The NYSDA-MLMIC Program Declares 5% Dividend for 2015

This past spring, MLMIC's Board of Directors was pleased to announce its approval of a 5% Program dividend for 2015. This dividend was applied to the policies of MLMIC dentists insured for their primary coverage as of May 1, 2015.

The Program dividend followed the 7.5% Special Dividend distributed to all policyholders earlier this year. In fact, 2015 marked the 7th consecutive year of dividends for dentists insured in the NYSDA-MLMIC Program.

Since the Program's inception in 1992, MLMIC has returned over $12 million in dividends to our dentist policyholders—an accomplishment unmatched by competitors writing dental professional liability coverage in New York State.

Giving a Deposition as a Dental Witness

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The deposition, simply stated, is the question and answer portion of the “discovery” process of a lawsuit. In civil litigation, discovery is the pre-trial period or the period between the commencement of the action and the actual trial in which information is gathered “to ascertain truth and to accelerate the disposition of suits.” Rios v. Donovan, 21 A.D.2d 409, 411 (1st Dept., 1964).

Truthfully, especially from a defendant’s perspective, this discovery process seems to be an interminable exchange of documents. While it is the defendant’s role to assist in the collection of information and documents in this paper phase of discovery, the first face-to-face encounter with the adversary comes at the deposition.

This question and answer session is conducted by attorneys who represent parties to the litigation. As a person being deposed, you must take an oath or otherwise affirm that the answers you give will be truthful. A court reporter or stenographer records each question and answer, which will later be transcribed into book form. The deposition has two underlying purposes: 1) to find out what you know; and 2) to preserve testimony for trial.

By the time a trial begins, the parties should know who will testify and what their testimony will be.

As stated, the questions and answers will be reduced to a book form and copies distributed to all attorneys involved. This transcript can be used at trial to contradict testimony given by the witness and to impeach that witness’s credibility with any inconsistencies. Under some circumstances, a deposition transcript can be used in lieu of trial testimony. In
Case Study

The Dangers of Changing One’s Testimony

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In late August 2007, a 16-year-old female was first seen for a cleaning by a general dentist. The dentist, a solo practitioner, had previously treated her parents. The patient’s dental history included an examination (with x-rays) performed by another dentist seven months previously. She brought the x-rays from that visit with her. Aside from having had braces removed in 2003, the patient’s dental history was unremarkable. She advised the dentist that she brushed her teeth twice a day and flossed daily. A set of bite wing x-rays were taken and were unremarkable.

Since the patient was a minor, the patient’s mother completed and signed the health history. She also attended most visits with the patient. The patient had a history of smoking cigarettes. Her medications included birth control pills, Allegra, and oxycodone as needed for back pain. She had also completed a course of prednisone three days prior to this appointment. The prednisone and oxycodone had been prescribed to treat injuries to her lumbar vertebrae, which were sustained in a motor vehicle accident in April 2007.

The office hygienist cleaned the patient’s teeth, and then she was examined by the dentist. He found her teeth to be within normal limits. Her dental hygiene was also noted to be good.

An appointment for the patient in January 2008 was cancelled by her mother.

The dentist next saw the patient in late March 2008 for a routine checkup. She had undergone back surgery in October 2007. Her medications were unchanged. Her chief complaint was that she had an indentation at the gum line on the upper anterior teeth. Three periapical x-rays of her upper teeth were taken. These x-rays revealed decay in teeth #7, 8, 9, 11, 12, and 15. Decay was also noted in #30; however, no x-rays of the lower teeth were performed. The dentist recognized that this was a significant change in the condition of the patient’s teeth, since the teeth appeared to be demineralizing and she had seven teeth with caries. Although he did not document his conversation with the patient and her mother about the multiple caries, the dentist claimed he discussed with both the patient and her mother that her diet might explain the substantial change in the condition of her teeth. However, her diet did not appear to be a contributory factor. Nor did her oral hygiene appear to be the source of the problem, as her gingiva was healthy. The dentist prescribed PreviDent toothpaste and told the patient to floss daily. He planned to fit her with fluoride trays before she went to college (but never did so). He developed a treatment plan for the seven fillings, and discussed this plan with the patient and her mother.

On June 17, 2008, the patient returned to see the dentist. She now had three additional carious teeth, #27, 28, and 29. These teeth were symptomatic, so they were immediately treated. The patient was advised to return to have the remaining fillings completed.

On June 18, 2008, the patient’s father called the dentist’s office with concerns about the total cost of the proposed treatment. He was advised that the 3 teeth filled the previous day were not in the original treatment plan. The father also advised the dentist that the patient was scheduled for further back surgery on July 1, 2008 and requested that the remaining fillings be completed prior to that surgery. However, the patient had cancelled her June 23, 2008 appointment with the dentist.

On July 31, 2008, the patient returned to the dentist’s office. He placed fillings in teeth #5, 6, 7, and 8. No x-rays were taken at this visit. Nor did the dentist document the current condition of the patient’s teeth.

At the next visit on August 19, 2008, the dentist placed fillings in teeth #9, 10, 11, and 12 and replaced a filling in #7. He also documented the presence of a new cavity in tooth #10. X-rays were not taken at this visit, despite the new cavity.

On September 29, 2008, the patient was again seen by the dentist. The dentist observed that tooth #30 had crumbled distally from decay. The patient, however, refused to undergo any treatment that day and was scheduled to return for further treatment. The dentist failed to document that he had spoken with either the patient or her parents about the continued serious deterioration of her teeth. He only documented his diagnosis of “decay.”

The patient was next seen on November 26, 2008. The dentist observed and documented an increase in the hypomineralization of the patient’s teeth. His notes state that her teeth...
appeared to be “literally crumbling” and realized she was experiencing unusual degeneration of her teeth. Despite this, once again, he took no x-rays at that visit. As a result of his findings, he suspected that the patient had amelogenesis imperfecta, a genetic disorder which causes demineralization. He conferred by telephone with a prosthodontist, who recommended that he refer the patient to an oral pathologist to confirm the diagnosis. The dentist claimed the patient was in his office at the time of the telephone call. He also stated that the now 18-year-old patient was given the names of, and contact information for, both the oral pathologist and the prosthodontist and told to promptly see them. However, he failed to document that conversation and the details of the referral.

He did not see the patient again until April 2, 2009. She had multiple fractured teeth with sharp edges. The dentist’s records documented that he placed temporary fillings in her front teeth. The patient was again advised to see the oral pathologist for diagnosis and the prosthodontist for total mouth rehabilitation during her summer break. He took no x-rays and did not perform any further examination at this visit. This was his last contact with this patient.

On April 30, 2009, the patient finally saw the oral pathologist. His consultation report ruled out amelogenesis imperfecta and dentinogenesis imperfecta. The oral pathologist questioned the patient about her health and medication history, examined her mouth, and performed pH testing. He was advised that the patient had been taking Zyrtec and Lexapro. He then diagnosed xerostomia, resulting from those medications. He determined that as a result of the untreated xerostomia, she had developed rampant decay. The consultation report was the first time the dentist was aware that the patient was taking these medications.

Subsequently, the patient underwent extensive and costly total mouth rehabilitation by the prosthodontist. This included extractions, root canal treatment on all her remaining teeth, implants and restorations. Given her young age, it was anticipated that the restorations would require periodic replacement during her lifetime. Of note, the patient and her parents had exhausted their financial reserves and their dental insurer had refused to reimburse them for the extensive reconstruction she required. This was likely a precipitating factor resulting in the patient’s commencement of a lawsuit against the dentist.

Expert dental reviewers opined that the dentist treated the patient within the normal standard of care. The reviewers felt that the patient had greatly contributed to her problems by not going to the oral pathologist as advised on November 26, 2008. Furthermore, they believed that the patient and her parents were culpable for not advising the dentist of changes in her medications, particularly the addition of Zyrtec and Lexapro.

In addition, the dentist’s treatment was reviewed by the professional liability committee of the dentist’s district dental society. This committee also found the dentist’s care to be defensible. The decision of the committee was based upon the culpability of both the patient and her parents in failing to report medication changes, and their failure to act on the referral to the oral pathologist in November 2008. The committee felt this was a strong defense to the lawsuit. Unfortunately, the dentist had no supporting documentation that he had questioned the patient about any changes in her medications. However, the dentist claimed that it was the custom and practice of both his dental hygienist and him to ask about medication changes at every visit. Since his recommendation

continued on page 4
to see the oral pathologist was also not documented, the defense of this lawsuit clearly hinged on this dentist’s credibility.

At his examination before trial (EBT), the dentist testified under oath that he spoke with the patient's father in late November 2008 about his concerns. He further stated that he had advised the patient's father that the patient required prompt evaluation by both the oral pathologist and prosthodontist. In contrast, the patient’s father testified at his EBT that the dentist neither discussed his daughter’s condition nor mentioned referral to the oral pathologist. Furthermore, at the patient's EBT, she testified that she promptly went to see the oral pathologist when advised to do so in April 2009.

The case proceeded to trial. The thrust of the plaintiff’s case was the dentist’s failure to properly update his records with respect to changes in the patient’s medications, his failure to appreciate the side effects of those medications, and his failure to promptly refer her to proper specialists despite her manifesting a significant change in the decay of her teeth.

The dentist was the first person to take the stand. To the surprise of defense counsel, the dentist’s trial testimony differed significantly from that given during the pendency of the lawsuit and his testimony at his EBT. Throughout the case, the dentist had claimed that he had contacted the prosthodontist on November 26, 2008, while the patient was still present and in the chair. He had further claimed that he provided her with the contact information for the oral pathologist and prosthodontist on that same day. However, when questioned at trial, he testified that he could not actually recall whether the patient was still in the office when he called the prosthodontist.

Additionally, he had no documentation to confirm that he had, in fact, provided the referral information to her on that same day.

As a result of the change in the dentist’s testimony, his credibility was impeached and the foundation needed to support his defense was damaged.

In contrast, the patient testified before the jury that same day that she had advised the dentist that she was taking Lexapro and “allergy” medications in July 2008. She also testified that she went to the oral pathologist in April 2009, as soon as she was “told to do so.”

Due to the unexpected changes in the dentist’s testimony, which severely undermined his defense, he was advised to settle the case. A settlement in the amount of $450,000 was reached on behalf of the dentist.

In this case, there were several factors which contributed to the unusually large settlement during the trial.

Although the expert reviewers believed that the dentist’s care was defensible because of the parents’ culpable conduct, it certainly would have been an easier case to defend had the dentist been more thorough. The relatively rapid progression of the patient’s dental decay should have prompted a more detailed assessment of the patient at each office visit. The dentist should have obtained and documented an updated, detailed medical history and medication list each time the patient came for an office visit, especially since the patient was undergoing ongoing medical and surgical treatment for her back injury. There was no indication in the chart that he ever did this after her visit in March 2008. Further, dental x-rays could have been important given the patient's dental deterioration.

Because the patient’s father expressed concerns about the cost of the proposed treatment, this may have influenced the dentist not to proceed with any treatment which would have increased the cost to the family. Cost concerns, however, cannot dictate the course of good clinical treatment. We live in a country where, unfortunately, an increasing number of people lack sufficient dental insurance. There may be a strong temptation to lower clinical standards and forego indicated tests and therapies because of financial considerations. This can result in substandard care, or a delay in diagnosing a serious condition, all to the patient’s detriment. If cost is a serious issue and a barrier to care, both the need for further testing and alternatives must be explored with the patient and, in this case, her family so that the patient’s health is not jeopardized. If this is refused, the refusal must be well-documented.

Lack of documentation in this patient’s chart turned out to be a pivotal issue in the case. The dentist did not document many of his conversations with the patient and her parents. There was no documentation that he questioned her about any medication changes at each visit, although the dentist alleged that it was his office practice to do so.
But the most important omission was his complete failure to document his claim that in November 2008, he personally spoke with a prosthodontist about the patient while the patient was still in the examination room, and that he gave the patient the names and contact information of both the oral pathologist and the prosthodontist. It was only when the patient returned in April 2009 with multiple fractured teeth that her referral to an oral pathologist and a prosthodontist was documented. The fact that she immediately complied with these referrals, and the lack of any documentation of earlier referrals, cast serious doubt on the dentist’s claim that he had referred her to these specialists in November 2008.

At trial, the defense had to rely upon the dentist’s own testimony as to what he said and did during the patient’s course of care. This forced the jury to judge his credibility and reliability as a witness. However, this dentist gave inconsistent statements under oath on two different occasions regarding if and when he referred the patient to an oral pathologist and prosthodontist. Therefore, at trial and in front of the jury, his credibility was called into question, and he was impeached as a witness.

The purpose of impeachment is to show to the jury that the witness is lying about a material fact. Using prior sworn testimony is the most effective form of impeachment. Since prior testimony given under oath is subject to the penalties of perjury, it carries particular weight when the credibility of a witness is attacked. It also may be introduced not only to attack the witness, but to prove the facts of the prior testimony were not true. Impeachment generally makes a big difference in the way a jury views a witness. Effective impeachment basically discredits the witness as a reliable source of information, shows a lack of credibility, and often influences the jury’s final decision.

In this case, the expert reviewers for MLMIC believed the dentist’s care could be defended, so a decision was made to take the case to trial. However, since the dentist was either too nervous to recollect his prior testimony, not sufficiently prepared, or had a change in memory, his abrupt change in testimony on a significant issue reflected poorly on his honesty.

Because of the plaintiff’s young age, the years of restorative work ahead of her, and the pain and suffering she had endured and would continue to endure in the future, settlement during the course of the trial was deemed to be the best way to resolve this case rather than face the possibility that the jury would return a punitive verdict against the dentist. ♦

2015 Event Calendar

MLMIC representatives will be in attendance at the following events:

**OCTOBER 2015**
28 Nassau County Dental Women’s Conference Scrubs & Stilettos

**NOVEMBER 2015**
2 Nassau County Dental Society General Meeting
13 Fifth District Dental Society Fall Seminar (Clayton, NY)
18 Ninth District Dental Association General Meeting (Rye, NY)
18 Suffolk County Dental Society General Meeting (Upsky Hotel)
11/29 – 12/2 Greater New York Dental Meeting

**DECEMBER 2015**
11 Nassau County Dental Society’s CE Course

For more information on MLMIC’s participation at these events and others, please contact Pastor Jorge, Advertising/Marketing Administrator, at 212-576-9680.
The Americans with Disabilities Act (ADA) requires places of public accommodations (including dentists’ offices) to permit service animals to accompany people with disabilities to all areas where the public is allowed. The term “disabilities” includes physical, sensory, psychiatric, intellectual or other mental disabilities. Effective in March 2011, only dogs are recognized by the ADA as service animals. The law defines a service animal as a dog trained by a recognized or professional trainer. Additionally, the dog must perform specific tasks for the patient. A dog that has not been trained to perform specific tasks for the patient is not a service animal, and does not have to be accommodated.

The types of tasks performed by service animals include: guiding blind persons; pulling a wheelchair; alerting a deaf person to danger; alerting and protecting a person who is having a seizure; reminding a mentally ill patient to take his/her medication; and calming a person with post-traumatic stress disorder during an anxiety attack. However, an “emotional support” dog is not considered a service animal under the law.

Service animals are permitted to be in waiting rooms, private offices, clinics, and non-sterile examination rooms. Service animals, however, may be excluded from operating and examination areas where the presence of the animal might compromise a sterile environment.

Within permissible areas, the service animal must be harnessed, leashed, or tethered, unless doing so interferes with its tasks or the patient’s disability. In such situations, the dog’s owner must maintain control of the animal through voice or other signals and commands. Finally, a service dog must also be housebroken.

When a patient arrives at your office with a service animal, and it is not obvious what service the animal provides, your staff may only ask two questions:

1. Is the dog a service animal which is required due to a disability?
2. What work or task(s) has the dog been trained to perform?

Staff cannot ask about the patient’s disability or request medical documentation of the patient’s disability, documentation of the training the dog has completed, or documentation of its vaccinations. Staff allergies and fear of dogs are not sufficient reasons to deny access or refuse to provide dental services to a person with a disability. However, a reasonable accommodation should be provided as well for an allergic staff member.

Exclusion of Service Animals
In certain instances, such as when the animal is out of control or the handler does not act effectively to control it or the animal is not housebroken, a service animal can be excluded from the premises. However, the patient must be offered the opportunity to be seen and treated without the dog being present. Finally, the patient is solely responsible to provide food and other care for the animal, or for arranging to have someone do so, while the patient receives

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1. 28 C.F.R. § 36.104.
2. 73 F.R. 34508, 34553 (June 17, 2008).
care from the dental staff and dentist. Of course, thorough and complete documentation of the situation is required to justify the exclusion.

The Use of Miniature Horses

Patients who use a wheelchair sometimes prefer to use miniature horses rather than dogs to pull them. Miniature horses are generally 24 – 34 inches tall and weigh 70 – 100 pounds. Although the recent changes in the law initially limited the definition of service animals to dogs, a specific provision of the law\(^3\) still permits the use of miniature horses which meet certain requirements described below.

Just like a service dog, a service horse must have been trained to perform specific tasks for disabled patients. Further, there are four factors designed to assist a place of public accommodation to determine and assess whether or not a miniature service horse can accompany a patient into the office. They include: the horse must be housebroken; the horse must be under the patient’s control; the facility must be able to accommodate the horse’s type, size, and weight; and the facility must determine whether the presence of the horse will compromise legitimate safety concerns.

There are circumstances where a miniature horse may be excluded. These include: when the horse poses a direct threat to the health and safety of other patients, because it is not under the patient’s control; the horse is not housebroken; or the office cannot physically accommodate the size, weight, and type of horse.

However, as with service dogs, the patient must be given the opportunity to receive care and treatment without the horse being present and must be provided with a reasonable accommodation as an alternative.

There are cases which have challenged the exclusion of service animals. However, if one does properly exclude an animal, one must still be in full compliance with the law by providing another reasonable accommodation to the patient.

There are cases which have challenged the exclusion of service animals. However, if one does properly exclude an animal, one must still be in full compliance with the law by providing another reasonable accommodation to the patient. Further, one or more of the reasons for exclusion must clearly be present. For example, in 2009, the United States District Court in Oregon found that a hospital appropriately excluded a service dog from remaining with his owner, who was an inpatient.\(^4\) On numerous admissions, the dog had exuded a rancid odor. Despite being asked to do so, the owner refused to have the dog bathed. No one was available to care for the dog at all times and the patient, who was bedridden, could not do so. Additionally, the dog growled at the nursing staff and impeded their access to the patient. Therefore, the hospital showed the court definitive proof that the dog was both a direct threat due to its odor and an actual risk to the staff and other patients due to its actions. As a result, this service dog could be excluded every time the patient was admitted to the hospital.

In summary, a dentist must be careful to train his/her staff in how to deal with disabled patients who present to the office with a service animal. A patient cannot be excluded from a dental practice due to a disability and/or the presence of a service animal. Finally, if exclusion of the service animal from a specific non-public or sterile area of a facility is warranted, the patient must otherwise be reasonably accommodated at the practice and the legitimate reason for any exclusion appropriately documented in the patient’s record.

\(^3\) 28 C.F.R. § 36.302(c)(9).

fact, under the Rules of Civil Procedure, one party’s deposition transcript can be used “for any purpose” by an adverse party. CPLR 3117(a)(2). This rule simply allows for the deposition testimony to be read at trial as evidence of the facts testified to as if the witness were on the stand. This is done at times for convenience sake or when a witness is not available to testify. It is certainly the preference to have the witness at trial so that a jury can observe their demeanor and judge their credibility. Beyond this, transcript readings tend to lose the jury’s attention. More recently, attorneys have relied increasingly on videotaped deposition testimony. This provides for a more accurate record of the proceeding and gives the jury a better picture of the witness if he/she cannot appear at trial.

It is important to remember that, by the time of the deposition, the injury at issue has likely developed in one way or another through time and additional diagnostics, care, and treatment. The attorneys have the benefit of the passage of time and the ability to research the dental medicine in light of the patient’s development. While it is true that dental defendants have the initial advantage in technical knowledge over the questioning attorney, a veteran attorney will have consulted with the appropriate practitioners and conducted research in order to be conversant with the particulars of the field at issue. Don’t assume you are talking to a neophyte.

A deposition can range from simple inconvenience to the witness to a probing indictment of the care, establishing the standard of care, and a deviation from that standard. On the one side is the simple review of a record. It may happen that portions of your dental record, if it is still a paper record, are not clearly legible. An entire deposition may consist of your interpretation of your own handwriting. Obviously, this type of questioning can be over within minutes with little preparation and anxiety. (It can be quite embarrassing if you cannot read your own handwriting.) On the other end of the spectrum are sessions where the witness is asked to establish the standard of care, that the standard was breached, and that there was no justification for the breach. McDermott v. Manhattan Eye, Ear and Throat Hospital, 15 N.Y.2d 20 (1964) and Rivera v. Aniles, 8 N.Y.3d 627 (2007).

The standard of care and breach can be established through direct questioning i.e., “What is the standard of care when a patient presents with the following complaints and symptoms. . .” Or, “is it a departure from the standard of care to affix a titanium appliance to the patient’s inferior alveolar nerve canal?” Knutson v. Sand, 282 A.D.2d 42 (2d Dept., 2001). Additionally, the standard of care can be established through “authoritative sources.” If you acknowledge that a dental text, article or periodical is generally accepted as a reliable source of information among professionals in a given field, that source can be used as a measure of the care rendered in the plaintiff’s case. Spiegel v. Levy, 201 A.D.2d 1378 (1st Dept., 1994). Also, knowing the outcome, a witness can fall into a trap which leads to incriminating testimony. “The rule of reasonable care does not require the exercise of the highest possible degree of care; it requires only that he exercise that degree of care that a reasonably prudent dentist would exercise under the same circumstances.” New York Pattern Jury Instructions, 2:150. You must consider not the ideal, but the standard “under the circumstances,” with the information available at the time of treatment.

In cases involving allegations of failure to diagnose a dental problem or injury, the differential diagnosis practice can also be a daunting trap. In this vein, questioning will initially establish the purpose, function, and mandatory nature of recordkeeping and have you acknowledge the need to record all significant findings. Continuing down this road, the questioner will have you acknowledge your obligation to establish a differential diagnosis and rule out these potential diagnoses in a timely fashion. You will be asked to admit that the potential diagnosis should be approached with suspicion until it is ruled out by examination or studies. Where the ultimate diagnosis is recorded within the differential, the approach will be toward negligent examinations or studies conducted to rule out that condition. In cases where the diagnosis is not included within the differential, good deposition questioning will lead to the conclusion that it was never considered.

Beyond these focused example techniques, the rules permit attorneys to approach depositions as fishing expeditions. Deposition questioning is not limited by the boundary that the question calls for hearsay or is merely irrelevant, these objections are preserved for trial. However, unless a question clearly violates your constitutional rights or a legal privilege, questions are freely permitted and answers are required. Courts have established that deposition questioning in a malpractice suit “may roam far and wide and may be posed for the purpose of eliciting information calculated to lead to relevant evidence.” Wilson v. McCarthy, 57 A.D.2d 617 (2d Dept., 1977). In other words, irrelevance is not a sustainable objection if the question might somehow lead to something relevant.

Despite this, depositions frequently involve disputes between the attorneys on issues such as relevance, questioning based on facts not at issue, calls for hypotheticals and expert opinions. When a witness is instructed not to answer by counsel, often times the argument goes before a judge, either by a telephone call directly from the deposition or by motion after the fact.
Only in the rarest of circumstances is the witness permitted not to answer. The most common exception to this rule comes into play when the witness is not a party but, for example, a subsequent treating dentist. Those depositions are often challenging for the witness since the questioning attorney will invariably try to elicit expert opinion testimony to support his/her theory of the case. If an opinion is part of your record of treatment, it is discoverable. However, questioning a non-party witness also referred to as a “fact witness” as an expert is not permitted. Gilly v. City of New York, 69 N.Y.2d 509 (1987). In other words, hypothetical questions are not allowed, and the lawyer representing the witness may direct the witness not to answer. The general rule is: a party may not subpoena a witness and then treat him/her like an expert. Furthermore, a recent change to the law governing depositions of non-party witnesses states the attorney for the witness “may participate in the deposition and make objections on behalf of his or her client in the same manner as counsel for a party.” CPLR § 3113(c), effective September 23, 2014. Prior to this amendment, non-party witnesses in New York State had been effectively denied the right to counsel. But that’s another story and, thankfully for dental professionals, no longer the case.

In spite of the myriad facts and circumstances of any individual case, deposition questioning usually follows a pattern. Initially, questioning begins with education, typically from college forward with additional training, fellowships, training in the specific discipline of a case, and board certification. Following this, you will be asked about your independent recollection of this patient and the care at issue. In most instances, barring something unusual, you will not specifically recall the circumstances or the care rendered to the plaintiff patient. Given a practitioner’s number of patient interactions and the passage of time, this should not be considered a weakness and reliance on your record is appropriate.

Prior to appearing at the deposition, you should know the purpose of your testimony. Is this simply for interpretation of the records, or will you be asked questions supporting a breach of the standard of care by yourself or another practitioner? Beyond this, through discovery information provided by your attorney, you should understand the allegations of negligence and who the involved parties are. You should have an appreciation of where problems may exist and how to respond to questions which involve these potential problems.

It is not your role to provide a narrative justifying your decisions, care, and treatment. It is your obligation to answer only the questions asked. You must resist the compulsion to justify and explain. It should be remembered that the deposition is not the trial. Any favorable information not elicited by the opposition at deposition can still be revealed at trial. If a questioning attorney fails to ask a question which would lead to a critical piece of information at deposition, that opportunity is lost to the advantage of the witness. You will have the opportunity to defend yourself in Court if the case goes to trial. Related to this, witnesses often feel the compulsion to elaborate. Where a reasonable answer to a question is either yes or no, the answer should be either yes or no, without explanation. If the questioning attorney considers an answer to be vague or incomplete, he can ask follow-up questions. Keep in mind that longer answers cause longer depositions, not only through the length of the answers, but through generating additional avenues for the questioner to explore.

The witness should stick to the facts as they recall them or as they are documented in the chart. The deposition should not be a test of your ability to remember specific facts over the course of several years. It is perfectly reasonable for the answer to a question to be, “I don’t know.” or “I don’t recall.” Either of these answers is far preferable to an erroneous answer generated because the witness, at the time of the deposition, feels as though he/she should have all the answers. As a rule: never guess.

While a dental witness should be familiar with the appropriate standard of care, you should resist the temptation to conduct research in this vein. The witness will invariably be asked what

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Earlier this year, MLMIC announced a change to our NYSDA-MLMIC Program enhancing the discounts available to new dental school graduates and new dentists in practice less than 4 years. Recognizing the financial concerns faced by new dentists starting out in private practice, MLMIC made it even more cost effective for new dentists to obtain coverage with the NYSDA-MLMIC Program.

A flat rate premium of $50 for a first year claims made policy, or $172 for an occurrence policy, at limits of $1 Million/$3 Million, is available to qualifying newly graduated dentists entering private practice for the first time immediately following the completion of training.

Other new dentists who do not qualify for the flat rate premium may be eligible for a 75% discount off the standard rates for their first year of either claims made or occurrence coverage.

And, subsequent to the first year, claims made policies are also eligible for the following discounts:

- 60% 2nd year claims made rate
- 25% 3rd year claims made rate
- 10% 4th year claims made rate

These new dentist discounts, together with MLMIC’s personalized service, solid protection against claims, and benefits such as access to a variety of legal services related to the health professions provided by Fager Amsler & Keller, LLP, counsel to MLMIC, make MLMIC a solid choice for dentists just starting out.

To learn more about Claims Made vs. Occurrence coverage, go to www.mlmic.com/dentists/malpractice-coverage/.

Contact our Underwriting Department at one of our regional offices to see if you qualify for the new dentist discount: NYC 1-800-683-7769; Long Island 1-888-263-2729; Syracuse 1-888-744-6729.
The Risk:
The failure to properly handle and document after-hours telephone calls can adversely affect patient care and lead to potential liability exposure for the dentist. Further, should a telephone conversation become an issue in a lawsuit, and it is not documented, the jury is less likely to believe the recollection of the dentist, who receives a large number of calls on a daily basis.

Recommendations:
1. Establish a system to respond to after-hours telephone calls. This system should include a consistent process to help ensure that all after-hours calls are responded to in a reasonable time frame and are documented in the patient’s dental record.
2. Dental record documentation of after-hours calls should include the following:
   a. Patient’s name.
   b. Name of the caller, if different than the patient, and the individual’s relationship to the patient.
   c. Date and time of the call.
   d. Reason or nature of the call, including a description of the patient’s symptoms or complaint.
   e. Dental advice or information that was provided, including any medications that are prescribed.
3. If the patient’s condition warrants the prescription of medications, it is important to inquire about and document any medication allergies, as well as any other medications the patient may be taking.
4. When providing after-hours coverage for another dentist’s practice, a process should be in place to ensure that documented telephone conversations are promptly forwarded to that practice.
5. If you use an answering service, it should be periodically evaluated for courtesy, efficiency, accuracy, and proper recordkeeping.
6. The use of answering machines for after-hours calls is not recommended for the following reasons:
   a. There are no safeguards in the event of an answering machine malfunction.
   b. Patients do not always understand that no one will call back, even if this is stated in the message, due to limited English proficiency, anxiety, or other impediments.
   c. If, as a last resort, an answering machine must be used, the message must be brief and simple: “The office is now closed. Please go to the emergency department if you believe this is a dental emergency.”
documents were reviewed in preparation for testimony. Whatever is revealed must then be made available to all counsel. If a witness reviewed a dental text or journal in preparation for testimony, it will be argued that that document is now an “authoritative source,” to be used to criticize the care and treatment rendered. Along these lines, you should not discuss the facts of the case with anyone other than your attorney and, if at a facility, the risk manager. Discussions which fall outside of recognized privilege also become a useful source to the opposition, through the identification of additional witnesses and the cause for further testimony.

Over the course of the deposition, you may feel that your competence and credibility are being challenged. The real challenge is to stay calm and composed and don’t argue with the questioner. As stated earlier, part of the purpose of a deposition is to establish the credibility of a witness and how appealing the witness will appear to a jury. If you lose composure under questioning, the questioner will certainly take note of your “trigger points” and use them against you at the time of trial. If you misspeak or make an error in your answer, take the opportunity at the deposition to correct the answer. As stated, a permanent record will be made of the testimony to be used at trial. It is difficult to explain to a jury that, “Yes, I did say that under oath at deposition, but that’s not what I meant to say.” Shortly after the deposition and long before trial, you will be provided with a copy of your deposition transcript. At this time, the transcript should be carefully read and, if any errors are noted, they should be discussed with your lawyer so that changes can be properly made.

Finally, don’t talk to anyone but your lawyer about the deposition testimony that you have given. Any conversations you might have about your deposition can become the subject of someone else’s deposition and, as in all instances, information is power. In the deposition setting, give precise answers only to the questions asked. It is highly unlikely that unsolicited tangents, explanations, and digressions will convince the lawyers that you don’t belong there. If asked what time it is, don’t tell the lawyer how to build a clock. ✴