at this
10 examination, are reserved; and, in
11 addition, the failure to object to any
12 question or to move to strike any
13 testimony at this examination shall not be
14 a bar or waiver to make such motion at,
15 and is reserved for, the trial of this
16 action.
17 IT IS FURTHER STIPULATED AND
18 AGREED that this examination may be signed
19 and sworn to by the witness being examined
20 before a Notary Public other than the
21 Notary Public before whom the examination
22 was begun, but the failure to do so, or to
23 return the original of this examination to
24 counsel, shall not be deemed a waiver of
25 the rights provided by Rule 3116 of the
0004
1 .
2 C.P.L.R. and shall be controlled thereby.
3 IT IS FURTHER STIPULATED AND
4 AGREED that the filing of the original of
5 this deposition shall be waived.
6 * * *
7 , having been first
8 duly sworn by a Notary Public of the State
9 of New York, upon being examined,
10 testified as follows:
11 EXAMINATION BY
12 BY MR. OGINSKI:
13 Q What is your name?
14 A .
15 Q What is your address?
16 A
17 New York, .
18 MR. OGINSKI: Mark the doctor's
19 chart as Plaintiff's 1.
20 (Whereupon, the above-mentioned

document was marked Plaintiff's Exhibit 1 for identification.)
Q Good morning, doctor.
A Good morning.
Q What are implants?

A Sorry?
Q What are implants?
A Metal screws acting as replacement to roots of the teeth.
Q And what is the purpose of an implant?
A To replace -- to replace the void in the mouth where teeth are missing, one or more.
Q What is a healing cover?
A That's a cover on top of the implant which is wider. There are several of them, several sizes going from one to four, and they are thicker than the original cover of the implant.
Q What are indications for using an implant in general?
A Replacement of natural teeth.
Q What is a bone graft?
MR. : Just so I'm clear, this is general and not specific to this case?
MR. OGINSKI: Correct.
A It is just addition to the bone

where some bone is missin
Q Are you familiar with a term known as guide holes?
A Yes.
Q What does that mean to you?
A It's a way to get the implants into certain spaces.
Q How do you do that? Is it a template? Is it something else?
A It could be template. It could be a guiding instrument to check the angle and the space between the teeth.
Q In the year did you have any type of instruments that would assist you in making these guide holes?
A Yes.
Q Did that instrument have a particular name?
A Yes. I didn't use the name for a long time, but -- just -- I just can't get it.
Q Doctor, all of my questions are going to relate to the time period of to unless I indicate otherwise.

0007

A O .
Q Are you familiar with the term known as pilot holes?
A Yes.
Q What does that mean?
A Well, that's the initial hole, the initial hole into the bone that would be the place where the implant's supposedly going to be inserted.
Q Whether it's guide holes or pilot holes, these are the initial holes that are made where you put the implants?
A Yes.
Q Are you familiar with something known as study models?
A Yes.
Q What are those?
A Impressions taken and being poured by a stone and getting the impression is the negative of the existing condition, and after pouring the stone, it gives you the positive, the exact replica of the teeth or jaw present in the mouth.
Q In did you have in your

0008

office the ability to perform and make study models?
A Yes.
Q What is a mold?
A I'm sorry?
Q A mold, is that similar to an impression?
A Yes.
Q What is a CT scan?
A That's a type of picture or x-ray that gives you the situation in the mouth.
Q What is the purpose of a CAT scan as it relates to the type of work that you did as far as using it for implants?
MR. : Objection. That assumes he uses it for implants.
MR. OGINSKI: Sure.
Q Doctor, are you familiar with CAT scans being used as a tool to assist dentists such as yourself in planning implants?
A Yes.

0009

Q What is the purpose of using a tool such as that?
A Well, it's an additional tool.

There are many tools that assist a dentist for doing many surgeries in the mouth including dental implants.

Q How does a CAT scan assist a dentist in planning a patient's implants?

A Well, it gives you some information as to the amount of bone existing for placing the implants. It's one of the tools.

Q Have you ever used CAT scans --

A Yes.

Q In your practice, doctor, again, from and before that time, you have used CAT scans to aid you in planning for implants?

A Sometimes.

Q What is a panorex?

A Panorex is an x-ray that gives you a picture of the entire mouth including the condyle joints and sinuses.

Q Are you familiar with the term

0010

bite wing films?

A Yes.

Q What are bite wings?

A Well, this is small x-rays that give you the picture of teeth on the top and on the bottom on the same -- of a small particular area of the teeth.

Q Are those also known as periapicals?

A No.

Q What is the difference between periapicals and bite wings?

A Bite wings are basically to give you a picture of the crowns of the teeth, on the top and on the bottom. They usually practically never show you the apex of the teeth.

Q The periapicals do show you the apex?

A Should.

Q Is there any other distinction between the bite wings and the periapical films?

A No. Both of them -- both of

0011

them use the same x-ray except that for the bite wing you place a kind of holder that allows you to place it in the mouth and when you bite on it, it shows -- it extends somewhat to the top crowns and the lower crowns of the teeth.

Q What is the difference between a bite wing film and a panorex?

A A bite wing is just for a small area for the width of two to three teeth as opposed to panorex which is the entire dentition. Bite wing is also only for teeth, really, not for edentulous areas.
Q Can you evaluate bone loss from a bite wing film?
A I wouldn't.
Q Can you evaluate bone loss from a periapical film?
A Not bone loss but the existing bone.
Q Tell me why you wouldn't use a bite wing to evaluate bone loss.
A Because the distortion would be -- in my situation, you know, the

0012

distortion would be more than with a periapical x-ray.
Q When you say distortion, you are talking about the normal distortion that occurs from a particular type of x-ray; correct?
A Yes.
Q How much of a distortion would you expect to see in a bite wing film?
A More than I would expect. More than I would want to.
Q Can you quantify for me in any fashion the amount of distortion that you see using a bite wing film?
A No. It could be different times different positions. It would be different.
Q And the distortion that you mentioned, in fact that magnifies what it is you're looking at; is that correct?
A It depends on the position of the x-rays. It can shorten it or lengthen it.
Q Is there also distortion

0013

associated with periapical films?
A Yes.
Q In comparison to the bite wing films, is it more, less or the same type of distortion?
A Less.
Q Is there also associated distortion with a panorex film?
A Yes.
Q How would you describe the difference between the distortion on the panorex film compared to a bite wing film?
A In my situation, the periapical

would give me a better idea than the panorex to any specific area.
Q When you say in your situation, tell me what you mean by that.
A I get better estimates with periapical than with panorex.
Q Is there a greater distortion in a panorex film than in a bite wing film?
A Could be. It all depends. Everything -- it all depends on the operator, you know. Even with panorex you

0014

could get a lot of distortion, less of a distortion and the same thing with periapicals.
Q What is the difference between a panorex film and the CAT scan for purposes of the type of work that you did in terms of putting in implants and using it as tools to help you?
A Panorex is two-dimensional. Whereas CAT scan can be used also as a three-dimensional.
Q How does that assist you, if it does, in evaluating the structures of what you're looking at?
A Depends on the condition. Depends on each case. Sometimes I would need to be assisted by it and sometimes not. In my experience of 30 years of doing implants in certain cases I don't need the help of a CAT scan.
Q How do you decide whether to obtain a CAT scan?
A If it's -- if in my estimate, in my -- in my particular case if I would

0015

feel that it's very -- it's -- how should I say it? Borderline case, a very difficult case, then I would need or I would seek the assistance of a CAT scan.
Q What information would a CAT scan provide that a panorex could not provide?
A The panorex would not show you the width.
Q Can you be more specific as to what you mean by that?
A Well, the width of the bone that would give me -- should I need the assistance of a CAT scan.
Q Are there any other benefits to using a CAT scan over a panorex other than obtaining the width of the bone?
A Not really. Not in my

situation.
Q In the past when you have used CAT scans to assist you in determining placement of implants, do you rely on a radiologist to read and interpret the CAT scan film or do you read it yourself?

A I read it myself.
Q Tell me about the type of training you have had in order to enable you to read CAT scans.
A Well, I've attended courses in oral surgery and implantology throughout my 30 years of experience and sometimes we aided our decisions by taking either a panorex or a CAT scan.
Q Am I correct that in you did not have a CAT scan facility within any one of your offices?
A No.
Q You would have to have the patient go to an outside facility?
A Yes.
Q The courses that you just mentioned, would they be courses that you'd go to for a day or part of a training program or something else? What would they be?
A Training programs and courses for a day. I attended many many courses.
Q These training courses you've

mentioned, would they be focused solely on the reading and interpretation of CAT scans or would they be part of other courses taught about the topics you are involved in?
A Mostly part of other courses that I took.
Q Out of the courses that you trained in to learn about how to interpret CAT scans, can you give me the longest length of time any one of these courses lasted, whether it be a few hours, a day or more or some other time?
A No, I can't recollect. No recollections.
Q When was the last training course that you took before regarding the interpretation of CAT scans?
A I don't remember. I can't recall. I can't say it specifically.
Q Would it be more than ten years before ?
A No. Less than ten years.

Q More than five years?

A I would say less than -- to my recollection, less than five years.
Q Do you recall where it was that you obtained or went for these courses?
A The courses given by --
Q Was it in New York? Was it out-of-state? Was it out of the country?
A One was in Florida in -- the name of the place just -- Disneyland, where is it?
MR. : Orlando?
A In Orlando, right.
Q Disney World?
A Disney World. O .
About two years -- two, three years ago I attended by the American Dental Society of Implantology. I don't know if the name is exact, you know, but that was the last.
Q Were you familiar with any standard of care back in that recommended the use of CAT scans when deciding whether to put in two to four implants?

A Nobody ever told me in any courses that I would have to take CAT scans for every case I do.
Q Were you familiar with any type of standard of care -- I am talking about a written standard of care -- concerning the recommendation to use a CAT scan when deciding to put in more than ten implants in a patient's mouth?
A You mean ten implants in one jaw or both jaws or what?
Q In any one jaw.
A I never placed more than ten implants in one jaw.
Q I'm sorry. My question wasn't clear.
Were you familiar with any standard of care that required the use of obtaining a CAT scan for the purposes of aiding you in planning for implants when you were intending to put in ten implants or more throughout the patient's mouth?
A I'm not familiar with any standard of care for every case of placing

an implant, no.
Q Were you aware of any literature

that addressed the use of CAT scans to assist dentists such as yourself when planning to place implants?

A Yes. In some of the articles that I read, you know, in some of them they talked about CAT scans and some of them they didn't talk about CAT scans. It was not -- to my knowledge it was not 100 percent a must of taking a CAT scan. No.

Q How do you determine, doctor, if a patient is a candidate for implants?

A Besides the theoretical, you know, like attitudes of the patient, his oral health, his smoking, smoking habits, his, you know -- other than that, I would examine the amount and size of bone present to enable me to place an implant.

Q How do you examine the amount and size of bone that's present?

A I take intra-oral measurements. I take the periapical and the panorex and I -- even though I know that there are

0021

some distortions, I look not for the exact height of bone or the exact width of a bone. I just have to know that I have -- since there are a lot of diameters, a lot of different diameters of implants, a lot of different lengths of the implants, the amount and size of bone varies in different situations. I can have less than -- there is no specific size of bone. As long as it's within the size of the smallest diameter and smallest length of the implant.

Q Now, you just told me, doctor, that you don't look for the exact number, the exact dimension of a particular area of bone. Am I correct to understand that you really are, based on your experience and eyeballing it, looking to see if there is sufficient bone there that would hold the implant?

A Well, yes, in my experience at the time that I did Mr. --

Q I am not talking about Mr. yet. I'm just talking in general.

0022

A Well, I've been doing implants for over 25 years. I need less -- I have more experience and I would measure the amount of bone to give me sufficient bone in the width of the crest of the ridge, the width of the bone to be sufficient to place a -- any specific diameter of an

implant. It can go anywhere, in my experience, the smallest diameter to be 2.9 millimeters and it can go to 6.0 millimeters in diameter and the same thing about lengths. It can be anywhere between eight millimeters long or 16 millimeters long.

Q You mentioned that the crest of the ridge of the bone is something that you need to evaluate. Tell me why.

A I would have to know if at least I have enough width of bone to support the narrowest diameter of implant that exists.

Q What happens if there is insufficient bone to accommodate an implant? What do you do then?

A I tell the patient tough luck.

0023

Q The intra-oral measurements you measured, what exactly are you measuring?

A The width of the bone.

Q How do you do that?

A I had an instrument that -- I forgot the name, but it looks like a pyramid-like and it has a gauge in between and you place one side of the instrument on the palatal side or the lingual side and the other end, the other side, if you will, if you want to call it a fork to the labial or to the buccal side and on the gauge it tells me the width.

Q Why do you take the intra-oral measurements if you don't rely on them to make a determination if there is sufficient bone since you said you don't look for the exact number?

A I don't follow your question.

Q You told me a few moments ago that you are not looking to see the exact measurement to see whether or not there is sufficient bone but rather you base it upon your experience and visually whether

0024

there is sufficient bone, so my question is why then do you take the intra- oral measurements?

A I have to know the minimum necessary width to determine if I have sufficient width of bone to place the least diameter of an implant.

Q Are you able to determine the width of bone from the panorex?

A No.

Q Are you able to determine the width of the patient's bone from a bite

wing?
A No.
Q Or from a periapical film?
A No.
Q Are you able to determine the width of a patient's bone from a CAT scan?
A Yes.
Q Now, the width you measure using this instrument as part of your examination, what do you do with those measurements? Do you record them so you don't forget them, so you know what they

0025

are in each particular area?
A No, I don't really record them. I just know. I know I have enough -- if I schedule the patient to do an implant or two or three, whatever the amount, I know whether it's a go or no go. Then I tell the patient. I'm sorry. You don't have sufficient bone and at that time, you know, I don't do it.
Q You told me a moment ago, doctor, that different parts of the bone, of the jaw has different sizes; correct? There might be different widths along the way?
A I didn't say that.
Q I'm sorry.
In a patient, does a patient usually have the same width of bone throughout their entire mouth?
A Oh, no.
Q When you measure and you take these intra-oral measurements, am I correct that sometimes you get different measurements for different parts of the

0026

bone along their jaw?
A Yes.
Q How do you determine and how do you remember what size implant to use for a particular width of bone if you don't record those measurements down when you do your exam?
A Well, at the present -- within the last few years as my experience got better and better, my proficiency got better and better in general. I know from these measurements that I have enough bone to place the number of implants that I want to place, so --
Q I'm not asking about the number of implants. I'm talking about the size of the implants that you discussed with me

a moment ago.
A Yes.
Q Is it possible that when you put in implants, that different implants could have different sizes? In other words, you could put in one particular size of implant in one part of the jaw and a

0027

different size in another part of the jaw?
A Oh, very much so.
Q So my question is when you take these intra-oral measurements, you told me that it has a purpose; so that you know how much width is there to accommodate the implant.
A That's correct.
Q So my question is if you don't record that information and now the patient comes back to you at a later time to do the procedure, how do you know what size implants to put in if you haven't recorded what width bone there is for a particular part of the jaw?
A I don't really have to record and to rely on the exact measurements that I took a week or two weeks or a month before because there are no changes in the width of the bone from a week, two weeks or a month earlier, so I know on the day of the surgery I know that there is sufficient bone and I can see just looking at the arch, the jaw, I can see where I

0028

can place these implants.
Q But how do you know the size of the implant to put in if you don't record those measurements in each particular area?
A O . I know that there is sufficient bone for the smallest diameter, at least for the smallest diameter and then intraoperatively I place the smallest diameter of the implant and then I examine and I go to the next diameter if I can. If I can't, I just stop there and at that time I know the diameter, the minimum of the diameter that I would need. As long as it is within the smallest diameter, I'm satisfied because I know that at least I can place this diameter.
Q What is the purpose of taking the periapical films to determine if a patient is a candidate for implants? How does that help you?
A The periapical x-ray is more

specific. It gives you more detail of the area and that's basically it.

Q How does the panorex assist you in evaluating whether or not a patient is a candidate for implants?
A Well, it gives me a general picture of the jaw that would assist me. No periapical x-ray or panoramic x-ray -- each one of them is a tool in determining the availability of the height of the existing bone, of the given bone.
Q Is that different than the width of bone you just told me about a little bit earlier?
A No.
Q How many periapical x-rays do you take when evaluating to see whether or not a patient is a candidate for implants?
A It depends on how many implants I'm going to place.
Q How do you make that determination?
A How many teeth are missin
Q If a patient has no natural teeth, how many periapicals would you expect to take?

A Anywhere between six -- between four to six.
Q Are you familiar with the term known as a full mouth series?
A Yes.
Q What does that mean?
A Full mouth series, it includes bite wings and it's for me full mouth x-rays would be necessary more for existing teeth that may need or may not need fillings or root canals or things like this.
Q If a patient has no natural teeth, would a full mouth series be of use to you in evaluating a patient as to whether or not they are a candidate for implants?
A Not really.
Q Are there times when a full mouth series would be useful to you to evaluate a patient's condition as to whether or not they are a candidate for implants?
A When the patient is edentulous,

I don't think you need full mouth series,

not in my -- not in my experience.
Q In your opinion, doctor, is a panorex film a better tool to evaluate the extent of a patient's existing bone than a bite wing film?
A Not really.
Q What is the best tool in your opinion that you can use to evaluate the patient's current existing bone?
A It could be periapical or periapical and panorex. If I'm satisfied with periapicals, I'll just use periapicals. Like I said before, they give you more specific knowledge of the existing situation. The panorex is more generalized.
Q And the CAT scan you mentioned has a benefit because it's a three-dimensional view as opposed to a two-dimensional panorex or PA film?
A Yes, but in many situations clinical observation is as good as a CAT scan.

0032

Q The patients who typically came to you, do they have dental insurance?
A Yes. Many of them do.
Q In deciding whether or not to recommend a CAT scan to evaluate whether they are a candidate for implants, was the cost factor ever at issue for the purposes of deciding whether or not to recommend a CAT scan?
A Never.
MR. : You mean an issue for the doctor?
MR. OGINSKI: Yes.
A Never. Never. Cost was never a determining factor in telling the patient you should or if the patient said he doesn't have enough money and I deemed it extremely necessary to do it, I will tell him, well, I can't do it.
Q Are there different types of implants?
A What do you mean by that?
Q Is there only one implant that's made?

0033

MR. : You're talking about manufacturer or style? It's a complex area.
Q You've told me what an implant is.
A Yes.

Q Does more than one company make implants?
A Yes.
Q Are there different types, styles, models of implants?
A Yes.
Q Tell me about the different types of implants that were available in .
A I've used only two types of implants, so I do not concentrate on other types, so I did not go too far into looking for them. I was satisfied with what I've used.
Q I'll ask you first, since you bring that up, tell me what are the two implants that you use?
A I used the screw vent -- I used

a company by the name of Zimmer, Z I M M E R, and another company, its name is MIS.
Q That's the name? MIS?
A Yes.
Q And you mentioned screw vent. Was there another one you told me?
A Both companies have screw vents. To me a screw vent is a -- it's a screw vent tapered implant. I used only screw vent tapered implants.
Q What is a tapered implant?
A It's tapered. The top of the implant is slightly --
Q Wider?
A -- wider. The diameter is wider.
Q What other type of implants were you aware of that were on the market in ?
A Like I said, there are many types of implants and I used only two types, two different.
Q You mentioned a screw vent. What was the other one?

A I used only screw vents.
MR. : Off the record.
(Discussion held off the record.)
Q Doctor, what is a core vent, C O R E, V E N T, implant?
A Well, to me core vent signifies it's a titanium implant that has grooves and it has spaces -- I mean holes at the apex of the implant.
Q What is the purpose of that?

A The purpose of that is to have cartilage and bone over the years build into it and, you know, by that even one hole is sufficient. It helps the stability of the implant.
Q Now, in your practice did you use core vent implants?
A Yes.
Q Is that the same as screw vent?
A It's basically the same.
Q Any particular difference that you are aware of?
A Not really.

0036

Q Made by both Zimmer and MIS?
A Mostly by Zimmer. The name, at least. But the name doesn't signify to me much of a difference.
Q The screw vent implants that you used, were those coated or noncoated?
A The screw vent HA tapered came from Zimmer company that I used for the top teeth.
Q Was it coated or noncoated?
A It was coated with HA.
Q That's hydroxyappetite?
A Yes, sir.
Q And the core vent implants that you used, was that coated or noncoated?
A No. The other one was an MIS implant which is a -- which is the same as the -- the same tapered and the same -- basically a copy of the screw vent from Zimmer that was manufactured by MIS.
Q But was it coated --
A No, this one was not coated.
Q The core vent was not coated?
A No. The MIS was not coated.

0037

The Zimmer was coated.
Q Hang on.
The MIS that makes core vent you're saying was not coated?
A I don't call it coated. I call it a tapered implant, but that was not coated.
Q What is the difference between a coated implant and a noncoated implant?
A There isn't much difference except the coated implant is coated by hydroxyappetite.
Q Why? What's the purpose or benefit of having one coated and one not coated?
A Well, in the literature some

clinicians see the benefit of having coated implant and some swear by it and some don't swear by it.
Q What is the reported benefit of having a coated implant?
A Well, those that hold that this implant is better because it's better -- better -- better contact, I should say.

Q What do you mean?
A The bone, the natural bone and the coated HA would -- would -- I forgot the term. Would merge, would bond. The bond between the coated HA and the bone would be better than the noncoated one.
Q To which school of thought did you belong? The use of coated or noncoated implants?
A In my experience, it went either way.
Q In other words, it didn't matter to you whether you were using coated or noncoated?
A That's correct. I would likely use coated on the maxilla and, you know --
Q Why was that your practice, to use the coated implants on the maxilla?
A Well, I didn't have much -- I didn't really see that much of a difference between, but nevertheless I used it. I thought it cannot hurt.
Q And is there a reason why you didn't use the coated implants on the

mandible?
A No, there is no reason. It's just a different company.
Q Was there any benefit to using the coated implants for the mandible?
A Not really.
Q Just so we're clear, doctor, the mandible is the bottom jaw?
A Yes.
Q The maxilla is the upper jaw?
A Yes.
MR. : Let's take a quick break.
(Short recess.)
Q Doctor, the screw vent that you told me about made by Zimmer and also MIS, what did that cost?
MR. : You are talking about per --
MR. OGINSKI: Per implant, yes.
Q The cost for you to purchase the

implant?
A Well, I think the cost, to my best recollection, would be around the

high 200, but in my case since I was, I think -- I think, the best purchaser of either companies in the United States, for that matter in the world -- I purchased a lot of implants -- they gave it to me in the -- for high discount.
Q Do you mean because of the volume of discounts you purchased they were able to work something out with you so you paid less per implant?
A Yes.
Q Would the same be true for the core vent implant we talked about?
A Yes.
Q So approximately somewhere in the $200 range?
A That I paid?
Q Yes.
A I would say even less.
Q Can you give me an idea?
A An implant that cost about 200 by MIS I got for about, I would say, a hundred or so. The one that's 280 or so, the core vent I got for about 150, 160.

Q How do you determine if there's been bone loss when a patient comes in to be evaluated?
A Well, there's always an existing bone loss where there is a missing tooth or missing teeth. It all depends on the amount of time elapsed since the extraction of the teeth. Also, it all depends whether the teeth that were missing or still existing had periodontal disease, so all these are factors in loss of bone.
Q If you feel on an exam that a patient has insufficient bone in one part of their mouth but sufficient bone in another part, have you in the past been able to put in implants where there was sufficient bone and left the other area alone?
A Like I said before, I would not place an implant when there is to my -- I should say to my desire, to my expectation is insufficient.
Q I'm sorry. I wasn't clear.

I'll rephrase it.
If you find that a patient has sufficient bone in one part of their mouth but insufficient bone in another part, could you still put in the implant in the part that has good bone and leave the other part alone?
A Upon consultation with the patient. You know, if he desires to have only implants on one side, at least complement that side with teeth or a denture, then the answer is yes.
Q Over the course of your career, doctor, have you published any articles in any peer review journals in the field of implants?
A I was a clinician. I didn't look for --
Q I'll ask you that in a minute.
A No.
Q Thank you.
Did you personally perform any clinical studies throughout the course of your dental career that you have

0043

published?
A No.
Q Did you perform any studies for which you accumulated data but have not published?
A No.
Q Over the course of your career did you teach dental students?
MR. : You are talking about ever?
Q From the time you went into private practice up until the time you finished?
A No.
Q Again, during the length of your career, doctor, have you taught other dentists?
A I taught other dentists about dental implants, not for the sake of them doing implantology.
Q For what purpose?
A But for general information, you know, for them to -- I had at different times four to five dentists working for

0044

me.
Q I'll get to that, but tell me under what circumstance you would teach other dentists. And, again, I am not talking about the people that might have

been working for you.
A I didn't teach other dentists other than those that worked for me.
Q Did you teach any courses or seminars or classes to other dentists?
A No.
Q Did you give any lectures to any other dentists as part of any national organization of dentists?
A No.
Q Or any State organization of dentists?
A No.
Q In order to maintain your license up until the year , were you required to take ongoing educational classes?
A Oh, yes.
Q To keep up-to-date?

A Yes.
Q Were you required to take a certain number of classes or courses each year or every two years or something else?
A Yes.
Q How many classes would you typically take in any given year?
A Enough. I don't recall, but at least I fulfilled the requirements for licensure.
Q Do you know what those requirements were as far as continuing dental education?
A No. About 50 credits or -- I can't recall.
Q Is that per year?
A I don't recall. You can check into the requirements and then I'll tell you I did more than that.
Q Out of all the classes or seminars that you took, did you get any type of certificate to confirm that you were present and you were there and you got these credits for being there?

A Yes.
Q Do you have copies of those?
A I may. I may not. You know, I'm sure you know I sustained a disaster in my office and have lost quite a bit of things.
Q I'll ask you this, doctor:
Those certificates that you would get from completing various seminars on continuing dental education, what did

you then do with those certificates? Where did you keep them?
A I kept them in a room near my office, but --
Q In which office?
A -- but in order to obtain the credits for licensure, I had to provide the society with the diplomas or certificates, whatever you want to call them, so I must have had. Otherwise, I would not be -- not because I'm a liar, but they wouldn't trust me if I didn't supply it to them.
Q I'm only asking, doctor, which

0047

office did you keep those records in?
A Most everything was kept in the office.
Q And that was the one that sustained the fire?
A Yes.
Q Now, the fire, am I correct, was in the basement?
A It started there, I think.
Q Did the fire go to the first floor where you had the office you've just described?
A Yes.
Q Were any records salvaged from that office?
A Yes.
Q Where are those records currently?
A In my home.
Q I would just ask that a search be made and if you find any of those records concerning the continuing dental education that you provide that to your attorney.

0048

MR. : Can you give me a time frame you're requesting?
MR. OGINSKI: Sure. Within five years before .
A I have conducted a search for charts, x-rays.
Q I'm not asking about that.
MR. : Based upon this transcript, doctor, I'll remind you, but you will know. There may be some other things, but if you have any of those records.
THE WITNESS: O .
A Not to my -- I don't know.
Q Are you familiar with something

known as failure rate when using implants?
A Yes.
Q What is failure rate?
A Well, everybody -- everybody has a different failure rate, you know.
Q What is it?
A The percentage of failure of implants.
Q What is the overall failure rate

0049

in general?
MR. : You are talking about all professionals?
MR. OGINSKI: Correct.
MR. : That he knows and if he knows.
A It varies. It varies from 98 percent to -- I don't know. It could be even 50 percent.
MR. : Failure rate?
Q Failure rate or success rate?
A 50 percent would be failure or -- I would say -- I would say the percentage as I described it --
Q I'll ask you about yours in a moment, but in general what is the overall reported failure rate in the literature for implants?
A Maybe in the 90's.
Q Meaning that 90 percent of the implants fail or 90 percent are successful?
A Successful.
Q So there would be approximately

0050

a ten percent failure rate?
A Approximately.
Q Specifically as to the rate you experienced in your practice, what would you say your failure rate was with the use of implants?
A Well, generally failure rate is slightly higher when you place implants on the same day that you extracted the tooth.
Q Why?
A I would say it's more prone to infection than a nonextracted site on the same day.
Q Why would infection increase the failure rate?
A Well, it depends. There are many, many reasons. One is an existing infection either in the soft tissue or in the bone. Some infections are not detected by clinical observation, you

know, but since bacteria is microscopic, you know, sometimes it's impossible to determine whether there is an infection or not.

Q But why would an infection cause an implant to fail?
A I'm sorry?
Q What is the mechanics by which a patient who has an infection, that the implant would fail?
A It would create less of an opportunity, I should say, you know, for bonding between the implant and the bone.
Q Why?
A Probably one of the reasons would be a softening of the bone over a certain time. It could be a week. It could be a month.
Q Doctor, would it be fair to say that if you observed evidence of a clinical infection in a particular area where you intended to place an implant that it would not be good practice to put an implant in when you see evidence of an infection there?
A That's correct. I should say acute infection.
Q O .

And would it be appropriate to ask the patient before attempting to put in any implants whether they experienced any evidence of any type of infection within a limited time before coming for the procedure?
A Well, generally I don't go -- most of the time I don't go by what the patient tells me because I don't think they are professionals enough, you know, to -- some patients will think they know everything and they say just he did it like this, he did it like that, so it doesn't go for me, so I conduct my procedures on my experiences and my observation, not an observation of a patient.
Q In your practice, doctor, would it be good practice to ask the patient if they have had any type of infection in the weeks leading up to the time that they're coming in to have implants put in?
A I would ask them, you know, but that would not be my --

it would not be my way of deciding whether to do it or not.
Q Sure.
But at least it's good practice to ask them whether or not they have had a problem in their mouth?
A Everything helps.
Q An implant that fails, is it in any way usually related to anything the patient does or does not do? In other words, is there something active that they might do that will cause an implant to fail?
A Absolutely.
Q How? What is it?
A Some people poking into implants with -- I've seen people do it with tooth picks. Some people tell me that they used the fork, one of the tongs of the fork, you know, to get -- some people think they can do everything and they don't report it even to the dentist, you know. They did it. You know, some patients you can't trust.

Q When you put the implant in, does the gum heal over it?
A Not all the time. Not necessarily.
Q If the patient has manipulated the implant after it's been put in, are you able to visually see if they've played around with it or done something to it?
A Not really.
Q Other than actively and intentionally trying to pick at the implant that's put in, is there anything else that a patient could do that would cause an implant to fail?
A Yes.
Q What?
A Biting habits. I've seen patients who had a denture on and they cleaned up the area where they thought they had an irritation and they did it by themselves, you know. Some of them would deny they did it. Some of them would agree, you know, tell me yes, they did. Sometimes there is an area of an implant,

you know, where either the same day to several weeks later they had some irritations and they poked their fingers into and played around. You know, maybe

there are other things, but I'm just not aware of it because --
Q Does the patient's oral hygiene affect whether or not an implant can fail?
A Yes.
Q How?
A If they don't rinse the mouth, they don't remove some remnants of food that gets stuck between the tissue and the implants and that is a cause of a beginning of an infection. Irritation, unnecessary irritation can cause to an infection, cause to loosening of approximation of tissues or things like that that may lead to infection.
Q When you perform implants do you explain to patients how important their oral hygiene is following the procedure?
A Absolutely.
Q Do you tell them what could

0056

occur if they don't follow your instructions on oral hygiene?
A Yes.
Q Do you also provide written documents to them so that they could read about what happens if they don't follow your instructions with regard to the oral hygiene?
A Sometimes I do. Sometimes I don't, but I verbalize it to a point where there should be no misunderstanding.
Q What type of documents did you have available that you could provide to a patient to address the oral hygiene issue?
A You know, oral hygiene, rinsing.
Q No. I'm asking the documents.
What paperwork did you have in your office that you could simply hand to them to reinforce what you were telling them?
A Well, that's what I'm saying, you know. Proper oral hygiene, reducing smokin
Q These are pamphlets or papers

0057

that you printed? What were they?
A These were papers that were given to me by the -- I think they were given by the implantology -- implantology -- no. Things that I saw in conventions, pamphlets, you know, for home care instructions that I picked up quite a bit of, quite a few of them. These are things.

Q Let's go back, doctor, to I asked you about your failure rate in your experience with implants. How would you quantify your failure rate?
A I would go in a nonextraction site, you know, edentulous, I would quantify it in the mid 90's.
Q Meaning successful?
A Success. Correct.
Q In an area where you needed to extract teeth, what was your percentage? What was the failure rate?
A Maybe two, three percent less, lower.
Q So in the low 90's?

A In the low 90's. Anywhere between the low 90's to the mid-90's.
Q Was the failure rate for an extracted tooth consistent with the reported failure rate for literature overall in using implants? Was it more, less or the same?
A I came across extraction sites, you know, the failure is slightly higher.
MR. : You are talking about in the literature?
THE WITNESS: Yes. Sure.
MR. OGINSKI: Off the record.
(Discussion held off the record.)
Q Let me clarify, doctor.
In cases where you put in an implant where there is no tooth there, in an edentulous situation, was your failure rate consistent with the overall reported failure rate in the literature?
A I don't want to brag about it, but in my experience I've done more than 15,000 implants, so overall I would say

that I had quite a success. In many cases I did place more implants in than the patient paid me for with his consent or her consent.
Q Why?
A I always wanted to have successful results and expecting that there are failures to me as to many others, so since I got implants at relatively very low cost, it would not -- and the time-consuming of placing an implant was not that much of a problem, so I didn't mind placing two, even in situations four more implants than the

patient paid me.
Q Did you do that knowing that there was a good chance that one or more implants would fail?
A Not that there is good chance. There's always a chance. I always told the patients there is always a chance of failure no matter what; extracted sites, nonextracted sites.
Q When you purchased these

0060

implants from the companies in this large volume that you told me about, would the representatives of the companies come to your office on a periodic basis?
A Yes.
Q To either introduce you to new products they were selling or to literally bring their product to you?
A I wouldn't say new products. I was extremely satisfied with my implants. They did not have any minuses to them as compared to other companies, so I basically used this type of an implant throughout many -- I mean, implantology -- implantology has been changed almost on a daily basis, the type of implants, duration of implants before applying restorations on them. You know, everything is being changed, you know.
In my first days of doing implants, you must have had at least minimum of at least six months of a wait between restoring, you know, for restoring the implants. Now they are talking about

0061

it's not necessary to wait any time, any length of time. So things change. Nothing is fixed.
Q Doctor, the company that you purchased these implants from, did they ever provide you with trips for any reason? Provide either educational trips or vacation trips, things like that?
MR. : Note my objection. You may answer, doctor. You are talking about any time frame?
MR. OGINSKI: Yes.
A Well, I brag about it. Yes. Absolutely. More than any other dentist in the world.
Q Tell me about that.
A Well, MIS took me -- they had -- it's an company. They had a convention where there were their

representatives throughout the world. They invited all their representatives come to to see the factory and then give them some good time, things like that. That was about five years ago.

I purchased from them tons and tons of implants, so they took me first class in Airline to .

Q With your family or your wife?

A With my wife, yes.

So we were -- I was the only dentist from anyplace, you know, that was invited.

And then Zimmer, they had a mini-convention, also, within the company, no dentists, in a resort area north of , 50 miles north of . It was five days or six days, so they give me an extra week in .

So these are the two.

Q How long ago was that?

A Everything within the last five or six years.

Q In addition to that, did they also provide you with any educational materials like textbooks or journals or reading material for your own benefit?

A Yes. Everything that's related to their implants.

Q Did they also take you out to dinners here in New York or provide you the opportunity to take your friends out to dinner at their cost?

MR. : Same objection to the line, but you may answer, doctor.

A They invited me, but I didn't have time. I did a lot of implants.

Q Did they provide any gifts to you over the course of five years or so before other than what you've told me about with the travel?

A Yes.

Q Tell me.

A They came up with -- well, MIS came to me with one of the instruments to measure parallelism between implants. There was a dentist in that is their advisor and he -- it carries his name and I forgot his name now. Getting old.

So they gave me about five, six years since -- even more than that. They give me a parallelism instrument that I've

0064

used quite a bit, and they gave me also posts for free, and the same thing with Zimmer company. They supplied me with things that I didn't have to pay.

Q And this was to thank you for being such a good customer?

A Yes.

Q Now, as part of these gifts and the trips, did they provide you with any documentation for tax purposes so you could then indicate that you received a particular gift?

MR. : Note my objection. Doctor, you may answer if you care to. I don't know that it has anything to do with the case, but it's up to you, about tax information.

A It was never given to me as a gift, per se. It was given to me as a way, you know, like a symbolic way of giving it to me for using -- for using their -- it was to their benefit more than to -- well, equal benefit to them and to me.

0065

Q It was a thank you in some form; right?

A In a way you can call it a thank you, you know.

Q Regardless of what they provided to you, the companies that did provide you with the trips and with this instrument and the posts, did either of those two companies provide with you any written documentation indicating the value of those gifts at any point so that you could then use that documentation and submit it with your taxes?

MR. : Objection to the form. Again, you're assuming that there's a tax implication. I don't know that to be so. That's why I'm objecting I'm just stating that for the record. I don't know that they had to do that and he had to report something to the I.R.S. That's why I'm raising the objection.

Q Did Zimmer ever provide you with written documentation about the value of

0066

the trip to ?

A No.

Q Did MIS ever provide you with --

I'm sorry. It was MIS that took you to ?
A Yes.
Q Did Zimmer ever provide you with any written documentation about the value of the trip that they paid for for you to go to ?
A No. I never knew the value -- monetary value?
Q Yes.
A No, I never know about it.
Q Did either of the two companies ever provide you at any time any written documentation about the cost of the materials they gave you as freebies, whether it be the posts, instruments or anything else they gave to you?
A Well, most of these -- most of these -- like you said, freebies. I don't call it freebies, but they gave me posts when I purchased implants, so they

included it in the same price. Because I didn't buy ten implants or 20 implants at a time. I bought hundreds of implants at a time.
So they gave me the posts also at the same time including, you know, the cost of the implants -- the cost of the implant included the cost of the post, which they didn't do to other dentists. Maybe they've done. I don't know. I never asked questions.
Q On either of the trips -- by the way, MIS took you to just one time?
A Yes.
Q Did they take you on any other trips?
A No.
Q How about Zimmer? Did they take you anywhere else besides ?
A No.
Q Any other companies you may have worked with that gave you trips to different locations?
A No.

Q At any time after you went on those particular trips did you ever indicate in any of your tax reporting requirements that you received these gifts or these trips from these particular companies?
MR. : Objection to the form. Again, you may answer if you

want to.
A Well, I wouldn't -- you can -- I wouldn't know in what terminology -- what terminology to use, but the purpose of these trips was educational.
Q I'm sorry. I'll rephrase the question, doctor.
At any time after going either on a trip to or the trip to did you ever report to the I.R.S. that you went on these trips and these trips were provided by these two companies?
MR. : Objection to the form. You may answer if you want to.
A No, because I considered it part

0069

of the education that was included in my purchase of the supplies, so if I purchased from them five or 7,000 implants, you know, I would consider this trip as part of the payment that I gave them for the purchased implants.
Q When did you start your career? When did you first go into private practice?
A I completed my oral surgery residency in 19 .
Q And you started practice in 19 ?
A Yes.
Q You're originally from ?
A Yes.
Q When did you come to the United States?
A I started college here in 19 .
Q So you left in 19 ?
A After military service, yes.
Q Let's go back to the implants.
How do you know where to place the implants?

0070

MR. : Again, in general?
MR. OGINSKI: In general.
A I know where I want to put them.
Q How do you know that?
A I know what type of restorations I'm going to use, so I know whether to place one or eight, maybe sometimes ten. Not very often. But how do I know? They have to be consistent with my ability to restore them.
Q But my question is a little more focused.
Within a particular jaw or bone

how do you know where exactly to place them?
A I decide one location where a tooth should be, o , and from then I calibrate it with -- I'm sorry. I can't remember the name. With the paralleling It has grooves for one tooth, two teeth, et cetera. Spacing
Q Is that like a template?
A No, it's not a template.
Q Now, you say you put it where

0071

you want it to be. Tell me what you mean by that.
A I know what type of restorations is going to be used because these restorations were done in my office, so I knew where I want it to be. How do I know? I know because I knew that these where tooth number so and so going to be and I knew where tooth number so and so is the next one, et cetera.
Q In your practice, doctor, do you use pilot holes?
A All the time.
Q Do you use guide holes?
A Guide holes? Well, these are still pilot holes, you know, spaced in a certain number of -- whether it's a tooth next to it or two teeth next to it. That would be another pilot hole. Pilot holes are holes to determine the position of the implant to be placed.
Q In other words, they are pre-drilled holes and that's where the implant is going to go into?

0072

A That's correct.
Q Do you use any type of marking device to identify the place where you're going to drill the holes?
A Yes, on study models, and frequently I make a template which I indicate, but, you know, that's not the rule. It's definite in certain situations -- in certain situations it's an aide to placing the implants. The paralleling device is also a tool to place the implants. All these are tools in edentulous placing
Q Tell me again, if you can -- I don't mean to go over it again, but this device, this paralleling device, what is the purpose of that device?
A It's a device to measure the

next placement of the implant and also implantology is based on parallelism, o . Sometimes you can accomplish it. Sometimes you cannot accomplish it.

Q Tell me what you mean by parallelism.

A Each implant is going to be angulated on the same -- to the same space, o , so that you can, you know -- like if you're going to have an implant in at 90 degrees to any surface, you want the next implant, if it's at all possible -- many times it's not possible, but there are ways to deal with it and that's with the posts.

Q But this device, this parallelism measuring device will allow you to hopefully get it at the same angle that you put in one implant?

A That's correct.

Q So whether you want to have the next implant one tooth over or two teeth, it will then provide some sort of guide as to how to put in the second implant; correct?

A Yes, to the best I can.

Q Did you have that device in your office in ?

A Oh, sure.

Q Did you use that on a regular basis when putting in implants?

A Oh, yes.

Q Was there ever a time where you put in implants and you did not use that particular device?

A Some situations, yes. Where I did extractions, sometimes the extraction site indicated the angulation of the teeth. In cases that they were really out of line completely, then you had to go in a situation that doesn't follow the position of the root of the tooth that was extracted.

Q In that measuring device that you just told me about which name you don't recall, if you were to put one implant next to or adjacent to the other one, does that indicate how much space is necessary to separate those two implants?

A A space should not be less than about three to four millimeters.

Q And what happens if it is?

A It would create some difficulty

to some restorative dentists.

Q Why?
A That's the fabrication of the bridge, you know. It may affect. It may not affect, but if it's not, there are still ways to correct it and --
Q That's in the post production?
A That's correct.
Q But specifically talking about the actual implants and the spacing of them, do you use that device to give you a guideline as to how much space should separate each particular implant?
A In a nonextraction site, yes.
Q You mentioned that in some instances you would extract a tooth and put an implant in on the same day; correct?
A Many times.
Q And other times there would be no tooth there and you would be able to put an implant in at that time; correct?
A Many times.
Q What is the benefit to either you or the patient to extracting a tooth

and putting an implant in in the same day?
A A good one is time. There are now more than ever -- and, as I speak, more than ever --
Q Again, I'm only focusing on from to , that time period. Tell me what was the benefit.
A The benefit is time that it takes to complete the job, the restoration.
Q And as far as is there any difference in cost between doing it the same day or having a patient return at a later date to come back and do it?
A I'm sure many many dentists have --
Q I'm sorry to interrupt you, doctor. I'm only asking about you.
A There is a fee for extraction. There's fee for the implant.
Q And is there less of a fee if it's done together at the same day?
A Not really. It depends. I didn't have set rules, if you want, you

know. I didn't have a set of rules. I

was a guy that did things ad lib, you know. Sometimes I did and sometimes I didn't.

Q Now, the marker that you mentioned that you would mark on study models on those molds or impressions we talked about, was there anything available to you that you would use markers to actually mark a place on the jaw itself as to where you would place the implant?

A Not really. I would -- I would -- what I would do is I would place a template or -- a template and just make an indentation into the tissue or into the bone.

Q A pre-hole?

A Correct. Very, very shallow.

Q Would you ever make marks on the patient's panorex film as to where you intended to place the implants?

A Yes.

Q And would you tend to do that in a marker, in a pen or some other marking

0078

device?

A With a pen.

Q Typically did you talk to the patient about where within their mouth you would be putting the implants in?

A Generally speaking, yes. Not specific site, but generally speaking, yes.

Q And what was the purpose of doing that?

A He paid me money. He should know as much as possible.

MR. : Let's take a break now.

(Lunch recess.)

Q How do you know how far to screw in the implant?

A Intraoperatively I took x-rays and I would say usually I take one or two x-rays intraoperatively just to make sure.

Q And so how do you know how far to screw it in?

A I can tell by the x-ray how far I am and I can tell how far I still have

0079

to go.

Q Do you need to drill into the bone a specific distance so that the top of the implant is flush with the bone or something else?

A Well, the top of the implant has

to be flush with the bone but there are different sizes, you know, so yes, every implant has to be flush with the bone but the apex of the implant has to go as far as it can not to damage sinus or to damage a nerve, you know. These are two things, topographic things we have to watch out for.

Q When you say the apex, tell me what you mean.

A The apex is the end of the implant, the part that goes into the bone.

Q The narrowest part?

A The narrowest part.

Q What do you call the top part, the widest part? Does it have a name?

A No. Just the top of the implant.

0080

Q How do you know if the implant is in the bone too far?

A Where it -- where it went into -- over the -- over the place where I wanted it to go.

Q Are you able to visually determine whether or not an implant is in too far or do you need x-rays to determine that?

A I need an x-ray and to place -- when the implant is being placed in, you know, the amount, so to speak, of the resistance that I have. The more resistance that I have, than I expect -- then I know I went too far.

Q Is it ever appropriate to screw the implant to the point where the top of the implant is below the bone line, the flush that we just talked about, that it's below that point?

A Yes, but crazy is the one -- the inexperienced one --

Q I'm sorry. Doctor, I'll rephrase it.

0081

If you are putting in an implant, is it ever appropriate to put it in below the bone line within it so that there's some type of depression or some area where it's not flush with the bone?

A Maybe a fraction of a millimeter, not more.

Q What happens if it is put in too much further than that?

A I don't know. I never did it.

Q When you put it in, do you screw

it in?
A You ratchet it in. Yes. You tap it in. That's the nomenclature, to tap it in. You screw it in like a screw.
Q And it has these grooves like a screw?
A Grooves. Yes.
Q And if you feel somehow that the implant is in too far into the bone, are you then able to reverse it and screw it up so it lifts back up or is it a one-way uni-directional?
A No. It's bi-directional. You

0082

can always -- I never did it, so I don't -- I don't -- I don't think it's beneficial to go over. Never experienced it, you know, so, to my recollection.
Q Is it good practice to take preoperative x-rays before putting in implants?
A Yes.
Q And that would consist of both the periapicals as well as the panorex?
A Either both of them or one of them.
Q Is it good practice to take intraoperative x-rays as well?
A Yes. I always did it.
Q Why?
A Just to make sure where I am.
Q So --
A Like I said before, there was some -- what's the terminology? Some -- the angle -- the measurement on the x-ray is not the exact one. There is some deviation or some, you know -- because of the angulation it's not perfect. The

0083

measurement of the length of the bone is not a perfect length.
Q Now, do you take intraoperative x-rays after each implant or do you wait until you've put in all the implants that you plan on putting in that day and then take intraoperative x-rays?
A No. The intraoperative x-rays are taken when I use the drills to make sure not to go too far with the drill, not the implant.
Q So this is before the actual implant is placed in?
A Before the implant is placed in, yes.
Q And you are looking to see the

depth?
A Yes.
Q And what will an intraoperative x-ray show you in relation to the depth that you're looking for?
A Whether I went too far.
Q Does it show you if you are close to or nearby a nerve?

A Yes.
Q Does it show you any other vital structures that you want to be aware of and stay away from?
A The sinus.
Q Are you able to visualize or obtain that information using the periapical films?
A Yes.
Q Are you able to visualize that information using the bite wings?
A All depends on the amount of bone. You know, if there is a lot of bone, then I don't think you can get the apex of the bone.
Q In order to evaluate the depth, as to whether you've gotten the right depth with these intraoperative x-rays, what x-rays do you use to check the depth?
A Periapicals.
Q Do you ever take another panorex film intraoperatively?
A No.
Q Why?

A Because the periapicals are sufficient for me. For anybody else, for that matter. Once you take a periapical, it gives you the whole -- the entire picture.
Q Are there times where you will take a film and for whatever reason, maybe artifact, maybe the patient moved, maybe the machine is not good, that you don't get a good quality film?
A Well, sometimes because the patient moved, because the improper placement of the x-ray, because of different reasons, you know, sometimes you have elongation or shortening of the picture, you know. Then you take another one.
Q Customarily, doctor, in your practice did you take postoperative x-rays?
A Yes.

Q Why?
A Just for me to see where the implants are.

Q What type of x-rays did you use when you would take the postop x-rays?
A Periapicals.
Q Can an implant get into the sinus when you are putting the implant in?
A It could. Never happened to me.
Q We are talking about the sinuses in the top part of the face; correct?
A Yes.
Q Or above the --
A Posterior teeth.
Q Thank you.
What sinuses are present?
A Maxillary sinuses.
Q And there are two sinuses in that area?
A One on each side.
Q From the periapicals that you take intraoperatively, are you able to see the distance between the bone and where the sinus begins?
A Yes.
Q Would the same be true of the panorex? You're able to visualize where

the bone ends and the sinus starts?
A I think periapical to me is more beneficial than a panorex.
Q Do bite wings assist you at all in identifying where the bone ends and the maxillary sinus begins?
A Like I said before, depends on how much bone it is. The more bone there is, the less beneficial is the bite win
Q Have there been any instances in your career where you have put in an implant in the upper jaw and have learned either intraoperatively or immediately postoperatively that part of the implant is sticking into the maxillary sinus?
MR. : Objection. You may answer if you have a recollection.
A To my recollection, no.
Q Have you read or heard about people who do implants that have for whatever reason placed the implant where part of it is sticking into the maxillary sinus?
A I don't know of any because I

didn't speak to many oral surgeons and I don't think -- I read it, you know, in the literature that it can happen, but nothing as a firsthand experience.

Q Are there any other sinuses that are present in a person's face that would be in close proximity to where an implant is being placed in the upper jaw?

A No.

Q If you observed an implant that was somehow going through or into the patient's sinus, is that something that would only be visible on an x-ray?

MR. : Objection to the form. You may answer it, though, if you understand it.

A Can you repeat it?

Q Sure.

How would you know whether or not the implant was in the sinus or not?

A I would know about it by taking an x-ray.

Q And that would be postoperative x-rays; correct? Because once the implant

0089

is in, you would take an x-ray; correct?

A I would know also by the intraoperative x-rays, you know, how close am I to the floor of the sinus.

Q In your experience, doctor, during the course of your career, have you ever had to repair a hole into the sinus as a result of putting in an implant or in preparation for an implant?

MR. : Objection to the form. You may answer it, though.

A I did so many implants, as I described to you before, that I don't really have any recollection of getting too dramatic into damages to the sinus, if you ask me.

Q My question was have you ever performed a repair to the sinus as a result of any implant or drilling that may have gone into the sinus?

MR. : Objection to the form. You may answer if you recall.

A I don't think about implants. You know, when I did extractions, some

0090

extractions, some teeth had infection at the apex of the roots and they destroyed the floor of the sinus and then I had to go and place synthetic bone graft and suture it, but I can't recall about

implants.
Q Are you familiar with a procedure called Caldwell-Luc?
A Caldwell-Luc, yes.
Q What is that procedure?
A It's a procedure whereby you get into the sinus and you get an infection out or you get foreign object out.
Q Have you ever performed that procedure in the course of your career?
A Yes.
Q When you put an implant in, you mentioned that one of the possibilities, one of the risks that can occur is that you can hit a nerve; correct?
A Sorry. Can you repeat again?
Q Sure.
One of the risks of putting an implant in is that you may hit a nerve;

0091

correct?
A Yes.
Q How do you take steps or what steps do you take in order to prevent hitting a nerve when placing an implant?
A Taking an intraoperative x-ray.
Q How will that assist you in preventing hitting a nerve?
A Telling me how far to go, when to stop.
Q Now, you told me earlier that an x-ray is a two-dimensional view; correct?
A Yes.
Q How do you know beyond that two dimensions where that nerve lays or where it runs?
A Usually the three-dimensional is not going to make that much of a difference to the two-dimensional because it is a very small narrow space that just because on the buccal side, if you will, the facial side is going to be dramatically different than the lingual side, the side of the tongue, or the side

0092

of the palate, so it would have to be really a big incline to make that much of a difference between the two-dimensional and the three-dimensional.
Q Does a three-dimensional image give you a clearer picture of where the nerve runs and which way it goes so you can take steps to prevent going near it?
MR. : Objection to the form. You may answer in that form if

you understand it.
A It would give you a better picture as far as the buccolingual, not so much or almost not at all as far as the length.
Q Can you tell me, doctor, what nerves run along the lower jaw?
A Mandibular nerve.
Q Any others?
A Yes. Submandibular nerve. What's the name of it? Well, submandibular, mandibular nerve.
Q What nerves run in the upper jaw?

0093

A The buccal nerve. In the upper you don't have really -- you have many nerves, you know, that are very, very small and insignificant.
Q In the lower jaw, the mandibular nerve, where is the insertion point? Where does it start?
A It starts in the head.
Q Does it split at some point to go to the left and right?
A Yes.
Q And do those have specific names or are they just identified --
A Yes. Lingual nerve and the buccal nerve.
Q And that's for the lower jaw?
A Yes.
Q When you are looking at an x-ray and looking at nerves, what does a nerve look like on an x-ray?
MR. : Objection to the form, but you may answer.
A It is a radiolucent area.
Q It shows up as white?

0094

A Dark.
Q If a patient has had root canal in a particular tooth and the tooth is no longer present, are you able to determine from looking at x-rays whether or not that patient has had root canal to a particular nerve or part of the nerve?
MR. : Objection to the form. If you understand it, you may answer it.
A You're incorrect by your statement.
MR. : Could you rephrase it?
MR. OGINSKI: Sure. I'll

rephrase it.
Q If a patient has had root canal and at some point after they have lost that particular tooth and you now take an x-ray of that edentulous area, are you able to tell from looking at the x-ray whether there is any nerve root remaining in that particular area?
A If the tooth is missing?

Q Yes.
A No.
Q What happens, doctor, if an implant is placed into or onto a nerve?
A It varies.
Q Tell me. What is the variation?
A Some people have very wide nerve and if you came close by or even if you touch it, you may have an insignificant, temporary, never a permanent, damage to the nerve. I know many cases. You may be familiar that a patient had a very wide nerve.
Q Are there other instances where a patient can sustain long-term permanent damage?
A Well, it does happen when you -- when a dentist takes a wisdom tooth --
Q No. I'm talking about placing implants and hitting the nerve.
A You can -- not as far as I'm concerned. If I ever had any, to my best recollection, it was a temporary partial, not a complete. Temporary. It was an

improvement as time goes by.
Q Hang on, doctor. I'm not asking specifically about your experience.
A I'll tell you in general.
Q Your knowledge in general.
A Yes.
Q If an implant hits the nerve, can the patient suffer permanent nerve damage as a result of that as one of the possibilities?
A If it just touches the nerve and the nerve is wide or close to being wide, you know, there is no -- there is no damage to the nerve as far as cutting it. There may be slight pressure, but in those cases it is a temporary and partial.
Q Fair enough.
What about those cases where the implant is put in more than what you've just mentioned or deeper or it cuts the

nerve? In those instances would you expect to see some type of longer term or permanent damage to the nerve?
A If it went through the entire

0097

canal where the nerve is, yes. Not to my knowledge. Although, you know, in the literature I can recall damages, complete damages to nerves, but in my experiences, not that there are many, very few, all of them, to my recollection, all of them ended up by temporary and partial.
Q If a patient has a nerve injury following the insertion of an implant, can you then conclude that there was some damage to the nerve?
A Not at the time of the insertion.
Q No. I'll ask it a different way.
If a patient has an implant put in and experiences some type of nerve injury that is evident after a period of time after the implant is put in and continues, can you say solely by virtue of the fact that they have some nerve deficit now after, let's say, a year or two years after the procedure, can you say that the injury is a result of the implant?

0098

MR. : Objection to the form. You may answer it if you understand it, doctor.
A In my experience, there was a partial and/or temporary damage to nerves, which most of the times, if not all of the times, there was a progression of improvement stated by the patient or determined by me to be improving and there are ways to -- there are ways to check it and some patients maybe, maybe not, not to my knowledge, can fake.
Q And there are certain tests that you have that would determine whether or not a person might be malingering or faking a particular injury; correct?
A Well, the tests that can be done, you know, to assure that the patient doesn't fake it or not is that you don't tell the patient anything and you just accidentally pinch the area that he is claiming and --
Q And if they feel it, you know that they're not telling you the truth?

0099

A Yes. Absolutely.
Q But my question was, doctor, if a patient exhibits an injury following an implant, can you safely conclude that that injury, assuming they had no other dental treatment, was a result of the implant?
MR. : Objection to the form. You may answer it.
A Well, I can tell you one thin
O ? Anybody who doesn't have a nerve damage but sees an opportunity to gain one way or another can always fake a damage, can always tell me I have damage. Listen, I went to doctor X and he did an implant or he took a wisdom tooth, so I have numbness.
And many people know about this because they know from friends or this and they know, so when the doctor comes and says well, let's check it, you know, they can fake it. Ouch.
Q Let's put that aside for a minute. I just want to focus on what I think is a simple question.

Assuming the patient has nerve injury following the insertion of an implant and it goes on for a period of years --
A Any patient, you mean?
Q Any patient in general.
And the patient has had no other dental treatment at all, can you conclude that the nerve injury is a direct result of the implant?
MR. : Objection to the form. Try to answer that if you can, doctor, yes or no.
A If there is no other procedure done and implant is placed and you take an x-ray and you see that the implant is about one millimeter or more or maybe half a millimeter or more from the nerve, there is no chance that, you know -- you know there's always a chance, but it's miniscule that there is going to be a damage to the nerve.
If the x-ray shows that the implant is just touching the roof of the

nerve -- the reason I'm saying roof is because the nerve's located inside a tunnel in the bone and the tunnel has a floor and a roof, so the roof is on the

top. So the implant can touch the nerve slightly. In those cases, you don't have paresthesia or you may have partial and temporary.

Just by touching the nerve or going slightly into it, that case would be definitely in my experience temporary and partial. Now, what do you call temporary can be anywhere from a month to a year. Different patients.

Q What would you call beyond a year with that type of paresthesia?

A It can be a year and a half.

Q What if it's more? Two, three years, would that be considered permanent?

A If it's over -- well, never happened to me. I don't know. I can't tell you.

Q I'm just asking you --

A If you tell me after ten years

0102

he's still numb, well, I say it's permanent. Anything below that I don't know. I can't testify to that.

Q How many teeth does a healthy adult have, assuming they have all their teeth?

A 32.

Q What is the maximum number of implants that you can place into a person's mouth? And I'm going to ask you to separate between the mandible and the maxilla.

A Well, if there is no problem of sufficient bone, you can place up to, I guess, you have enough room for -- there's another thing and that is the longer the patient is missing teeth, the longer the jaw is edentulous, the bone mass is being lost. The more -- the longer the time the jaw has been edentulous the less, you know -- it looks like as if the jaw sort of shrinks because you have less mass of bone so then you put more.

Q In the best circumstances what

0103

is the maximum number of implants you can put into the lower jaw?

A Theoretically 16.

Q And what about the upper jaw?

A Theoretically also 16.

Q What does it mean if someone is a restorative dentist?

A He is replacing the supra, the upper part from the gum up, whether it's a

denture, removable denture or a fixed denture which is permanent denture, permanent teeth, permanent bridge.

Q Do you consider yourself to be a restorative dentist?

A I did it.

Q But when you held yourself out to the public and to people who would come to you, did you consider yourself to be a restorative dentist?

A I'm an oral surgeon, but I'm not limited to just oral surgery. I throughout my years did some restorative dentistry also.

Q Would you agree, doctor, that

0104

implant treatment is a specialized area of dentistry?

A Not really.

Q General dentists can do implants?

A I know in every general dentist does it.

Q Let's talk about New York.

A Even in New York you have general dentists that do it.

Q Do you need any specialized training to do implants?

A Well, depends on the person. You know, there are some good guys and -- some good dentists and some bad dentists. You can have a dentist who is a general dentist and he can place implants better than a specialist, a periodontist or oral surgeon.

Q After a doctor finishes their dental school and any postgraduate training, is there -- I'll rephrase it. What is periodontistry?

A Gum dentist.

0105

Q Are you a periodontist?

A No.

Q What is prostodontistry?

A A restorative dentist.

Q And that's what we just talked about; correct?

A Yes.

Q You didn't hold yourself out as a prostodontist?

A No. I hold myself out as an oral surgeon.

Q What is an endodontist?

A Root canal man.

Q And you didn't hold yourself out

as an endodontist; correct?
A No.
Q When you say you're an oral surgeon, that means you have specialized training above and beyond what a general dentist has?
A Absolutely.
Q When a patient came to you for an evaluation of implants, am I correct that you would be the one to choose the

type of implant that you would insert?
A Yes.
Q The patient doesn't have the knowledge and the expertise like you do to dictate what implants they're going to have?
A Some think, but --
Q But you wouldn't allow that?
A No.
Some people think they know better than the dentist. I know somebody that you may know.
Q Can you tell me, doctor, the difference -- I'm looking now to the qualitative difference between the type of implants that you used, the two that you mentioned, and any others that were available on the market.
In other words, you talked about the screw vent and the core vent. How do those compare in quality to any others that you are aware of on the market at the time?
A O . In short, an implant is a

titanium screw. As far as I'm concerned, any titanium screw is as good as the other. The rest depends on the professional.
Q Were there some companies that you are aware of that were considered to be the top or the best made implant around and others that might have been considered of lesser quality?
A I don't think the representatives of any dental implant would consider themselves lower than another company.
Q No. I'm asking you.
A I don't know. I just did two companies and that's it. Both of them are equal to me.
Q How did you learn that those two companies that made those two products

were better than any other implant that might have been available on the market?
A The length of time I used them.
Q How did you get to start to use them instead of using other types of
0108
implants?
A I had a representative of the dental implant, Zimmer. It went through a lot of different names since the inception of this company. They were bought by another company and that company was bought out by another company. I started with them many many years ago and there was no reason why I should change them.
And then accidentally I was introduced to an MIS representative and I observed the implants and they didn't look to me any different than the Zimmer implant, so I started to use them also.
Q At any of the meetings you may have attended as part of any dental association, did you ever learn about other types of implants that were considered to be of greater quality than the ones that you were using?
A Some -- maybe some speakers had claimed that they are using this implant because they think it's better. If I was a speaker, I would probably say the same
0109
thing about Zimmer or MIS. I think they are better. If I didn't think Zimmer or MIS were as good as the other one, I wouldn't have used them.
Q Over time would you get literature or magazines or journals with advertisements from different manufacturers about different types of implants that were made?
A Yes. I had salesmen coming from other companies.
Q But just in your general dental literature, magazines, were there advertisements by companies to show their product and the different types of implants and the great qualities that they offered?
A I don't think I came across any literature, anything in the literature that would be written by or -- an advertisement of a company claiming to be better than another company. I don't think it's professional on their part, but.

0110

Q I talked to you earlier about the cost of your implants. My question is -- and if you can tell me generally that would be great -- what did you usually charge patients for the actual implants?

A Well, there are a lot of implants that I have used. These were much much narrower, but they were specifically for dentures.

I'm sorry. Could you repeat?

Q What did you typically charge patients for the implants?

A Well, I basically charged as a fixed price for the entire thing and the reason for that is that my office did everything It did the implants by me. I had the laboratory inside my office staffed by four laboratory technicians. They did dentures and fixed bridges, and I had -- some were general dentists. Some were prostodontists. Prostodontists are those that claim they are the specialists of restorative.

0111

And all these were performed by my office and I had no reason whatsoever to ever refer a patient, whether it's for oral surgery or dental implant or restorations of the implants by dentures or a different laboratory, because I had them all.

Q My question asked only what the cost was for the implants that you charged the patient.

A All right. It varied. You know, sometimes it was for the whole tooth about 1,400 to twenty-three, 2,500.

Q When you say for the whole tooth, do you mean --

A The implant and the crown.

Q The implant and the crown.

A Then there was another type of restoration which would have been removable denture, but it would be -- it would be -- it's fixed to either a substructure or to male/female-type of fixation, so the denture would be much stronger and enable the patient to bite on

0112

apples, corns, steaks as opposed to dentures that would not have been supported by implants.

Q In your opinion, doctor, the two types of implants that you used, were they in your opinion the best quality implants you could get for the money?
A In my eyes, yes.
Q Were you aware of any other implants that might be considered to be a better quality than the ones you were using?
A I told you before if there was better quality and better success, I would have used it.
Q How would your prices for the implants compare to other dentists' prices?
A Very low.
Q Tell me how you were able to generate a profit if they were so low.
MR. : Objection to the form.
A Everything is done in my office.

0113

I was quite efficient. I received parts at a much lower cost than anybody else. Everything was transferred into the patient and I was not as greedy.
Q The coating of the implant that you talked about with the hydroxyappetite, does that create a roughened surface on the outside, outer surface?
A Yes, it would be slightly.
Q Is that what creates a better bond with the bone?
A I don't think so. It's the material itself.
Q If you felt the patient did not have enough bone in a particular location, were you able to use a shorter implant or to cut the implant to size?
A You don't cut the implants to size. You put what you get. You don't modify it.
Q And are you able to obtain or use a shorter implant?
A Oh, absolutely.
Q So it comes in different sizes?

0114

A Absolutely, but you don't modify them. They come as they are.
Q In Mr. 's case --
A Do I know him?
MR. : Let him ask the question.
Q In Mr. 's case, did you shorten any of the implants?

A Absolutely not.
Q You talked about the distortion that is present on a panorex film. Have you ever heard anybody suggest that the distortion from a quantifiable measure is about 25 percent?
A I don't know percentage.
Q Do you know the percentage, quantifiable number of the distortion that is present in a periapical film? Whether it's three percent, five percent or some other number?
A Well, to repeat what I have said before maybe once or a couple of times, I used intraoperative x-rays. They were more important to me than the pre-op

x-rays, the dimensions. They are -- every -- the pilot drill and the subsequent drills for different diameters of the x-rays have also markings for length of -- correspond to the length of the different sizes of implant, so if you think that you don't have much room to play with, you go to the first marking, which is six millimeters or so, which is still shorter than the length of the implant and you take an x-ray intraoperatively and then you see should I go longer or not? Do I have enough room for another marking? Which would be from eight millimeters to ten millimeters. And if I go to ten millimeters, then I decide whether I do have room for 13 -- 11 millimeters. They came in different lengths. Each one has marking and each one correspond to the length of the implants.
So just because there is some distortion -- that's the word I was looking for before. If there is some

distortion, unless it's 50 percent or 40 percent, you know, as long as it's, you know, within normal limits, as I call it, o , the intraoperative x-rays are the kings.
Q In your practice did you ever use any type of computer software to help you identify the precise location of where the implant should be placed?
A No. This is a very most recent thin Like I said before, implantology is not fixed. It is developed. Everyday there is a new thin

Q And when planning to decide on the number of implants that you are going to put in, using your experience and your clinical examination of the patient, did you make a notation in the patient's chart as to how many implants you intended to place?
A Well, I made the notations for -- sometimes I made the notations for what I have charged the patient and sometimes I didn't make any notations. I

0117

just wrote it down later after I completed, you know, that I did place one or two or three extra implants in certain locations, so I may have -- I may have planned with the patients to do two or four or six implants. I may have -- I wouldn't say many many occasions, but on occasions I would have decided to give an extra one or two.
Q When Mr. first came in to see you in of , how many implants did he ask you for?
A He wanted -- he wanted ten teeth, I think.
Q Total?
A Yes.
Q How was it that you decided that instead of the ten teeth that he had asked for he would receive ten implants in the lower and ten implants in the upper?
MR. : Objection to the form. You may answer.
A I don't think I gave him ten on the top and ten on the bottom. Let me

0118

just consult my --
Q Sure.
And you are now looking, doctor, at the original chart you have for Mr. ?
A Yes.
O . On the top I put eight implants.
Q I'm just asking about what he asked for and what you decided to put in before actually doing any work.
A He didn't ask me for. O ? I told him what can be done. O ? And what does a patient know about I want just six teeth or I know I want only eight teeth or four teeth? He doesn't know what it is going to be the outcome as far as his ability to perform the things that he

want to perform like either smiling or chewing, chewing soft food, chewing hard food, corn-on-the-cob.
Q And the note that you were referring to, which date are you referring to that you just commented on? Was that

from the date or the date?
A The date.
Q And just for completeness, what is the date of that note, doctor?
A .
Q And you said you put in eight implants?
A Yes.
Q Upper or lower?
A I'm sorry. I placed ten implants.
Q And that's upper or lower?
A Upper.
THE WITNESS: It's ten. Implant three and 13. It was correct before.
MR. : Yes. We looked.
Q Am I correct that you put the upper implants in first?
A Yes.
Q And then shortly after you put in the lower implants?
A Yes.
Q Did Mr. explain to you

why he was only looking to have ten teeth put in?
A Mr. was very, very unhappy man.
Q I'm only asking if he told you why he only wanted ten teeth. I'll get into the other stuff later on.
A No, I don't know. Maybe somebody told him that you just need ten teeth.
Q Did your wife work in your office with you?
MR. : At what time frame?
MR. OGINSKI: Between and .
A Not as an assistant. Maybe just checking around the girls. That's all.
Q And your wife's name is ?
A Yes.
Q ?
A A.
Q When you would examine a patient and evaluate them for implants, would you

have an assistant in the room with you?

A Yes.
Q What would be the purpose of having an assistant in the room?
A If they were females, I don't like to be in with a female by myself in the room.
Q Let's talk about males.
A Males? Most of the time the girl was with me, you know, just to help me out with instruments and x-rays, to bring the head of the x-ray to the position, you know, things like that.
Q At the time that you're conducting your dental examination, your intra-oral examination, would you have your assistant make notes in the patient's chart about things that you observed?
A No.
Q When would you make notes in the patient's chart about your observations during your exam? Would it be intermittently while you are in the middle of the exam or would it be after you completed your exam?

A Different times. No fixed situation, you know. I could have done it during I could have done it after the patient was explained. I could have done it in a different room where I had my desk and a viewbox, you know. Different times.
Q Were there any times when you would actually dictate into a machine and record any notes or observations that you made?
A No.
Q You always used handwritten notes?
A Yes.
Q And the notes that appear that you've brought with you today, those are your own handwriting?
A Yes. Except one.
Q Sure.
MR. : Most of them are, but some are not.
A Just this one. Seven --
Q We'll get to them, doctor.
Just for completeness, the

documents where you have your notes, these are some type of orange or yellowish

paper?
A Yes.
Q And this is typical dental recording note paper where you can chart things?
A Well, they are not used by the general dentist. They are used by oral surgeons, I would estimate.
Q And, in addition, you have other documents as part of his chart as well; correct?
A Yes.
Q And we will go through that in a little while.
A Are we getting married?
Q Out of the ten implants that you were intending on putting into Mr. 's upper jaw, were any of those extra implants than what you would have originally told him you would put in?
A Yes.
Q How many were you going to tell

0124

him you were going to place in his upper jaw?
A I told him it varies. The minimum I put is six and there is a possibility of more and I consulted with him before I put them in, if it's o with him, and he said yes.
Q When you initially went to put in the implants, what was your intention on putting in before you added whatever extras you did? Did you intend on putting in just six or eight or some other number?
A Well, as I mentioned before, I occasionally gave extra amount of implants, be it one, two, four.
Q How many extras did you give in this case?
A Four on the top.
Q Which numbers of the implants did you consider to be extras?
A Three, four, 12, 13.
Q Did you intend on placing a bridge, some type of fixed bridge on top of the implants?

0125

A Yes.
Q How many teeth could that fixed bridge accommodate?
A If all these implants were successful, it would have been about 12 teeth. 12 to 14.
Q So there was still some room yet

within his mouth that the bridge would be able to fit?
A Yes.
Q Would you agree, doctor, that before starting any implant work it's important to create some type of treatment plan?
A I have done it for 30 years, you know. I did it -- I did write down what's good for me. O ? Because I didn't expect anybody to look at my chart. All right? I didn't plan, if you will, of being sued or something like that. O ? I've done it for 30 years and I really did not have any problems, so --
Q My question is is it good practice to create a treatment plan prior

0126

to actually starting any work?
A In my case, just general thin
Q What does your treatment plan consist of? In other words, how do you determine what treatment you're going to create as part of a plan?
A Well, marking the areas where I was going to place implants before I decided to give additional implants and places where I need to do extractions and how many implants I have decided to place and before deciding to give additional implants, if to give them any additional implants.
Q Now, you mentioned, doctor, that you generally know what's good for you and what you've done in the course of your career. How many patients did you typically see in any given day on a day you were in the office?
A It could come up to 30 patients.
Q How many patients would you see in any given week?
A A difference of --

0127

Q Just generally an estimate. I'm not asking for an exact number.
A On the days I did more than two, three -- it depends how many surgeries I would do. The more surgeries I do, the less postoperative and less other things to be done, and if I didn't have time because I had surgery, occasionally I would have a dentist that works for me.
Q I'm only talking about you.
A It varies. It could be ten patients if I had seven patients to do

surgeries on or it could be 30 patients if I had only two or three patients to do surgeries and the rest of them 27 to do postoperative or consultations. There was no set number.

Q Now, you mentioned you had a number of dentists working in your office at various times; correct?

A Yes.

Q Now, if you do not make a written notation about either a treatment plan or something that you have done for

0128

the patient, how then is the next dentist in your office who comes to see a particular patient going to know what treatment the patient had before they now see them?

MR. : Objection to the form. You may answer it.

A If I was there, I would just tell them orally.

Q Let's say you're not there for whatever reason and this dentist in your office now comes in to see a patient and they know that the patient was there before but they don't necessarily know exactly what was done because certain information is not in the record. How would they know what was done or how could they find out?

MR. : Objection to the form of that, but if the doctor understands it, he can answer it.

A Unless I told the doctor what I want him to do, in case I wasn't there, o , he basically would know to remove

0129

stitches because he saw stitches. He would know it's seven or 14 or 21 days postoperatively. He would know the time come to -- according to his observation also. The time comes to remove the stitches. If the patient comes and says he has irritation and some pain, sometimes he may do something Sometimes he may not do anything

Do something it could be even a healing collar. Healing collars. Healing collars are not placed by rule three months later or -- in my office I placed healing collars a week later or five months later.

Q Now, you had different offices; correct?

A Yes.
Q You had an office in --
A In , and in
.
Q And also in ?
A . It's
a main office.

Q How many days would you spend in
the office?
A Three days and one day each in
and .
Q And on the days where you were
in the or office,
did you have dentists working in the
office seeing patients?
A Yes, but not so much.
Q And the same question if you
were working in the office, did
you have other dentists that would work in
the and office?
A Not in .
never when I'm not there except maybe I
called sick maybe the same day, which
didn't happen quite often. When I worked
in , I could have had a dentist
working in .
Q Going back to the treatment
plan, regardless of whether you documented
it or not, would you agree that it's
important for you to formulate a treatment
plan to know what to do for the patient?

A The formulation of the treatment
plan would be primarily for placement of
the implants and then I would know
according to the number of the implants
whether I'm going to place ten teeth or 12
teeth or 14 teeth or for that matter 16.
Although 16 is a very rare situation.
Q In Mr. 's case where you
told me you intended on putting a fixed
bridge, would there be any need to put on
crowns on top of the implants?
A Well, all depends on -- all
depends on the number of -- I initially --
let's put it this way:
I initially planned on giving
him a denture that would be semi-fixed, so
to speak. Have a male and a female
appliances or like a tick-tock, if you
know what I mean. That would retain
denture, would be much more supportive,
would make the denture much much firmer
than not having the implants.

Q In order to accomplish that, did you need to put crowns on the implants?

A No.

MR. : Let's take a break.

(Short recess.)

Q Doctor, what is the purpose of making entries in a patient's chart?

A It's a record.

Q For what purpose? Why do you do it?

A Well, basically how many implants, what type of implants, what sizes of implants, if I used bone graft.

Q You're telling me what you put in. I'm asking you why do you document it? Why do you make notations?

A These are major things, you know, that I would want to have. These are not like placing two implants or four implants. That's not customary way. In different patient it's different, but, you know, things that are customary way of doing business which I've done for on implants 25 years out of my 30 years of doing implants, things that I don't do frequently -- I mean things that I do

frequently, common way of doing things, I usually don't see the necessity of recording it so much.

Q But my question is why do you make a record of those things that you feel necessary to do as to the type of implant, the number of implants and other things you just told me about?

A Well, I have to know what length of an implant I placed in a certain location.

Q Why?

A Just for my record, you know, when the patient comes in, you know, just to know what implant and what size I placed in, you know. I'm not going to memorize everything because one patient I use a ten-millimeter implant and another patient I use 16-millimeter implant. In the same patient one location ten, another location 16.

These things I want recorded, but things I do basically the same every time for these procedures, you know, I

don't see -- I don't see it necessary.

Just like one example. I don't -- not that I don't feel. I just didn't see the necessity of putting down, you know, that I took x-rays intraoperatively, just as I didn't see it necessary to keep the x-rays because they are insignificant to me after. As long as I have the postoperative x-ray of the implants, that's sufficient for me.

Q If you take an intraoperative x-ray that's part of the patient's treatment, are you saying that it's not important for you to keep those x-rays?

A No. I don't see any reason why I should.

Q Then why do you keep the preoperative x-rays?

A Because I want to know the way it looked before and the way it looked after. The beginning and the end. The in between in this case, the intraoperative x-rays are insignificant to me as long as they led me to place the correct implant.

0135

I don't need more than that.

Q Did you take intraoperative x-rays when you put in the upper implants?

A I always do.

Q How many did you take?

A About -- usually for this procedure I'll say between two to three.

Q I'm not asking usually. I'm talking specifically in this case how many intraoperative x-rays did you use?

MR. : If you recall.

A My customary way --

Q No. No.

A I don't recall. I don't recall.

Q And now you are talking about your custom and practice --

A Yes.

Q -- is that you take two to three intraoperative x-rays?

A Yes.

Q And those would be the periapical x-rays?

A Periapical x-rays, yes.

Q Have you ever taken more than

0136

two to three intraoperative x-rays?

A Yes. Not frequently, but yes.

Q In Mr. 's case did you retain those intraoperative x-rays?

A No.

Q What did you do with them?

A Just disposed of them.
Q Why?
A Because they were not necessary in this situation.
Q What situation?
A In his case.
Q What would have been the harm to putting it into his file along with his preoperative x-rays?
A No harm.
MR. : Objection to the form. You may answer.
A No harm.
Q What would have been so difficult to placing the intraoperative x-rays into his folder along with his preoperative x-rays?
MR. : Objection to the

0137

form. You may answer, doctor.
A It's not a matter of being difficult or not difficult. The same as writing down big paragraphs as to the treatment plan. These things are customary way of doing my surgeries, so this I don't have to elaborate to myself too much.
Q Did you make a note anywhere in any record in this patient's entire chart that you took intraoperative x-rays?
A No, because I don't -- I didn't deem it necessary. I knew that I took or I take on every patient.
Q If a doctor in your office were to look through your chart, how would they know that you took intraoperative x-rays?
A They don't have to know.
Q Why not?
A This is the x-rays, the postop x-rays (indicating). That's enough for them.
Q For the purposes of evaluating the treatment that was rendered and

0138

determining what was done, is there any way for a doctor in your office to know whether intraoperative x-rays were taken by looking at Mr. 's entire chart?
MR. : Objection to the form.
A It was not necessary for any doctor --
Q That wasn't my question, doctor. I'm sorry. I wasn't clear.
If a doctor in your office

looked through this entire chart, is there anything in here which would suggest to them that intraoperative x-rays were taken?
A They are not surgeons, so it's not necessary.
Q I'm only asking if there's anything in there which would tell them that intraoperative x-rays were taken.
A No.
Q Is there anything in Mr. 's records which would suggest to another doctor what your observations were

0139

intraoperatively.
A It's not necessary for them to know.
Q I'm only asking whether there's anything in the records in front of you that would tell another dentist looking at your record what your intraoperative opinions or findings were after looking at those intraoperative x-rays.
A For their purposes?
Q For any purpose.
A For their purposes, they don't have to know the intraoperative x-rays except the final x-rays.
Q I understand. You've told me that twice now.
A I'll say it three times.
Q No. No. I'm going to ask it a different way.
I only want to know -- I'll ask it a different way.
When you looked at the intraoperative x-rays, did you record your opinion as to what you saw anywhere in any

0140

chart for Mr. ?
A No.
Q Now, if a doctor, a dentist, whether in your office or outside, was to look at your chart and to look at all the notes in your chart, is there anything in here which would suggest to them what your thoughts were after looking at the intraoperative films?
A Yes.
Q Other than the fact that you went forward with the implants, is there anything in the chart to say what it was you thought about your opinion of the intraoperative films?
A Yes. The final size of the

x-ray which means the final size of the implant.
Q That's the postoperative x-rays. I'm asking is there any recording or notation about your opinion or observation of an interpretation of the intraoperative films.
A It's not important for any

restorative dentist that is associated with me to know about my intraoperative x-rays.
Q Regardless -- hold on, doctor. I understand what you're sayin
A We can dance around a long time and it's not --
Q Regardless of the importance, is there anything here that would give anybody an indication as to what you were thinking and what your interpretation of those intraoperative films were?
A What they would think is I used intraoperative x-rays to determine the final size of the implants. That's all they have to know.
Q How would they know that intraoperative films were even taken if there's no notation anywhere?
A They don't have to know. What do they have to know for? To continue the case? They don't need to continue the case. They have to know the final situation. Just like it indicates I put

bone graft, that I used PRP. They have to know that, but they don't have to know anything about intraoperative. What is important to them is the final position of the x-rays.
Q Do you charge the patients for intraoperative x-rays?
A No.
Q Do you bill the patient if they have dental insurance for intraoperative x-rays?
A No, I don't think so. No.
Q Why not? Why wouldn't you bill the patient for that?
A I'm not going to get paid for it anyway and it's not -- insurances don't pay for intraoperative x-rays. They pay for prior x-rays -- I mean postop x-rays and pre-op x-rays.
Q Is it standard practice to take intraoperative x-rays after you drilled

the holes but before putting the implants in?
A Always.

Q And I'm not talking about just for you. I'm talking about for doctors who do what you do.
A Yes.
Q And in your opinion that's standard practice?
A They should.
Q The treatment plan that you envision or create when a patient first comes to you, tell me what you said -- and I'm sorry I didn't catch all of it, but the most significant points of things that you would feel are important enough to record in a note.
A The number of implants, the size of the implants, the number of extractions, the number of teeth present, the anesthesia that's being used, the medication that I used, the synthetic bone graft or in this case -- the synthetic bone graft. That's all I used. I didn't use another type of bone graft.
And also PRP, which is certain medications to -- that helps promote

healin I used -- also, if I did a procedure that would come very very close to the sinus, which is a modified sinus lift, it's written down.
Q Hang on, doctor. I'm not talking about the actual procedure. I'm just talking about the treatment plan.
A Well, yes. The treatment plan? You have to ask me again. I'm sorry.
Q Sure.
A I'm getting carried away.
Q What are the significant things that you would normally record as part of the patient's treatment plan?
A Yes. That's exactly what I was saying, you know. The medications, the type of bone if I used a graft, the number of implants, the size of the implants, whether it's by Zimmer or MIS, the medication that I gave, the anesthesia that I used, sutures, whether I used them or not. These type of things.
Q Before doing any type of implant work, would you agree it's important to

discuss with the patient and to give them full informed consent about the procedure?
A Oh, yes. They got more informed consent than they can get by god.
Q Tell me why that's important.
A It's extremely important for the patient to know what's going on and what's going to happen and what is the indication, contraindication, advantages, disadvantages. All these things are like a Bible.
Q What happens if a patient is not given full information about the treatment that is proposed and the possible risks that can occur with a particular treatment plan?
A I don't know. It never happened to me.
Q If a patient is not given full informed consent, would you agree that then any decision that's made about treatment would be based on something that would be less, that they wouldn't be fully informed before making a decision?

0146

MR. : Objection to the form. If you understand it, doctor, you can answer it.
A I don't know. I gave informed consent and I have proof of that, you know.
Q Do you also talk to the patient when considering implants about the possibility that an implant can fail?
A Oh, that's one of the most underlined statements.
Q Why do you talk to them about that?
A Because that's the reality of things.
Q Now, as part of your practice, doctor, in addition to talking to a patient about the risks and the benefits and the alternatives to the procedure, the implant procedure, do you also give them written documents to read about informed consent?
A Absolutely.
Q And why do you do that?

0147

A It's got to be in black and white. There's no -- there is no telling me later I never knew.
Q And typically, doctor, how long do you spend talking to a patient about

the informed consent portion?
A Well, consultation about all this, minimum of half an hour the first visit.
Q I'm sorry, doctor. I wasn't clear. I'm not asking about the entire consultation. I'm only talking about the part where you're talking about the information they need to make a decision about the informed consent. How long do you spend with them on that?
A Half an hour, at least. This is the most important things, and that's in paragraph five, if anybody wants to read it, what I discussed with the patient.
Q Now, in addition to talking to them and giving them this document which you've shown to me, which is titled Statement of Consent for Core, C O R E,

0148

Vent Osteointerated Implants.
A It's osteointegration.
Q Is that what it says at the top? I'm just reading it.
A Osteointerated, osteointegrated. The same thin
Q I just want to get it right.
A Fine. You have it written down.
Q Do you make them read this document in front of you?
A Oh, yes.
Q And you ask them to initial each of the paragraphs; correct?
A After discussion with the patient, yes. Absolutely.
Q And you make them sign on the back of the page; correct?
A No. First before we do that, they have to sign -- I mean to initial every paragraph so there won't be any misunderstanding, and then after they agreed they understand, then sign the consent form.
Q And they date it; right?

0149

A Yes.
Q Now, do you typically have a witness in the room that observes and witnesses the patient's signature?
A Sometimes yes. Sometimes no. Most of the time yes because I have the secretary with me all the time.
Q And in this particular case on either or , , did you have any witness present to

observe Mr. sign the consent form?
A I can't recall.
Q Did Mr. read this document in your presence at the time that he initialed it?
A He initialed the consent form in my presence.
Q And did he sign the consent form in your presence?
A Yes, he did.
Q And this was done on the day that the implant procedure was going to be performed; correct? It was not done on the day of the first consultation?

A On the day of first consultation he was given the same information that's on the consent form.
Q Verbally or in writing?
A Verbally.
Q But he was not asked to sign it on the first consultation visit; correct?
A No. You sign it on the day of surgery.
Q Was Mr. with anyone? Did he come to the office with anyone on 5?
A I don't -- he never came with anybody that I know of, that I could recollect, no.
Q Was anybody in the room with you at the time that he signed the consent form?
A It's a customary way for me to have the secretary with me, like I said before.
Q You talked about customary. I'm asking specifically do you remember if anyone was in the room with you?

A A hundred percent I don't remember.
Q At the time that you first spoke to Mr. on -- what was the date? --
A 14.
Q -- 14, , was anyone else in the room with you during your verbal conversation about the informed consent?
A A customary -- I don't recall one hundred percent, but customary way or customary -- customary way, yes, there would be a girl, an assistant with me.
Q And how many different

assistants did you have at that time?
A Quite a few. It was a big office.
Q How many?
A Total of ten girls, I think.
Q And if any one of them was present in the room during this conversation, would you make a note anywhere in any part of your chart

indicating that a particular person was present?
A No.
Q How do you know if an implant has failed?
A Mobility, edema, you know, swelling, pus formation.
Q From infection?
A Pus formation, that's an infection.
Q Any other ways?
A Practically all failures are due to infection.
Q Are there any instances that you are aware of where you can have an implant failure without infection?
A Not really.
Q Do you give prophylactic antibiotics after performing implant procedures?
A Oh, sure.
Q Why do you do that?
A It's a prophylactic measure.
Q What is the purpose of that?

A In the best situation, to avoid infection.
Q Do you do that in every case?
A Practically all cases, yes.
Q Are there certain reasons why you would not give a patient prophylactic antibiotic?
A No.
Q Are there instances where you will need to premedicate a patient before doing a procedure?
A Yes. When they have a valve problem in the heart, history of hip replacement or knee replacement or things like that.
Q Would you agree, doctor, that when a new patient comes into your office, it's important when they first sit down to talk to you to obtain a thorough history?
A Yes.

Q And why is that important?
A You have to know the previous medical history, you know. There are some situations where it's contraindicated, you

know, more, you know -- basically some situations, you know, that it's contraindicated.
Q As part of the history, do you ask the patient questions about not only their medical history but also their dental history?
A Yes.
Q When you obtain a history from the patient, would you agree that it's important to record things that you consider to be significant in the patient's chart?
A O . In certain situations I go into more depth than in other situations.
When a patient presents to me with terrible teeth or missing teeth, I don't see it necessary -- I see, you know, decayed teeth, I don't deem it necessary to ask them about past medical history as far as dentistry is concerned because I see it in front of my eyes. If the patient is missing teeth, you know, if it

was five years ago or ten years ago, it doesn't matter. He's missing teeth. If he has broken teeth, when they were fixed, it's not important.
I can tell by the x-ray and by looking -- like in Mr. , for example. I mean, he should have had these teeth removed ten years before he came to me. He had a terrible mouth and --
Q Hang on. I'm going to get to him shortly. I promise.
A You don't have to promise me.
Q Would you agree that if a patient has a certain medical history that you feel to be significant that it would be important to note that in the chart?
A Yes.
Q And why is it important for you to note that in the chart?
A Well, because I told you there are some illnesses, diseases or illnesses that are contraindicated if they are not under control, you know. That's basically it.

Q What is an unloaded implant?
A An implant that you don't have a post or you don't have a temporary crown on top of it, no restoration is on top of it.
Q In other words, it's uncompleted? It's unfinished?
A You don't load a pressure or -- yes. You don't have anything on it.
Q And a loaded implant is one that's a completed restoration; correct?
A Whether it's a permanent or temporary, yes.
Q Were any of the implants that you put into Mr. functional as of the last date that you saw him?
MR. : Objection to the form. Doctor, if you understand what functional means, then I'll accept it. I don't know.
MR. OGINSKI: I'll rephrase it.
Q Doctor, when you put in an implant, am I correct that it's not a functional implant until you've fully

0157

restored it by putting a post and a crown on?
A Sure.
Q When I ask if an implant is functional, I'm asking whether it's ready to accept whatever it is that you're planning on putting on top of it; correct? It's a loaded implant?
A So in this case it was not loaded, so it's nonfunctional.
Q As of the last time you saw Mr. , were any of the implants that you put in loaded?
A No.
Q Were any of the implants functional at that point that you last saw him?
A Functional means that they are being used for any purpose? No, they were not -- passive.
Q Let's talk about the drills that you used to drill into the bone for the purposes of the implants.
Do you use the same drill to

0158

make holes for all the implants? I'm going to rephrase it.
If you intend on putting in ten implants in a jaw, do you use the same

drill for all ten implants?
A Most of the time, yes. Depends on -- there are some situations, especially on the lower jaw, that the bone is extremely, extremely dense and then if I feel that the cutting is not fast enough for this, I replace it, you know. It has to be sharp. Let's put it this way.
Q How often do you tend to replace the drills that you use to drill into the bone?
MR. : Can I clarify? Drill versus drill bit? Is there a distinction?
THE WITNESS: It's the same. Drill bits and drills are the same.
MR. : As long as you're using the same terminology. I don't know if there's different types of drills.

0159

Q How often would you tend to replace the drills?
A I would say every ten -- every ten times drilling the same implants, the same hole.
Q Did you sterilize those drills?
A Sure.
Q Did you have equipment in the office where you would be able to sterilize them?
A Oh, yes.
Q Is that called an autoclave?
A It's a sterilizer. Autoclave can mean also just steam autoclaving Sterilizing Pressure and heat.
Q How often did you sterilize the drills?
A After each patient.
Q Did you ever use disposable drills?
A No.
Q Are you aware of any implant manufacturer guidelines recommending when drills should be replaced?

0160

A You know, just by talking to the reps, yes.
Q What is your understanding of what information they provided to you?
A Just like what I do. You know, just don't use it too much. You know, if I did -- if I did ten implants in one sitting on one patient, I would be damn sure 99 percent that this drill is going

to be disposed of, if it's about ten or eight, or if it was done on the bottom, you know, there is more -- more frequency of changing than on the top because the bone on the bottom is much denser than the bone on the top.

Q Now, if you plan on putting in ten implants in one sitting, the drill that you use, is it typically a new drill or is it a drill that has been used previously but sterilized?

A If it's for ten implants, I most likely would not use it again, so I don't have to see whether it was sterilized or not.

0161

Q No.

A patient comes into you and you plan on doing ten implants.

A I use new drills.

Q That's my question.

A Yes. If I know it's ten implants, it's a new drill.

Q New drill for each implant?

A No. New drill for the patient.

Q O .

And if you only plan on doing a few implants, are there instances where you'll take a drill you've used before but have sterilized?

A Basically I will use it twice, most three times, you know.

Q Other than getting information from the manufacturer's representative, are you aware of any written guidelines by the manufacturers as to how often drills should be replaced?

A No, I am not aware. Maybe just didn't sink in. I don't remember.

Q Are you aware of any Dental

0162

Association guidelines, whether it be the American Dental Association or some implant organization, that recommends how often drills should be changed when performing implant treatments?

A Well, I consider myself with my experience, the last seven years or ten years, I have done more implants than anybody else, so this guidelines may be -- I can make the guidelines more than somebody else give me the guidelines.

Q Are you aware, though, of any guidelines written and in use in and that described how often drills

should be replaced?
A It may -- it may have come to my attention, you know, but I just don't have any recollection. Like I said before, I have so much experience in this that I know better than -- I hope I do. I think I do. Better than anybody. I'm an oral surgeon that did --
Q Hang on, doctor.
A O .

0163

Q How many times can you use a drill before you need to replace it?
A I don't know. You know, the more frequent -- the less time you use it the better.
Q Can you give me any range?
A I just told you. About eight to ten times.
Q Now, you said if the bone is dense like in the bottom jaw it becomes difficult and harder. Does that mean that the drill gets dull?
A Yes.
Q And what happens if you use a dull drill to make the holes?
A You don't use a dull drill.
Q What happens if you do? What effect will it have on the bone or the hole that you're making?
A It creates more heat. It forms more heat and heat can damage the bone.
Q Do you know the mechanism, how or why the heat can damage the bone?
A Any heat on hard tissue or soft

0164

tissue in the body is contraindicated. When it's excessive. We are not talking about lukewarm. We are talking about heat.
Q I know you told me that if you planned on doing ten implants you would use a new drill. How many times do you purchase the drills for the different implants?
A I bought them by the hundreds. Different sizes.
Q Let's talk now about the risks of implants.
A Sure.
Q And I know you touched briefly on it earlier. What is the greatest risk of putting in an implant in the upper jaw?
A The greatest risk? Other than infection? In the upper jaw, in the

posterior, it's getting into, you know -- the worst case situation is getting into the sinus.
Q And what is the biggest risk in the lower jaw putting in an implant?

A Damaging the nerve.
Q Now, in Mr. 's case, when he first came to see you on 14, , did you obtain any study models?
MR. : Obtain --
Q Did you do any study models?
MR. : Do any?
Q Did you do any?
Just for the record, doctor, you were actually reviewing your notes for the patient.
A I have no recollection, but it is customary way when we have an edentulous area or old teeth on a jaw to be extracted we do take study models, impressions for study models.
Q Show me where in your notes you indicate that study models were done.
A No, it's not indicated.
Q Does that mean that study models were not done?
A No.
Q Show me where in your billing records you indicate that study models

were done and billed for?
A I wouldn't charge for it anyway, so there's no reason for me to have it in the billing
Q If you were submitting bills to the patient's dental insurance company, would you expect to bill for study models?
A Not really because the payments that most insurance companies pay is miniscule, so inserting certain services are not necessary because we know that -- like in Mr. 's case, the maximum they would pay is a thousand dollars and you put two implants in there and you get to above the max already, so I don't think it was necessary.
Q Are you aware of the phrase, doctor, that if it wasn't written down it generally wasn't done?
A No.
MR. : Objection to the form.
A Absolutely not.
Q Is there anything, any notation

0167

anywhere in Mr. 's records to indicate to you that study models were done?

A No, but it's a customary way of doing it.

Q I understand it. I'm not asking about customary. I'm asking about anything recorded.

Were any molds made?

MR. : Because we used that interchangeably with study model before.

A The molds are done by the impressions, you know, so it's one -- if you don't take the impression, then you don't have the mold.

Q Were molds done --

A Yes.

Q -- in this case?

A Yes.

Q How do you know?

A He had -- he had upper and lower dentures done for him.

Q The mold is for what -- I'm

0168

talking about in preparation for the implants.

A Yes.

Q Are molds used for any reason other than for creating dentures?

A Oh, sure.

Q Can you show me whatever documentation you have indicating that molds were done in this particular case?

A No. I don't have any indication that it was done.

Q Do you have any bills or statements indicating that molds were done?

A No, but I know he had upper and lower dentures made by my office on the first or second visit, so I know for sure that he had it.

Q Would the molds be done before you started the implant treatment?

A Yes.

Q Where are those molds today?

A Must have been destroyed.

Q You say that it must have been.

0169

Do you know for sure one way or the other?

A I don't know. I don't know.

Q Where are the study models that

you say are customarily made?
A They are probably in the basement.
Q Which basement?
A In .
Q Have you made a search to see whether there are any study models relating to Mr. ?
A Nothing survived in this basement.
Q If study models were made, where would they be kept?
A Probably in the basement. Most likely.
Q Would they ever be kept somewhere with the patient's record?
A No.
Q If a mold was made, would it be kept ever with the patient's records?
A No.
Q Now, we talked about the models.

0170

Is that the same as the impressions?
A You create the models by taking the impressions.
Q Is there anything in your note to indicate that impressions were done?
A No.
Q Did you do a CAT scan --
A No.
Q -- before doing any implant work on Mr. ?
A No.
Q You did a dental examination on , ; correct?
A Yes.
Q And that was an intra-oral examination?
A Yes.
Q The purpose of doing an intra-oral exam was to evaluate his condition at that time; correct?
A Yes.
Q Did you do any periodontal charting as a result of your examination on ?

0171

A No. He had very few teeth and completely destroyed, so there was no necessity to do any charting. He had only six or seven teeth left in his mouth.
Q Is that information contained in your note?
A Yes.
Q What does that say about the

remaining teeth that he has in his mouth?
A They have to be extracted.
Q Did you indicate why?
MR. : I'm sorry. In the written note?
MR. OGINSKI: Yes.
A I have an x-ray to show --
Q Hang on. We'll get to it.
Is there anything in your note to indicate why those teeth need to be extracted?
A No. They have to be extracted.
Q Why?
A They are nonfunctional.
Q I'm only asking if it is in your note.

A If I put down they have to be extracted, then they have to be extracted.
Q I'm only asking why they have to be extracted.
A Because I look at the x-ray and they are completely broken down.
Q How many teeth did you indicate in your note?
A Seven.
Q Which teeth were they? In your note. And which page are you looking at and the date of that, please?
A
Q What is the date of that note you're looking at?
A The date is .
Q Let's go back, please, to the 14, , note. On that visit did you indicate which specific teeth needed to be extracted?
A No.
Q What was the condition of those seven teeth as of ?
A The patient came in initially

for an upper denture -- I'm sorry. For upper implants. He said that he has had it for a lot of time and it made him miserable.
Q This is your memory or is this your note that you're reading?
A No. He came for -- that's what I indicated in the chart. He came for an upper --
Q Wait, doctor. I'm going to ask you to read your note in a moment. I just want to distinguish between what you're reading in your note and what you

specifically remember about Mr. .
So my question is when you told me that he came in for upper implants, is that based upon your review of the note or something that you remember?
A Review of the notes.
Q O .
In preparation for today, am I correct you reviewed the records for this patient?
A Yes.

Q Did you review any literature regarding implants in preparation for today?
A No.
Q Did you review any deposition testimony that Mr. has given in this case?
A Yes.
Q Did you review any deposition testimony that his wife has given in the case?
A No.
Q Did you review any other documents in preparation for coming here today?
A No.
Q If you observed periodontal disease during the course of your intra-oral examination, would you have expected to make a note of that in the chart?
A Not in this case.
Q No. I'm asking in general if you see evidence of perio disease, would

you make a note of that in the chart?
A I will place the note in the chart only if these teeth were not indicated for extraction.
Q Did Mr. have evidence of periodontal disease?
A I'll have to review the x-rays, but according to what I know by reviewing the chart before I came here, I looked at the x-rays just to refresh my memory and I saw how horrendous they are, you know, really, really, really bad, so that would indicate, you know, that for whatever reason the most important reason that these teeth had to come out is because they are all chopped and broken down to the core, really bad.
Q My question is did he have

evidence of periodontal disease.
A He may have -- he had a little bone loss, yes.
Q And in your opinion, doctor, is the use of the term periodontal disease consistent or equated with the word bone

0176

loss?
A Not really, no. You can have bone loss just because of time, age, not necessarily because of an infection.
Q I'll go back to my question that I asked you a moment ago.
Did Mr. have evidence of periodontal disease?
A Just bone loss.
Q And is the bone loss something that you would consider to be part of periodontal disease?
MR. : It's been asked and answered.
A Not necessarily.
MR. : He just answered that.
Q Did Mr. have perio pockets on the existing teeth that were still there?
A He had really not so much pockets, no.
Q Were they inflamed?
A He didn't have severe case of

0177

periodontal disease, but he had an average, normal -- I'll put it this way:
If the teeth were not indicated for extraction, o , I would not recommend to take these teeth out because of periodontal disease.
Q Did you make an evaluation on 14 as to whether he had sufficient bone throughout his mouth for implants?
A Yes.
Q Did you make any notation in your record indicating that there was sufficient bone?
MR. : That specific phrase or words?
MR. OGINSKI: Yes.
A No. I just -- I knew that there is sufficient bone, if that's what you're talking.
Q On the first visit you took a panorex film; correct?
A Whether it was the first or --

where was it? There was a panorex taken
0178

on , but I don't think he came on
that visit. I think the date here was
confused. The x-rays were taken on 9-14.
Q Why do you say that the x-rays
were confused with the date?
A Because there is no -- there was
no visit on .
Q Is it possible that the patient
came to your office solely to have the
panorex done?
A Yes. Probably. Probably, yes.
And it was not taken by me. It was
probably taken by somebody else that
didn't put -- didn't insert it in the
chart.
Q When you say didn't insert it,
what do you mean?
A Didn't write it down into the
chart.
Q When you say that the x-ray
wasn't taken by you, you mean it was done
in your office?
A Yes. Yes.
Q But you were not the one that
0179

actually physically did it?
A No. I don't take panorex
x-rays.
Q Can you pull out the original
panorex film, please?
A I don't have it with me.
Q Where is it?
A Probably got destroyed. I have
no record of it.
Q Wouldn't the patient's panorex
film be contained within the patient's
chart?
A No.
Q Where would it be kept?
A In another place where all
panorex x-rays are saved. There was no
room here in the folder or in the drawers.
MR. : Off the record.
(Discussion held off the
record.)
MR. OGINSKI: Mark this as
Plaintiff's Exhibit 2.
(Whereupon, the above-mentioned
x-ray film was marked Plaintiff's
0180

Exhibit 2 for identification.)
Q Doctor, am I correct that you

are unable to locate the actual panorex film that was taken according to your note on ?
A Well, apparently I did locate them, but I had no memory of it, but --
Q But as we sit here now, it's not contained within your chart?
A It is.
Q You have the --
A This is part of the record. Where is it?
Q I'm only asking about the panorex.
A Yes. Yes. Here it says. This is part of the record. It say it was taken on .
Q Do you have the film, the original film?
A The original?
Q Yes.
A I'd have to look for it.
Q As you sit here now, you don't

have the original?
A As of today, no.
Q I'm going to show you a film that you mailed to my office and it's a panorex film and it has a red sticker on it. It says and it has a date and underneath that is the word copy which we marked as Plaintiff's Exhibit 2 and I'd like you to look at that, please.
A O .
Q That came in an envelope addressed with a return address from you to my office. Do you see that?
A Yes.
Q Tell me what it is that you are looking at right now, that panorex film. What is it?
A It's a panorex x-ray of Mr. .
Q Is that a preoperative x-ray?
A It's a preoperative x-ray.
Q Can you describe for me the quality of that film?

A For all purposes in my situation it is -- it's o . Let's put it this way.
Q It's o to use for your purposes; correct?
A For my information, it's o .
Q Can you visualize the seven

teeth on the bottom of the jaw on that film?
A I see between five -- between five or six or seven. No, I can't visualize it perfectly, but in conjunction with the periapicals, I can make sure -- I can tell you for sure it's seven teeth.
Q Can you tell me whether there is bone loss visible on the lower jaw based on that film?
MR. : You just want to confine him to this film?
MR. OGINSKI: Yes. Correct.
MR. : Again, it assumes -- if you can't tell, tell us.
A Wait. I can't a hundred percent tell by this x-ray, but in conjunction

0183

with the periapical I can tell you.
Q I'm only asking right now based on this panorex film. Is there evidence of bone loss on the lower jaw in that film?
A Insignificant.
Q Is there evidence of bone loss on the upper jaw?
A Yes.
Q Where?
A All over.
Q How would you characterize that amount of bone loss?
A It's consistent with absence of teeth for a long time.
Q Would you say that Mr. had significant bone loss on the upper jaw?
A Not significant.
Q How would you describe it?
A An average.
Q Are you able to determine the width of the available bone in the upper jaw from that panorex?

0184

A No.
Q Are you able to determine the width of the available bone in the lower jaw from the panorex?
A No.
Q Can you determine from that panorex whether any of those seven teeth on the bottom jaw had prior root canal?
A Not from the panorex itself, no.
Q Can you tell whether any of the seven existing teeth had any type of restorative treatment such as crowns or

caps placed on them?
A Yes.
Q What do you observe?
A I observe crowns in each of the teeth that are presented on the x-ray, on the panorex.
Q Is there evidence of decay underneath the crowns in those seven existing teeth?
A Like I said before, panorex is not a precise or very diagnostic to determine decay on teeth. That's where

0185

the periapicals come into play.
Q And I'm going to get to that, but looking at the panorex are you able to visualize any evidence of any decay on any of those seven teeth?
A Yes. On two or three of them, yes.
Q Can you identify those teeth, please?
A I can tell you on the x-ray.
Q Yes. Give me the tooth number.
A Let's see. That's the left side.
I don't have here an indication whether -- where is the right or left side? It probably got lost in the process of taking the x-rays, but -- I cannot tell on this x-ray whether it's the right side or the left side.
Q Can you tell me or identify the teeth that you do observe decay in some other fashion? From the right side, the left side, the middle or any other way you can describe it for me?

0186

A I would say all of the teeth are involved with decay.
Q Can you determine or tell me the extent of that decay just from this film?
A On two or three of them substantial.
Q Which of those two or three teeth do you observe --
A I can't tell you whether it's the right side or the left side.
Q You're looking at -- here we go, doctor. At the top of this film in a diamond shape there is an L at the top left and there's an R up at the top right. Do you see that?
A You got better eyes than I do. Yes, now I see it.

Q Based upon --
A I have to go to my optician.
Q Based upon --
A These glasses are three-dollar glasses. What do you expect from them?
Q Now that you've identified those landmarks, can you tell me and identify

the teeth that you observed the decay in?
A O . That's on the left side, so it's 22, 23 and 24.
Q And is that decay evident underneath the crown --
A Yes.
Q -- or in some other place?
A It's under the crown inside the crowns.
Q Is there evidence of nerve root structures for each of those seven teeth?
A No.
Q None that you can observe or there are none?
A On this x-ray I don't see any structure of a nerve inside the teeth.
Q Did you learn from Mr. whether he had had root canal on any of those seven existing teeth?
A I didn't have to learn it from Mr. . I saw it on the periapical x-rays.
Q Only if you asked him if he had work done.

A I have no recollection of asking him or not. He probably wouldn't even know.
Q Is there anything in your note to indicate that you either asked or got some response as to whether he had prior work done on those seven teeth?
A No. It was visual to me. I didn't have to ask him or to look under the microscope to see. It's quite evident.
Q Did Mr. make any complaints to you about his existing seven teeth?
A Not initially.
Q Did he have any type of appliance at the time he first came into your office?
A An upper denture.
Q And is that something you remember him having?
A I knew that he had it for at

least ten years, he said. I recollect.
Q Other than you recalling it, did
0189

you make any notation of that fact in any
of your notes?
A The length of time he had a
denture?
Q Yes.
A No. It was insignificant to me.
Q Did that upper denture fit?
A He was cursing it.
Q Did he tell you that it fell out
often?
A That's why he came.

Q What type of work --
A He's younger than
me.
Q What type of work did Mr.
do?
A What did he do for a living?
Q Yes.
MR. : In other words, what
he told you back then.
A Back then he told me he's
working for the in some
capacity, which is not what I saw in his
0190

deposition. I thought he was a big shot
over there.
Q Did he tell you that?
A Yes. He didn't tell me that he
was a or or
and
things like that. No. I thought --
Q Did you ask him what he did at
the ?
A No. He told me he was a
or something like that. That's
my impression that he gave me.
Q Let's take a look, please, at
the periapicals that you have. Doctor,
I'm opening up a packet containing eight
originals in there.
A Yes.
Q How do you know that those
particular periapicals are Mr. 's
and not someone else's?
A You must be kidding me.
Q Based upon the fire you told me
about and certain things being destroyed
and not having your original panorex with
0191

you, I'm only asking how do you know that

those periapicals are this patient's and not someone else's?
A Because these seven teeth were indicated for extractions and in conjunction with the panorex and it was in his folder and it was in the packets or envelopes, in small envelopes that I put x-rays and that's basically that.
Q In did you use digital x-rays?
A No.
Q In did you use digital x-rays?
A No.
Q When you would take these periapicals, did you or someone in your office put them into some frame where you can insert and remove the periapicals or did they just go in a little packet that you have here?
A They go into packets.
Q Looking at those periapical films, doctor, tell me what the condition

0192

of those seven existing teeth show.
A Horrible. Beyond description.
Q In what way?
A All of them had previous root canals. All of them had posts and crowns. Hanging onto the roots of the teeth by a hairline. I don't even know how they stayed in. Taking one as the worst and a hundred as the best, I would say they are number one.
Q What did you tell Mr. as a result of your observation of those teeth?
A I tell him that he has very bad teeth and he should get rid of them A.S.A.P.
Q What would happen to him if he kept those teeth in?
A They would break down on him any minute, any time. Just looking at this. I mean, you show it to first-year dentist and he would tell you these teeth are smashed. I don't know how you say.
Q What did you tell Mr. you

0193

could do for him in order to treat those seven teeth?
A Well, you can place implants in there.
Q What would be the benefit of putting implants in place of those

existing teeth?
A Well, the implants would restore his lower -- would replace most of his missing teeth and the ones that have to be extracted because these ones can be breaking any second or any minute.
Q Did Mr. tell you that he had a history of teeth breaking down and falling apart?
A He said all his life he had teeth falling apart.
Q What did you learn from Mr. about his hygiene and specifically his oral hygiene on the first visit?
A Well, it was -- I couldn't determine the oral hygiene where missing teeth were.
Q I'm not asking your observation

0194

during your exam. I'm asking what information did you obtain from him about what he did for oral hygiene.
A He didn't really say anything except that he has number of bad teeth on the bottom.
Q Did you ask him what his oral hygiene was like and how he goes about keeping his mouth healthy and clean?
A No. I knew exactly what the situation of his mouth and oral hygiene was.
Q Did you ask him how often he brushed?
A It wasn't necessary.
Q Why?
A Because these teeth don't show any person who takes care of his teeth.
Q Can you still get the type of dental condition that you observed on even in a person that takes care of his teeth?
A Absolutely.
Q So before jumping to any

0195

conclusion, to be fair, how did you know that the condition of his teeth related to his failure to take care of his teeth?
MR. : Objection to the form. You may answer if you understand it.
A If he took care of his teeth, he would not have had this situation in his mouth.
Q Well, he did have root canal; correct?

A Yes, but that's a long, long time ago.
Q And he did have the restoration for the posts and the crown?
A A long time ago.
Q So that's some form of taking care of teeth that may have been deteriorating; correct?
A Maybe.
Q So my question to you is what other -- withdrawn.
Dental hygiene includes brushing; correct?

A Brushing his teeth -- brushing his teeth -- on his teeth would not make the difference.
Q But part of dental hygiene includes primarily brushing his teeth?
A I don't know what you're referring to dental hygiene. To me dental hygiene means existing teeth, taking care of, being proper and attended to within a normal period of time. Not in this case because this indicates that there is neglect for minimum of ten years, I would estimate.
Q If the patient had no complaints, what is it that he should be taking care of that you described he needs to do?
A Take care of his teeth, existing teeth.
Q How?
A You go to dentists.
Q Would you agree that it is important as a treating dentist to try and preserve a patient's natural teeth as much

as possible?
A For any dentist?
Q For any dentist.
A Yes. Absolutely. That's what you go there for.
Q And the reason why you try to preserve a patient's teeth is because there's nothing better than the patient's own original teeth; correct?
A Absolutely.
Q So short of extracting a person's teeth who has already undergone root canal and restoration, what else is available to make the patient take care of their teeth short of extracting it at that point?

A Detecting beginning of decay so that this situation would not occur.
Q And is it your opinion, doctor, that if the decay had been detected earlier that a simple clean-out and further restoration of the tooth would have saved and prevented the continued deterioration?

0198

A Absolutely.
Q Did you ask Mr. who was the dentist he had last been to?
A It was irrelevant and immaterial to me.
Q Did you ask him when he had last been to a general dentist to get his mouth checked?
A I don't remember specifically, but he told me a long long time ago.
Q Did you ask him whether he had been to any implant specialist before coming to you?
A I think he told me.
Q And what did he say to you?
A He said he can't afford those prices.
Q And what type of prices did he tell you about?
A He didn't specify. I didn't -- I knew what the average cost is there.
Q And what was that?
A I don't know. In his case, 50, 60,000.

0199

Q And you gave him a price of $22,500; correct?
A That's correct.
Q Do you know why these other implant doctors were quoting him that price of 50 or 60,000?
MR. : Objection to the form.
Q Did you ever see any estimate from Mr. of any of these other doctors or specialists he consulted before coming to you?
A Nothing that I can recall.
Q When did you perform the extractions of the lower teeth?
A .
Q On the same day that you performed the extraction of those seven teeth, you placed implants in their place?
A Yes.
Q Going back to the implants that

you put in in the upper jaw first on , in the course of deciding where to place those implants, did you use any guide holes?

A Yes.

Q How did you do that?

A How did I do the guide holes?

Q Yes. How did you measure and determine where those implants were to go?

A I usually go by the customary way of doing it, is I go by the denture that has teeth on it and then I indicate where the implant should be for any number of teeth.

Q And the denture that you talked about, is that a general denture for anybody or one made just for him?

A One made just for him.

Q I'd like you to read, please, your note for , and if there is an abbreviation, tell me what that represents.

A December or ?

Q , .

A Consultation, maxillary and mandibular fixed bridges, all options, which means all options of restorative --

Q Just read it and then I'm going to ask you questions about it.

A Sinus lift, modified sinus lift, bone grafting, et cetera.

Q Now, the sinus lift and the mock --

A Modified.

Q -- modified sinus lift and the bone grafting, those are all options that you're saying you discussed with him; correct?

A That's correct.

Q At the time you saw him for consultation you did not know which of these procedures you were going to perform; correct?

A I basically knew.

Q Which ones were you going to perform?

A He was going to have a modified sinus lift.

Q And what is a modified sinus lift?

A It's the ability to add a few

more millimeters to the length of the implant.
Q How do you do that?
A You take an osteotome and first you drill with a drill. You drill all the way to the floor of the sinus and you take an osteotome rounded at the edge, and using a mallet tapping on it to break the thin bone of the floor of the sinus. By that extending this Sniderian membrane by extending it up. Usually it goes up by about a good three to four millimeters.
Q What was the purpose of accomplishing this?
A Elongating the area for placing a longer implant had it not been for the modified sinus lift.
Q And why did you feel it was necessary to perform this?
A In order to place the size of the implants that I wanted to place, although it wasn't as much as I wished we could, but it was sufficient to place implants, you know, to place implants.

Q Is that because he did not have sufficient bone on the top jaw to accept the implants?
A No. He had sufficient bone to accept the implants, but I wanted to gain more space to place the implants.
Q And is this a procedure that you had done in the past?
A Many times.
Q And did you actually perform this particular procedure?
A Yes.
Q And did you talk to Mr. about doing this particular procedure?
A Yes.
Q And what other options were available to him other than -- well, what options were available to him?
A A sinus lift or bone graft or bone grafting with an autogenous bone, you know, oneself's bone, and then taking a bank bone and the cost of it was out of his -- I don't know how you say. Out of his hand. Out of his pocket. And the

answer was no.
So the only other alternative would have been to do a modified sinus lift, which we did, and that included also a bone graft which is a putty -- it's not

a bone -- with a membrane and PRP.
The PRP is -- you create a -- it's not a medication, but you create a situation where you use the patient's own blood and clotting it and squeezing out of it all the unnecessary blood constituents except the red blood cells and the red blood cells contain quite a few enzymes which --
Q That's what you called the platelet rich plasma?
A That's what PRP stands for, yes.
So we did everything that anybody could have done for this gentleman.
Q Those seven teeth --
A That's on the bottom.
Q -- that were existing, were they vital?

A No.
Q What did they look like physically to the eye?
A Disgusting
Q Did they look darker than what a normal healthy tooth looked like?
A Broken, chipped, porcelain, lots of spaces between the crown and the root. The teeth were sustained -- held only by a thread of the post that was placed in after the root canal that was performed on these teeth. All the teeth had root canals and posts and crowns.
Q In your opinion were any of those seven teeth restorable?
A Absolutely not.
Q Did you send Mr. out to get a second opinion before you ultimately extracted those seven teeth?
A Second opinion for what?
Q About the teeth, the seven remaining teeth.
A You must be kidding me.
MR. : Just if you can

answer the question.
A No, I didn't.
Q Did you ever suggest to Mr. that he get a periodontal consultation before undergoing implant treatment?
A Oh, no. To restore what?
Q I'm just asking whether you did.
A No.
Q Did you ask him to go to a

prostodontist evaluation before starting treatment?
A No. I had them in my office.
Q Did anyone in your office see him for the purposes of possible prostodontist treatment?
A I can't recall.
Q Is there any note to indicate that you asked or that somebody in your office did come to see him for a prostodontic evaluation?
A Well, until 2002, I believe, that I started to employ dentists, on all my previous implants I did, the

restorative -- for years I did the restoration myself.
Q I'm only talking from '05 to '06.
Is there anything in your note to indicate that any prostodontist in your office saw him?
A No.
Q Did you tell Mr. on the first visit how long he would go without having any actual teeth?
A Yes.
Q What did you tell him?
A I told him since he needed extractions and he had not enough bone to restore it with the longest implant, it would take anywhere between three to six months, probably even more.
Q That would get him to some functional level where he would have teeth and be able to use them?
A Well, he could have used the temporary dentures that we gave him, but if you are talking about a permanent

situation, no.
Q What alternatives were available to Mr. rather than undergoing implant treatment?
A Nothing short of a denture that he has had for ten years or so and same thing on the bottom.
Q Was there any way to put a denture on the bottom without putting in implants?
A Yes.
Q How?
A Just put a denture on top, on top of the gums.
Q And in your opinion was that an

option?
A A bad option, but anybody that doesn't have money, it's an option for them.
Q Did Mr. tell you that in order to go forward with your recommended treatment plan he would need to take out a loan or a home equity loan to pay for it?
A He may have. I don't remember,

but it's not my, you know -- either he can or he cannot.
Q And if he told you --
A I was not going to loan him money, if that's what you mean.
Q If he told you he didn't have money, would you have recommended that he just have a denture placed on the bottom and fix the one he had on top?
A Absolutely.
Q Would you have performed the insertion of dentures if --
A Probably somebody in my office.
Q Did you discuss with him the possibility of just putting in dentures?
A Oh, yes.
Q As part of your discussion, did you make a note of that anywhere?
A Consultation, maxillary, mandibular, fixed bridge, all options, sinus lift, modified sinus lift, bone grafting, et cetera.
Usually I say more options than I did here, but this is basically --

Q The fixed bridges that you just mentioned, tell me what you meant.
A Fixed bridge is a permanent bridge that you secure to the implants and you don't take it out.
Q And can you put in fixed bridges without implants?
A On existing teeth, if the teeth are good.
Q And in his case would it be fair to say that you would have to extract the teeth and then simply put a denture on the lower?
A Oh, no way I could do that.
Q You could not attach a bridge to those existing teeth?
A Absolutely not. They were history.
Q I want you to tell me as best you recall what Mr. said to you on

the first visit.
A I can't recall. I know what he came for.
Q Did he tell you how he happened

0211

to get your name?
A Yes.
Q How?
A Found it in the newspaper.
Q And you advertised at that time; correct?
A That's correct.
Q In what different newspapers did you advertise?
A New York Post, Daily News, Pennysaver in some locations.
Q Did you advertise often?
A Oh, yes.
Q And the ads that you had, did you have one ad that you advertised continuously in different papers or did you have multiple ads?
A Basically they were all -- well, not the same, you know, but different prices at different times, but the message is that it's done by an oral surgeon; we have a dental laboratory, you know, everything done in one office.
Q Did you know that Mr.

0212

traveled from to come see you?
A Oh, yes. That's why I was very kind to him and I gave him more implants than he should have for the money he gave me.
Q Did you also give him additional implants in the upper jaw?
A Yes.
Q How many did you originally attempt to place in his upper jaw before you decided to give him the extra ones?
A Well, I knew I was going to give him a minimum of six implants, but I told him, you know, if I'm going to have enough bone and a successful sinus lift, you know, I would add more.
Q So the six you knew you were going to put in and you gave him four more?
A Yes. The guy came from .
I was kind to him.
Q Does Mr. have any family in New York, to your knowledge?

0213

A I don't think so because he was coming and going on the same day.
Q Are you aware if there are any implant dentists in or New Jersey?
A It's not -- it's not a backwoods country. I'm sure there are.
Q As well as oral surgeons or restorative dentists in those two states?
A Absolutely.
Q Other than the advertisement, do you know why he bypassed the other available surgeons and restorative dentists in those two places, in and New Jersey, to come to you?
A Well, he wasn't Rockefeller or close to him, so. He didn't have money.
Q What is it that you advertise in your ad that would cause a man to drive more than 200 miles to come see you?
MR. : Objection to the form.
MR. OGINSKI: I'll rephrase it.

Q Did Mr. tell you what it was about your ad that caused him to want to come see you?
A I think the price.
Q What was it about the price that attracted him to your office?
A He couldn't get it anywhere else.
Q Meaning that you were offering a lower price than anyone else was providing?
A That's correct.
Q And the prices that you had in the ads, you said it differed from time to time?
A Yes. Not substantially.
Q The prices that you're talking about, did those prices include the cost of an implant?
A Yes.
Q And did it also include the cost of the crown to finish and load the implant?
A Whether it was a crown or a denture, yes.
Q Do you recall what prices you had listed in those different advertisements?

MR. : He just said they varied. Do you want to be more specific?
Q Of the ones you recall, you can tell me.
A Well, most of the time, if not all of the time, it says up to -- no. I'm sorry. A certain number, whether it was 400 or 700, you know. How can I phrase it? From a certain number and up.
Q Meaning the minimum price?
A The minimum price, yes.
Q And anything else you wanted would be extra?
A Yes. And different times the prices were different.
Q What is an immediate load implant?
A An implant that you restore at the same time when you place the implant.

0216

Q I think you mentioned earlier today that that had a lower success rate than one that is done in an edentulous area.
MR. : Objection. I don't believe he said that, but I'll let him answer if he understands.
Q Is that correct?
A No.
Q When you extracted a tooth on day one and put an implant in on the same day, do those implants have a lower success rate than one where you simply placed the implant into the bone without having to do any extraction?
A Yes. I said it before.
Q That's what I wanted to check.
What is an oral and maxillofacial surgeon?
A Well, it's -- the extent of our ability to restore facial bones like the malar bone, the condyle and the lower jaw fractures and things like this.

0217

Q Did you hold yourself out as an oral and maxillofacial surgeon?
A Oh, yes.
Q Are you a medical doctor?
A No.
Q Did you go to medical school?
A No.
Q Did you perform any surgical residency?

A Yes.
Q What surgical residency did you perform?
A Oral and maxillofacial surgery.
Q Where?
A Hospital in
Q From when to when?
A From to . Three years.
Q Did you do a dental residency?
A Yes.
Q Where?
A From to in
Q Did you complete that?

A Yes. One year.
Q And that was general dentistry?
A That's correct.
Q And the oral and maxillofacial surgery, that was a separate residency?
A Three years separate from the general, yes.
Q Did you complete that program?
A Yes.
Q Were you given any type of certificates of completion or diploma for finishing that program?
A Yes.
Q After completing that training, did you go on to do any additional training?
A What is there to do?
Q I'm just asking if you did.
A No.
Q Where did you go to dental school?
A ,
College.
Q Where?

A .
Q From when to when?
A to .
Q When did you become licensed to practice dentistry in the State of New York?
A .
Q From 19 up until the year 20 was your license to practice medicine ever suspended?
A No.
Q I'm sorry.
From 19 up until the year 20 was your license to practice dentistry

ever suspended?
A No.
Q Was your license to practice dentistry ever suspended at any time between 19 to 20?
A No.
Q Am I correct that you are no longer licensed to practice dentistry in the State of New York?
A Yes.

Q And you surrendered your license in of 20 ; correct?
A Yes.
Q

MR. : Just note my objection. You may answer for purposes of the discovery, but there may be a privilege claim.
A I don't know. I had an attorney.
Q I'm not asking about that.
A All right. I don't know.
Q Did you voluntarily surrender your license?
A Yes.
Q At some point before surrendering your license

MR. : Objection to the form, but if you know, you may answer

for purposes of discovery.
A Can you repeat it again, please?
MR. OGINSKI: Read it back.
(Whereupon, the record was read.)
A Not before.
Q Were you charged, doctor, with

?
MR. : Objection to the form.
Again, doctor, just so it's clear from the record, I'm not the attorney handling this aspect of the case. I'm going to let the doctor tell me if he needs a conference on this or wants to exercise any privilege or answer the question or defer to his other counsel or send me

a discovery notice. I'll leave it up to the doctor.
A I don't know. Like I said before, it was in the hand of an attorney.
Q Doctor, I'm going to show you a

document which is from the State Education Department, the New York State Board of Regents, and in it under license surrenders it says, and I quote,

I'm going to ask you to take a look at that.
My question is is that an accurate statement?
MR. : Again, note my objection and I'll let the doctor decide whether he can answer that or not.
I'll just note I'm objecting both on possible privilege -- it's obviously post-accident, the decision, and it doesn't specify what time frame, just looking at this for the first time, that if this is so, that he was allegedly doing that, but this is not a conviction of anything or an admission of anything It's a license

surrender notification.
A The license was surrendered after, I think, you know -- maybe I shouldn't say to you.

Q Are you licensed in any other

0224

state?
A I took -- well, not -- I took the Regional Boards and I had a license, but I didn't renew it for over many years.
Q When you say the Regional Boards, what do you mean?
A It's a group of many states that you take one exam and it's good for all of them.
Q And Regional Boards in what?
A Well, .
Q What specialty or subspecialty?
A Dentistry. Every dentist has to take State tests. In the case of New York, you can take the Regional Boards, which if you take it, it's good for many states; and others, I think.
Q What is a Doctor of Medical Dentistry?
A It's D.M.D. It's -- some schools give D.M.D. Many schools give

0225

D.D.S.
Q And what degree did you receive?
A D.D.S.
It's the same as D.M.D. It's no difference.
Q Were you certified by any accredited medical board as an oral surgeon?
A No.
Q Were you certified by any accredited dental organization or dental board as an oral surgeon?
A No.
Q Is there any type of accreditation or crediting board for oral surgeons in the State of New York or in the country?
A In the country, yes.
Q What is that?
A It's American Board of -- I don't know the exact. American Board of Oral and Maxillofacial Surgeons.
Q Did you ever take the examinations to become certified by the

0226

American Board of Oral and Maxillofacial Surgeons?
A No, but I took a test by the

American Society of Oral and Maxillofacial Surgery and I was admitted to a membership in the Oral and Maxillofacial Association.

Q Can you tell me is there any particular reason why you did not attempt to obtain Board certification from the Oral and Maxillofacial Surgeon Board?

MR. : Objection to the form. You may answer it, though, doctor.

A I didn't deem it necessary. You know, as time went by, you know, I found it to be less and less important. It wouldn't have made me a better oral surgeon.

Q Are you Board certified in any field?

A No.

Q Were you a member of the International College of Oral Implantologists?

0227

A Yes.

Q And in order to become a member of that organization, what did you need to do?

A Well, I was a member. I didn't have to do anything

Q In other words, you fill out a form --

A An application.

Q -- and send in the fee and you're member?

A Well, there are general dentists that are accepted as members also, but oral surgeons did help.

Q Were you a member of the American Dental Society of Anesthesiology?

A Yes.

Q And in order to become a member of that organization, what did you need to do?

A I had to be an oral surgeon.

Q Did you have to take any examination to become a member of that organization?

0228

A No. Just the fact that I was Board eligible in oral and maxillofacial surgery with the training that I had I was admitted to it without any tests.

Q Am I correct, doctor, you said you never took the examination to become Board certified for the American Board of Oral and Maxillofacial Surgeons?

A That's correct.
Q And when you say you're Board eligible, you mean you graduated --
A If I take the test, I can take it all the time.
Q Board eligible means you have taken the required courses and residency necessary to sit for the exam?
A That's correct.
Q That examination to go become Board certified, that was both a written and oral examination?
A I'm sorry?
Q Was it a two-part exam; written and oral?
A For what?

Q To become Board certified.
A I think so, yes.
Q And you never took the written; correct?
A No.
Q Now, this organization you mentioned, the American Society of Oral and Maxillofacial Surgeons, do you know where they are based out of or where they are located?
A Maybe Chicago. I don't know.
Q What type of test were you asked to take in order to join that organization?
A I took an oral test in one of the conventions.
Q Was that an all-day test or was that a couple of hours or something else?
A Couple of hours. Oral examination.
Q What was the purpose of that oral examination?
A To become a member of the American Society of Oral and Maxillofacial

Surgeons.
Q In your advertisements did you hold yourself out as being a member of that particular organization?
A No, I didn't say that.
Q The American College of Oral and Maxillofacial Surgeons, is that the college that certifies doctors for Board certification?
A There are two -- let me see this. There are two societies of oral and maxillofacial surgeons. International College of Oral -- that's --

Q Hang on, doctor. You are now looking at a copy of an advertisement that you had at one time in one paper, at least one paper; correct?
A Yes.
Q And what organizations are you referring to about the American College of Oral and Maxillofacial Surgeons?
A It's -- that's the Society of Oral and Maxillofacial Surgeons.
Q And is that organization --

0231

A Medical and dental.
Q Is that organization different than the American Board of Oral and Maxillofacial Surgeons?
A Yes.
MR. OGINSKI: We are going to break for now and we are going to reschedule and come back at a different time.
(TIME NOTED: 4:50 p.m.)

_____
(Signature of witness)
Subscribed and sworn to
before me this_____
day of_____,
2008.
_____

* * *

0232

I N D E X

R E Q U E S T

* * *

E X H I B I T S

* * *

15
16
17
18
19
20
21
22
23
24
25
0233
1
2 CERTIFICATION BY REPORTER
3 I, Josephine Winter, a Notary Public
4 of the State of New York, do hereby
5 certify:
6 That the testimony in the within
7 proceeding was held before me at the
8 aforesaid time and place;
9 That said witness was duly sworn
10 before the commencement of the testimony,
11 and that the testimony was taken
12 stenographically by me, then transcribed
13 under my supervision, and that the within
14 transcript is a true record of the
15 testimony of said witness.
16 I further certify that I am not
17 related to any of the parties to this
18 action by blood or marriage, that I am not
19 interested directly or indirectly in the
20 matter in controversy, nor am I in the
21 employ of any of the counsel.
22 IN WITNESS WHEREOF, I have hereunto
23 set my hand this 29th day of February,
24 2008.
25 _____
0234
1
2 ERRATA SHEET
VERITEXT/NEW YORK REPORTING, INC.
3
200 Old Country Road 1350 Broadway
4 Mineola, NY 11501 New York, New York
10018
5
NAME OF CASE: vs
6 DATE OF DEPOSITION: February 27, 2008
NAME OF DEPONENT:
7
PAGE LINE CHANGE REASON
8 _____/_____/_____/_____
9 _____/_____/_____/_____
10 _____/_____/_____/_____
11 _____/_____/_____/_____
12 _____/_____/_____/_____
13 _____/_____/_____/_____

_____/_____/_____/_____
_____/_____/_____/_____
_____/_____/_____/_____
_____/_____/_____/_____
_____/_____/_____/_____

_____

SUBSCRIBED AND SWORN TO BEFORE ME
THIS_____DAY OF_____, 20 .

_____ _____
NOTARY PUBLIC MY COMMISSION EXPIRES