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SHORT FORM ORDER

INDEX No. 09-6524
CAL. No. 11-00460DM

SUPREME COURT - STATE OF NEW YORK
I.A.S. PART 17 - SUFFOLK COUNTY

PRESENT:

Hon. PETER H. MAYER
Justice of the Supreme Court

MOTION DATE 5-31-11
ADJ. DATE 9-8-11
Mot. Seq. # 001 - MD
002 - MotD CASEDISP

TINA and FRANK MUSMACKER,

Plaintiffs,

- against -

JOSEPH R. MORRIS, D.D.S.,

Defendant.

CASTRO & TRODDEN, LLC
Attorney for Plaintiffs
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Smithtown, New York 11787

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New York, New York 10017

Upon the reading and filing of the following papers in this matter: (1) Notice of Motion/Order to Show Cause (001)by the defendant Joseph Morris, DDS, dated May 6, 2011 , and supporting papers 1-17 ; (2) Amended Notice of Cross Motion (002) by the defendant Joseph Morris, DDS, dated May 12, 2011, and supporting papers 18-21; (3) Affirmation in Opposition by the plaintiffs, dated August 9, 2 011, and supporting papers 22-40; (4) Reply Affirmation by the defendant Morris, dated August 19, 2011 , and supporting papers 41-47; (5) Other ___ (~~and after hearing counsels' oral arguments in support of and opposed to the motion~~); and now

UPON DUE DELIBERATION AND CONSIDERATION BY THE COURT of the foregoing papers, the motion is decided as follows: it is

ORDERED that motion (001) by defendant Joseph Morris, DDS, for an order granting partial summary judgment dismissing plaintiff's complaint as to allegations of dental malpractice alleged to have occurred prior to August 18, 2006 on the basis that they are barred by the applicable statute of limitations, and for a further order precluding the plaintiff's expert from offering expert testimony in opposing defendant's motion, has been rendered academic by service of the amended notice of motion (002) and is denied as moot; and it is further

ORDERED that motion (002) by defendant Joseph Morris, DDS for an order granting partial summary judgment dismissing plaintiff's complaint as to dental malpractice alleged to have occurred prior to August 18, 2006 as being barred by the applicable statute to limitations; and dismissing the complaint as to the dental malpractice alleged to have occurred from May 3, 2004 to September 2, 2008, is granted and the complaint is dismissed as to all allegations of dental malpractice alleged to have occurred from May 3, 2004 to September 2, 2008; and it is further

ORDERED that the branch of the motion which sought an order striking the plaintiff's answer or precluding the plaintiff's expert from offering expert testimony in opposing defendant's motion has been rendered academic by dismissal of the complaint and is denied as moot.

This dental malpractice action is premised upon the alleged negligent departures from good and accepted standards of dental practice by the defendant, Joseph Morris, DDS, lack of informed consent, and a derivative claim on behalf of the plaintiff's spouse, Frank Musmacker, relating to the care and treatment rendered to the plaintiff, Tina Musmacker, beginning on or about May 3, 2004 during a continuous course of treatment through on or about September 2, 2008. It is claimed that the defendant negligently and untimely performed dental, treatment, and maintenance, and failed to refer the plaintiff to a prosthodontist, orthodontist, periodontist, oral surgeon, or other dental care provider, delayed in providing treatment, and in permitting dental decay and deformity to develop, which necessitated additional care and treatment and procedures. The plaintiff alleges she was not provided proper informed consent, or advised of the risks and alternatives available regarding her dental care and treatment.

Joseph Morris, DDS seeks summary judgment dismissing the complaint on the bases that the plaintiff failed to follow Dr. Morris' recommendations for routine maintenance to keep her teeth and gums healthy; that she returned for only "patchwork" care when she had a specific problem; that she delayed recommended work due to financial concerns; that she failed to present for routine dental care within the time frame recommended; that she had a propensity for decay due to the medication she was taking; and that any claims for dental malpractice alleged to have occurred prior to August 18, 2006 are barred by the statute of limitations.

The proponent of a summary judgment motion must make a prima facie showing of entitlement to judgment as a matter of law, tendering sufficient evidence to eliminate any material issues of fact from the case. To grant summary judgment it must clearly appear that no material and triable issue of fact is presented (***Friends of Animals v Associated Fur Mfrs.,*** 46 NY2d 1065, 416 NYS2d 790 [1979]; ***Sillman v Twentieth Century-Fox Film Corporation***, 3 NY2d 395, 165 NYS2d 498 [1957]). The movant has the initial burden of proving entitlement to summary judgment (***Winegrad v N.Y.U. Medical Center***, 64 NY2d 851, 487 NYS2d 316 [1985]). Failure to make such a showing requires denial of the motion, regardless of the sufficiency of the opposing papers (***Winegrad v N.Y.U. Medical Center***, *supra*). Once such proof has been offered, the burden then shifts to the opposing party, who, in order to defeat the motion for summary judgment, must proffer evidence in admissible form...and must "show facts sufficient to require a trial of any issue of fact" (CPLR 3212[b]; ***Zuckerman v City of New York***, 49 NY2d 557, 427 NYS2d 595 [1980]). The opposing party must assemble, lay bare and reveal his proof in order to establish that the matters set forth in his pleadings are real and capable of being established (***Castro v Liberty Bus Co.,*** 79 AD2d 1014, 435 NYS2d 340 [2d Dept 1981]).

In support of this motion, the defendant has submitted, inter alia, an attorney's affirmation; copies of the pleadings and plaintiff's bill of particulars and supplemental bill of particulars; the expert affirmation of Ronald Maitland, DMD; the unsigned copies of the transcripts of the examinations before trial of Tina Musmacker and Frank Musmacker dated November 12, 2008; the signed copy of the transcript of the examination before trial of Joseph Morris, DDS dated June 17, 2008; a copy of a report concerning a dental examination of the plaintiff dated November 16, 2010 by Mark Pancotto, DDS;

copies of plaintiff's dental records; and defendants combined demands served upon the plaintiff on April 3, 2009. The unsigned copies of the deposition transcripts are not in admissible form as required by CPLR 3212 (see ***Martinez v 123-16 Liberty Ave. Realty Corp.***, 47 AD3d 901, 850 NYS2d 201 [2d Dept 2008]; ***McDonald v Maus***, 38 AD3d 727, 832 NYS2d 291 [2d Dept 2007]; ***Pina v Flik Intl. Corp.***, 25 AD3d 772, 808 NYS2d 752 [2d Dept 2006]), however, the defendant has demonstrated that a copy of the transcript of Frank Musmacker was sent to counsel for defendant, and such deposition is therefore considered. While the transcript of Tina Musmacker is not accompanied by proof of service upon the plaintiff pursuant to CPLR 3116, the plaintiff has submitted a copy of her transcript with the opposing papers. As such, the testimony contained in her transcript will be considered as adopted as accurate (***Ashif v Won Ok Lee***, 57 AD3d 7000, 868 NYS2d 906 [2d Dept 2008]). The letter by Mark Pancotto, DDS concerning his clinical dental examination of Tina Musmacker on November 3, 2010 is not in admissible form as it is unsworn.

In opposing this motion, the plaintiff has submitted, inter alia, an attorney's affirmation; copies of the pleadings, plaintiff's bill of particulars and supplemental bill of particulars, and various discovery demands; the affirmation of plaintiff's dental expert dated August 9, 2011; a copy of a letter dated February 2, 2011; copies of plaintiff's dental records from Dr. Morris, and the uncertified dental records of Dr. Wolfer and Dr. McLaughlin; a copy of the unsworn report concerning the dental examination of the plaintiff dated November 16, 2010 by Mark Pancotto, DDS; and transcripts of the examinations before trial of Joseph R. Morris, DDS and Tina Musmacker.

The requisite elements of proof in a medical malpractice action are (1) a deviation or departure from accepted practice, and (2) evidence that such departure was a proximate cause of injury or damage (***Holton v Sprain Brook Manor Nursing Home***, 253 AD2d 852, 678 NYS2d 503[2nd Dept 1998], *app denied* 92 NY2d 818, 685 NYS2d 420). To prove a prima facie case of medical malpractice, a plaintiff must establish that defendant's negligence was a substantial factor in producing the alleged injury (*see* ***Derdiarian v Felix Contracting Corp.***, 51 NY2d 308, 434 NYS2d 166 [1980]; ***Prete v Rafla-Demetrious,*** 221 AD2d 674, 638 NYS2d 700 2d Dept 1996]). Except as to matters within the ordinary experience and knowledge of laymen, expert medical opinion is necessary to prove a deviation or departure from accepted standards of medical care and that such departure was a proximate cause of the plaintiff's injury (*see* ***Fiore v Galang***, 64 NY2d 999, 489 NYS2d 47 [1985]; ***Lyons v McCauley,*** 252 AD2d 516, 517, 675 NYS2d 375 [2d Dept 1998], *app denied* 92 NY2d 814, 681 NYS2d 475; ***Bloom v City of New York,*** 202 AD2d 465, 465, 609 NYS2d 45 [2d Dept 1994]).

To rebut a prima facie showing of entitlement to an order granting summary judgment by the defendant, the plaintiff must demonstrate the existence of a triable issue of fact by submitting an expert's affidavit of merit attesting to a deviation or departure from accepted practice, and containing an opinion that the defendant's acts or omissions were a competent-producing cause of the plaintiff's injuries (see ***Lifshitz v Beth Israel Med. Ctr-Kings Highway Div.***, 7 AD3d 759, 776 NYS2d 907 [2d Dept 2004]; ***Domaradzki v Glen Cove OB/GYN Assocs.***, 242 AD2d 282, 660 NYS2d 739 [2d Dept 1997]). "Summary judgment is not appropriate in a medical malpractice action where the parties adduce conflicting medical expert opinions. Such credibility issues can only be resolved by a jury" (***Bengston v Wang,*** 41 AD3d 625, 839 NYS2d 159 [2d Dept 2007]).

Tina Musmacker testified to the extent that Dr. Morris has been her dentist since she was a child. Between 1995 and 1999, she treated with Dr. Schrank who participated in her husband's dental plan. Dr. Schrank performed cleaning and x-rays, as well a some dental work consisting of a root canal procedure. With respect to her treatment with Dr. Morris up until May 2004, Dr. Morris bonded six or eight of her front teeth in 1995 as she was unhappy with the way they looked, and he also took care of root canals, cavities, and crowns. He sent her to an oral surgeon for removal of her wisdom teeth when she was about twenty. From May 2004 through September 2008, Dr. Morris provided dental care and treatment, but she could not recall any specific care other than routine cleaning twice a year and x-rays. She also experienced bleeding from her gums around all her teeth with daily flossing.

Ms. Musmacker did not remember if she made any complaints to Dr. Morris about her teeth from 2004 through 2008, but then testified that she told Dr. Morris that she had pain in her teeth and the back of her mouth, and that Dr. Morris told her that it was her sinuses. She testified that on June 20, 2008, while the hygienist was cleaning her teeth, Dr. Morris came into the room and the hygienist asked him why she had so much decay. She stated that Dr. Morris excused the hygienist from the room, then advised her that they were going to have to work on those teeth. Ms. Musmacker stated that the decay was under the bonding which had been performed approximately twelve years earlier during a 1995 pregnancy. She stated that Dr. Morris had not charged her for the bonding as he was learning how to bond teeth, and she was his guinea pig. She had three bonded teeth of which the crowns fell off periodically, and Dr. Morris glued the crowns back on. Some of the bonding just cracked off the teeth.

Ms. Musmacker testified that in June 2008, Dr. Morris gave her a quote of $6,000 to fix all the bonding. He offered her a position working in his office to help pay for the costs. She left Dr. Morris after that June 20, 2008 appointment, and started treating with Dr. McLaughlin for two visits and a second opinion. She obtained an additional opinion from her current dentist, Dr. Wolfer who placed posts and crowns on all the front teeth that had been bonded by Dr. Morris. She lost a lower tooth, #30, in which two files were found. Dr. Wolfer sent her to Dr. Mancuso to remove the file by surgery, but he was not successful. Another dentist, Dr. Elgort, attempted root canal on the tooth to remove the files, but he was not successful either, so the tooth was extracted, and an implant was inserted by Dr. Ginsberg.

Dr. Morris testified to the extent that he has been licensed to practice dentistry in New York State since 1984, and has provided consulting services and expert testimony for NADENT. He has had a private practice, Joseph R. Morris, DDS, LLC. He stated that he treated Tina Musmacker since about 2001, but was not able to get the prior treating records from her prior dentist. He stated that Ms. Musmacker returned to his care in about 2004. He described his relationship with Ms. Musmacker as a very warm and pleasant professional relationship, and that he knew she had a tough time with her children. Prior to 2001, he did some porcelain veneers on her upper anterior teeth as she had spacing and was very unhappy with her smile. He first discussed orthodontics with her, but she did not choose that option. He stated that they spoke about porcelain veneers which are the gold standard as they are stronger, more aesthetic, and last longer, anywhere from five to ten years, or longer, depending on the care by the patient. The risks can include chipping of the veneers which can be easily replaced or repaired. He continued that in significant cases, where there is extensive decay or reparation, there can be nerve degeneration or nerve death and the tooth can be treated with root canal therapy. Bonding was not an option with Ms. Musmacker, he stated, as she did not like her smile and wanted to improve it. He recalled, however, that she had ongoing dental and periodontal problems. Her history of decay did not

influence his decision to use porcelain veneers. Dr. Morris also testified that prior to 2001, Ms. Musmacker had money problems, so she would come in for some treatment and then disappear for a period of time. Dr. Morris continued that Ms. Musmacker did not complain about the upper anterior teeth, although she complained about a lot of things such as her looks, her weight, her kids, and expressed that she hated her teeth. He stated that was the way she was since he knew her.

Dr. Morris stated that in the first ten years of his career, from 1984 to 1995, he had probably done about a thousand or more veneers. He offered to place veneers on Ms. Musmacker's teeth for free, because, in his opinion, she had a pretty tough time of it. She hated her teeth and he wanted to help her. In return, he took a couple pictures to show other patients under similar circumstances. Prior to the veneers, her teeth were yellow, so she was never happy. She had spaces, some flaring, and some white spots which indicated hypocalcification. On June 28, 2008, her teeth looked good. There was one area of decay on #9, and there was nothing abnormal which could be visually observed with regard to her teeth.

Dr. Morris described in detail the care and treatment provided with reference to the plaintiff's teeth after she returned to his care on May 3, 2004. He stated that he did not know who did the restoration work to teeth # 18 and 19. Dr. Morris stated that there was no treatment plan from May 2005 to February 13, 2007 as there was an ongoing treatment plan from May 14, 2005. If there were problems that arose, he would normally take care of the problem the same day. Dr. Morris continued that on December 22, 2006, decay with nerve exposure was noted on tooth # 18 when he was performing a root canal procedure. He took measurements and a root canal file separated in the root, which he stated meant that it had broken. He informed Ms. Musmacker. He could not remove the file despite attempts to do so. He offered her referral to a surgeon for an apicoectomy and to evaluate the treatment from there. The other option was to complete the root canal to see if the canal could be navigated and the file removed. The final option was to leave it, seal it, and continue to re-evaluate it. He discussed the risks, benefits and alternatives concerning the file, then sealed the distal and mesial buckle with gutta percha, and planned to navigate the mesial lingual canal on the next visit. He considered how close the file was to the apex of the tooth and indicated that if the file is close to the tip of the root, it can seal the root canal. If the file separates at the end of the cleaning process, which is the most important aspect, the file could be left behind. So he sealed it, and he was not aware that she suffered any complications. A risk of leaving the file in place would be a recurrent infection.

Dr. Morris continued that the June 20, 2008 x-rays revealed deterioration in certain areas and stated that generally, there can be degeneration when patients have issues based upon diet and medications which can cause dry mouth. Dr. Morris stated that gastric bypass surgery, allergy and anti-depression medication are all definitive for dry mouth. The medications were noted on the dental history registration form dated May 3, 2004. At that time he advised her that she needed to take proper care of her teeth with treatment on a regular basis, and that she had to maintain proper oral hygiene, and be careful about her diet. Periodontal screening exams were performed by the hygienist in his office, and he reviewed the findings. He indicated she had mild periodontal disease for which a four month re-care would be initiated, but that Ms. Musmacker had difficulties with that due to financial and family concerns.

Dr. Morris testified that he did not fill any of the plaintiff's teeth from when he first started seeing her in May, 2004 until June, 2008 at her last visit. He opined that when there is porcelain veneer on the surface of the tooth and decay behind, there is too much risk of the possibility of breaking the porcelain veneer, and that it is better to totally eradicate the decay. He continued that, at that point, it is necessary to place a crown versus another veneer because there is too much tooth structure taken away. Placement of crowns would be the treatment of choice. He stated that recurrent decay means that there is an existing restoration and the decay is underneath the existing restoration, whether that restoration is a crown or a filling.

The defendant's expert, Ronald Maitland, DMD, affirms that he is a dentist licensed to practice medicine in New York State. He is a Fellow of the American College of Dentists and International College of Dentists. He indicated the records and materials reviewed, and upon which he based his opinions, and set forth his opinions with a reasonable degree of medical certainty. Dr. Maitland opines that Dr. Morris' care and treatment of the plaintiff was consistent with the standard of care and that no intervention or lack of intervention by Dr. Morris was a proximate cause of the plaintiff's claimed injuries concerning teeth #'s 2, 4, 5, 6, 7, 8, 9, 10, 11, 18, and 30, and that Dr. Morris never made any diagnosis for, or rendered any treatment to, #11.

Dr. Maitland opines that the plaintiff did not follow Dr. Morris' recommendation for routine maintenance to keep her teeth and gums healthy, frequently went to Dr. Morris for "patchwork" when she had a specific problem, and delayed recommended work due to financial concerns. Dr. Maitland also opines that the plaintiff reported that she smoked cigarettes and took anti-depressant medication, Zoloft. He continued that smoking is an irritant which can create periodontal problems wherein the gums swell creating more areas for food to collect. Zoloft can cause decreased saliva, which is a risk factor for decay.

Dr. Maitland affirmed that the plaintiff testified that she always carried a balance for work performed by Dr. Morris and had "trepidation" in telling her husband about the costs associated with her dental care. Her financial concerns delayed the performance of a full mouth series of x-rays until insurance paid for it in June 2008. This was a significant factor that led to her dental problems, along with the failure to present for routine dental care on a prescribed time frame to keep her teeth and gums healthy, and to undergo dental work when it was recommended. He states that the standard of care requires a full mouth series of x-rays every three to five years. Insurance will pay for a full mouth series every three years. He agrees with Dr. Morris that a full mouth series should be offered to the patient whether or not insurance will pay for it, but it is the patient's decision whether or not to undergo a full mouth series when insurance will not pay for it.

Dr. Maitland states that in June 2008, when Dr. Morris was able to obtain full mouth series x-rays when insurance paid for it, he appropriately advised the plaintiff of the needed dental work which carried a price tag that concerned the plaintiff. The plaintiff and her husband decided to get second and third opinions, then underwent treatment with Dr. Wolfer, who gave the most expensive estimate, and then commenced this action against Dr. Morris seeking reimbursement of the dental fees for which treatment was needed, regardless of who performed the treatment.

Dr. Maitland stated that although it is alleged that Dr. Morris re-cemented several pre-existing crowns which fell out one of more times, there is no claim that Dr. Morris made these crowns. He continued that he agreed with Dr. Morris' plan to re-cement the crowns and advice to the plaintiff of the option to make new crowns, and that if an infection were present, to perform an extraction, refer to an oral surgeon for an apicoectomy, or to perform root canal surgery, and if root canal surgery had already been performed, further root canal therapy to remove the infection. With the risk of recurrent infection, the dentist must impress on the patient that further treatment is warranted, but it is ultimately the patient's decision whether or not to go forward with treatment or to just re-cement the existing crown.

Dr. Maitland states that plaintiff's upper front teeth, #'s 6-10, had veneers applied in the 1990's to improve her smile. He opines that veneers will last five to ten years, depending on the care of the patient. Risks associated with porcelain veneers are chipping, extensive decay, and potential nerve death that is treated with root canal therapy. Because of the amount of tooth that is removed in preparation for the veneer, if decay develops, it is necessary to remove the veneer and make a crown to provide proper support for the tooth.

Dr. Maitland set forth the dates of treatment for specific teeth and the treatment provided and specific findings. His review reveals that Dr. Morris never made any diagnosis of, or rendered any treatment to tooth # 11. The treatment rendered to teeth #'s 3, 12, 15, 19, 29, and 30, prior to August 18, 2006, represents distinct, isolated treatment that was completed prior to August 18, 2006. After August 18, 2006, Dr. Morris rendered treatment as follows: re-cemented the pre-existing crown on #30; excavated a cavity and made a crown for # 29, performed a root canal and made a crown for #18; re-cemented pre-existing crowns on #'s 4 and 5; took a full mouth series x-ray on June 20, 2008 which revealed decay at # 2; possible decay at # 5; and recurrent decay at #'s 6-10 and 18, 19, and 20.

Dr. Maitland states that a review of Dr. Wolfer's record reveals that he provided treatment consisting of # 2 - filing; # 5 - re-cementing crown, root canal therapy, core and post, gingivectomy and crown, and lengthening crown; # 6 - filing, crown; # 7 - root canal therapy, post and core, crown; # 8 - filing, crown; # 9 - root canal therapy, post and core, crown; # 10 - crown; # 11 - filing, gingivectomy, crown; # 18- gingivectony, crown; and # 19 - crown lengthening and crown. Dr. Maitland continued that tooth # 30 had to be extracted because it contained a broken root canal file that could not be removed and that the tooth had a recurrent infection, however, there is no claim that Dr. Morris performed root canal therapy on that tooth that led to the broken file, and, thus, he is not responsible for the broken file or the need to extract the tooth and insert an implant.

Dr. Maitland continues that although the plaintiff alleges that there were short clinical crowns on teeth #'s 2, 5, 7, 9, 20, 11, 28, 19, and 30, Dr. Morris did not make the pre-existing crowns for teeth #'s 2, 5, 6, 7, 8, 9, 10, 11, and 30; he only made the crowns for #18 and #19, which crowns never fell out. Teeth #'s 5, 6, 7, 8, 9, and 10 had veneers which developed decay, and that it is necessary and appropriate when decay develops under the veneer, to replace the veneer with a crown to support the remaining tooth structure. The crown made by Dr. Morris for tooth #18 was made in accordance with accepted standards of care and was well-fitting. He continues that the crown for tooth #19 is beyond the statute of limitations. Dr. Maitland continues that the marginal tooth decay at teeth #'s 2, 4, 5, 6, 7, 8, 9, 10, 11, 18 and 19 was caused by the medication that the plaintiff was taking, her smoking, and her failure to return for routine maintenance as directed. Teeth were not missing at #'s 5, 6, 7, 8, 9, 10, 11 and 30,

but had pre-existing restorations. Dr. Maitland opines that his review revealed no splaying, mobility or instability of the teeth. He continues that the dental treatment secured by the plaintiff from Dr. Wolfer was necessary to maintain the plaintiff's dentition regardless of who performed the work, and, thus, Dr. Morris is not responsible for her pain and suffering. Likewise, the plaintiff's diet and speech alteration and protracted poor appearance necessitated treatment to maintain the plaintiff's dentition regardless of who performed the work. He concludes that there is no evidence that future surgical intervention will be required.

Based upon the foregoing, it is determined that the defendant has established prima facie entitlement to summary judgment dismissing the complaint on the bases that the defendant did not negligently depart from good and accepted standards of dental care and treatment, that he did not proximately cause the injuries alleged by the plaintiffs, and that he gave informed consent to the plaintiff about the care and treatment needed, and options available.

The plaintiff's expert affirms that he is licensed to practice dentistry in New York State and sets forth the records and materials which he reviewed in support of his affirmation. He set forth his opinion with a reasonable degree of medical and dental certainty that there were departures from the accepted medical care, that these departures were a substantial contributing cause of the plaintiff's injuries, and that the defendant failed to provide the plaintiff with informed consent. The plaintiff's expert states that Ms. Musmacker met with Dr. Morris beginning on May 3, 2004 and continued through September 2, 2008, during which time Dr. Morris obtained x-rays on the dates set forth and also made visual observations of the plaintiff's teeth.

The plaintiff's expert opines that during the 27 visits that the plaintiff made to Dr. Morris, that he should have observed the decay forming at teeth #'s 5, 6,7, 8, 9, 10 11, 18, and 19, on at least November 17, 2007, and that the failure to diagnose and treat this decay caused delays which resulted in further decay and crowns at those teeth. The plaintiff's expert does not support his conclusory opinion that there was decay present for four years, and does not present the dates that the decay was present, or how much it increased, as documented by x-rays or other admissible proof. Further, the plaintiff's expert does not opine that the plaintiff would not have needed crowns on these teeth based upon the life expectancy of the veneers. It is noted in Dr. Wolfer's records, referred to by the plaintiff's expert, that it is stated at the entry dated September 23, 2008, that "pt may want 6-11 PVC instead of veneers." Thus the plaintiff's expert has not demonstrated that the crowns from #'s 6-11 were caused by the alleged departures by the defendant as opposed to a choice in treatment options by the plaintiff. The plaintiff's expert does not indicate the basis for the opinion that decay should have been observed on at least November 17, 2007. While he states that radiographically, teeth #'s 5, 10, 13, 18 and 19 reveal open margins and recurrent decay, he does not state the date of the x-rays, and the location of the margins and recurrent decay.

The plaintiff's expert further opines that treatment options should have been discussed with the plaintiff well before June 20, 2008, however, he does not set forth those risks, alternatives, or benefits, the date or time frame she should have been advised of the same, and whether the treatment would have been any different from the treatment ultimately obtained from Dr. Wolfer. Additionally, the plaintiff's expert states that the decay was visible on teeth #'s 10, 18, 19, 30, and that the defendant failed to diagnose and treat the decay, however, he does not set forth the basis for such conclusory opinion in that he does not indicate how he determined that the decay was visible or when it was visible.

The plaintiff's expert continues that Dr. Morris opted for a crown on tooth # 19, and root canal, post and crowns on #'s 13, 14, 15, and 18. The plaintiff's expert states that Dr. Morris failed to provide proper informed consent to the plaintiff, however, he fails to state what should have been discussed with her except that she had decay. The plaintiff's expert does not establish when the decay was diagnosable, except for an unsupported and conclusory opinion. The risks and options of which the plaintiff's expert opines the plaintiff should have been advised are not set forth by him. Additionally, the plaintiff's expert does not opine what appropriate treatment should have been initiated instead, or that the treatment would have been any different, or that it was a departure to re-cement crowns. The plaintiff's expert states that the crown made by Dr. Morris for # 18 was a short clinical crown which caused the plaintiff's injury, however, he does not give a basis for this conclusory opinion and does not set forth measurements or other evidentiary proof in support of this opinion.

The plaintiff's expert states that there was a file left behind in tooth #30, but he does not indicate when the root canal was performed on tooth #30, although he states that Dr. Morris failed to diagnose the file until 2006. However, the plaintiff's expert does not state how he determined that a file was in tooth #30. He does not state that Dr. Morris performed the root canal on that tooth, or when it was performed, or that the plaintiff would not have had to have that tooth extracted whether or not it was diagnosed. The plaintiff's expert does not indicate the date of the x-ray which revealed the file in tooth # 30 while the plaintiff was under Dr. Morris' care and treatment. The plaintiff's expert states that an apicoectomy may have saved this tooth had it been performed. However, on September 23, 2008, the subsequent treating dentist, Dr. Wolfer, indicated that the treatment plan is to redo the root canal therapy on tooth # 30. On July 15, 2009, nearly a year later, Dr. Wolfer's notes indicated that such treatment was started, and that there may be a need for a possible apico after the fill. On what appears to be a note dated July 21, 2009, with reference to tooth # 30, Dr. Wolfer notes that "endodontist could not remove broken files from previous dentist." Thus, even with treatment proposed by the plaintiff's expert, the tooth needed to be extracted. The plaintiff's expert states that the negligent treatment by Dr. Morris contributed to tooth failure, but he does not indicate how it contributed or that it was the proximate cause of the tooth having to be extracted. The plaintiff's expert further opines that the defendant failed to provide mobility analysis in his chart which would have helped to diagnose and treat #'s 30 and 18 due to the periapical areas that were evident from the poor root canal fill and the broken file. However, he does not indicate that Dr. Wolfer made findings with regard to mobility as to teeth #30 and 18 to demonstrate that there was mobility.

The plaintiff's expert opines in a conclusory manner that Dr. Morris further failed to document a proper treatment plan, and failed to document that he discussed the risks, benefits and alternatives to all of his treatment. However, the plaintiff's expert does not set forth what the proper treatment plan should have been at the various visits, what risks, benefits and alternatives to the treatment should have been provided, and how this lack of documentation proximately caused the plaintiff's alleged injuries. The plaintiff's expert states that the defendant never did a single filling on the plaintiff during the 52 months he treated her, and generally opines that this was a departure from the standard of care. However, the plaintiff's expert does state which teeth should have had fillings and when such fillings should have been placed in the plaintiff's teeth to support his conclusion. The plaintiff's expert continues that restorations at teeth #'s 5 and 13 did fall out, however, he does not indicate when they fell out, or by whom they were placed, or how they were treated. He further indicated that restorations at #'s 18 and 19 were removed

due to decay under the ill-fitting crowns, but he does not indicate when the restorations were removed and when the decay was diagnosed in those teeth.

The plaintiff's expert states that while medications and sporadic returns for routine maintenance may contribute to decay, they do not excuse the defendant's negligence as Dr. Morris failed to have periodontal charting documenting the plaintiff's periodontal condition, however, he does not indicate at which teeth the plaintiff had periodontal disease which needed treatment, and whether the subsequent treating physician referred the plaintiff to a periodontist for treatment, other than the perioprophy provided by Dr. Wolfer. It is further noted that plaintiff's expert relied on the examination of Mark Pinched, DDS in his review, which letter of November 16, 2010 is not sworn to and is not in admissible form. However, upon periodontal clinical examination, nearly two and a half years after the plaintiff completed treatment with Dr. Morris, Dr. Pinched found that the probing depths were mostly within normal limits with the exception of inflammation around the crowns on teeth #'s 3, 18, and 19; and radiographic periodontal examination reveals good bone levels in all areas with tooth #9 showing a slight mobility problem. The plaintiff's expert does not opine that the alleged improper charting of the periodontal condition proximately caused the injuries which the plaintiff claims to have sustained.

Based upon the foregoing, although the plaintiffs have established departures from the accepted standard of medical and dental care based upon the defendant's failure to properly chart and document all of the care and treatment provided to the plaintiff, the plaintiffs have failed to establish that the alleged departures by the defendant proximately caused the injuries claimed by Tina Musmacker. The plaintiff's expert has not demonstrated that she would not have needed the care and treatment recommended by the defendant on June 20, 2008, and ultimately provided by Dr. Wolfe from September 16, 2008 through May 10, 2010, but for the negligence of the defendant relative to the established departures. With regard to the other departures from accepted standards of dental practice as set forth by plaintiff's expert, it is determined that those alleged departures were based upon unsupported and conclusory opinions and speculation, as addressed above, and thus did not raise factual issues to preclude summary judgment.

Accordingly, motion (002) is granted and the complaint of this action is dismissed.

Dated: 2/6/12

Peter H. Mayer
PETER H. MAYER, J.S.C.