

**Miccio v Gerdis**

2013 NY Slip Op 30506(U)

March 6, 2013

Supreme Court, Suffolk County

Docket Number: 10-36727

Judge: Hector D. LaSalle

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SUPREME COURT - STATE OF NEW YORK  
I.A.S. PART 48 - SUFFOLK COUNTY

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**P R E S E N T :**

Hon. HECTOR D. LaSALLE  
Justice of the Supreme Court

MOTION DATE 12-20-12  
ADJ. DATE 2-5-13  
Mot. Seq. # 002 - MD

-----X

LAURA MICCIO and BRYAN MICCIO,  
  
Plaintiffs,  
  
- against -  
  
ELLIOT GERDIS, D.D.S. and ELLIOT  
GERDIS, D.D.S., P.C.,  
  
Defendants.

-----X

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Upon the following papers numbered 1 to 22 read on this motion for summary judgment; Notice of Motion/ Order to Show Cause and supporting papers (002)1 - 14; Notice of Cross Motion and supporting papers   ; Answering Affidavits and supporting papers 15-20; Replying Affidavits and supporting papers 21-22; Other   ; (~~and after hearing counsel in support and opposed to the motion~~) it is,

**ORDERED** that motion (002) by the defendants, Elliot Gerdis, D.D.S. and Elliot Gerdis, D.D.S., P.C., pursuant to CPLR 3211 (a) (5) and/or CPLR 3212, for summary judgment dismissing the complaint as to any claims for dental malpractice arising on or before April 1, 2008 and for further order dismissing any claims asserted against them based upon lack of informed consent for any dental treatment on or before April 1, 2008, is denied.

In this dental malpractice action, the plaintiff, Laura Miccio, alleges that the defendants, Elliot Gerdis, D.D.S. and Elliot Gerdis, D.D.S., P.C., departed from good and accepted standards of dental practice in the care and treatment rendered to her. The plaintiff further contends that the defendants failed to provide her with informed consent. A derivative claim is asserted on behalf of plaintiff's spouse, Bryan Miccio. The plaintiff alleges that the defendant provided dental care and treatment to her from 2002, up to and including May 28, 2008. She alleges that the defendants failed to diagnose and treat her condition of loose teeth on the lower side of her mouth. Thus, they failed to diagnose a benign neoplasm, allowed tooth # 22 to be loose without bone support for many years, allowed teeth 21, 23 and 24, to be without bone support for a protracted period of time, depriving the plaintiff of a substantial chance of cure, and they otherwise failed to provide her with informed consent and disclosure of the alternatives to treatment with the associated risks and benefits. As a result of the alleged departures, the plaintiff alleges that she was required

(RR)

to undergo surgery for removal of the tumor and two teeth on May 10, 2010, with subsequent follow-up procedures.

CPLR 3211 (a)(5) provides that a party may move for judgment dismissing one or more causes of action asserted against him on the ground that “the cause of action may not be maintained because of ... statute of limitations...” In this post-note of issue motion, the defendant has clearly charted a course of action for summary judgment, and the notice of motion clearly apprise the plaintiff that the defendants seek summary judgment as set forth therein. Accordingly, this motion is decided pursuant to CPLR 3212.

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]).

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 [2d 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 injuries of the plaintiff (*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]).

CPLR 214-a provides in applicable part that the statute of limitations in a dental malpractice action is two years and six months of the act or omission or failure complained of, or last treatment where there is continuous treatment for the same injury or illness or condition which gave rise to said act or omission or failure. While the plaintiff has not set forth a specific date for the commencement of her treatment with the defendants in either the complaint or the bill of particulars, such date is determined from the records and testimony of the various deponents.

Laura Miccio testified to the extent that she first went to Dr. Gerdis’ office in the spring of 2003, and last saw Dr. Gerdis in the spring of 2008. One year prior to the spring of 2003, she had been under the care of dentists at American Dental Center for three years. She presented with a history of a heart murmur, which required pre-medication with an antibiotic before any treatment. She was also missing some of her lower front teeth as she was “born this way.” In 2007, she learned that she no longer needed pre-medication prior to dental appointments. She presented to Dr. Gerdis twice a year for cleanings. She also had an x-ray and two cavities filled, but she could not remember which part of her mouth that involved. When Dr. Gerdis examined her teeth, he told her that she had beautiful teeth when she asked him why her bottom tooth on the left side was loose and why her gum was receding. She never offered any complaints to Carmella, the hygienist, when she went for cleanings. She first noticed the receding gum in 2004 around the front and back of the “eye tooth and the tooth next to it towards the front of the eye tooth.” The tooth in front of the eye tooth was loosening, followed by loosening of the eye tooth. She testified that she did not notice if the gum recession changed through her last visit with Dr. Gerdis in 2008, but then stated that she noticed the gum line getting lower during that period of time. She then testified that she did not tell anyone at Dr. Gerdis’ office, except for Dr. Gerdis, whom she told once a year that she had the receding gum and loosening teeth.

Ms. Miccio stated that she switched from Dr. Gerdis to Dr. Steiger for her dental care, as she no longer worked in Melville. She was referred by Dr. Steiger to Dr. Drew, an oral surgeon. Ms. Miccio testified that she first saw Dr. Steiger on April 13, 2009, approximately 11 months after her last visit with Dr. Gerdis, and during that time, her teeth did not become more mobile or loose and there was no additional gum recession. She filled out a patient history form for Dr. Steiger, and entered “no” to the questions concerning whether she had swollen or tender gums, or loose teeth or broken fillings, or sensitivity biting.

Dr. Gerdis testified that he had a private practice for dentistry which he sold to Dr. Bram on June 3, 2008, and continued to work part-time, two days a week, for about two months, and stopped working completely in August 2008. He stated that he had no independent recollection of Laura Miccio. He continued that if a patient presented with complaints of lowering gum line or loose teeth, he would note the same in the patient’s chart, take further x-rays, do further examination, and make a possible referral to, most likely, a periodontist. He would also compare those new x-rays to previous x-rays. If he found something unusual on the x-rays, he would chart it on the patient’s record. During his years of practice, he saw two cases of benign neoplasm, one on the tongue and one on the cheek, presenting with unusual mucosal findings, atypical in color and swelling. Such condition would be diagnosed with a biopsy. If there were a benign neoplasm, its x-ray presentation would possibly be a dark, radiolucent area.

Dr. Gerdis testified that the full sets of x-rays from February 6, 2003, February 4, 2004, April 19, 2005, September 26, 2006, and May 5, 2008 are missing from his records. He was shown four bite-wing x-rays and two periapical x-rays dated May 5, 2008, which had been given to the plaintiff by his office manager. Dr. Gerdis described a periapical x-ray as one that shows the entire tooth on an x-ray and is typically taken of the upper and lower anterior in the front. A bite wing is one that shows just the coronal portion of a tooth and is typically taken of the upper and lower right and left posterior teeth. A full mouth series involves taking periapical films around every tooth and four bite wings. When questioned, Dr. Gerdis testified that from 2003 to 2008, if he took a periapical x-ray of the front portion of the front teeth that the alveolus, the bony structure of the jaw bone, would typically show on the x-ray as a dark area. The anterior mandible would have also been shown, and if there was bone loss, it would have shown up as dark areas on the x-ray. Lowering gumline could be measured, and if such measurement were taken and was normal, the measurement would not be entered into the patient's chart.

Dr. Gerdis testified that Laura Miccio was first seen on January 30, 2003, at which time full mouth x-rays were taken, and she was given a prescription for pre-medication to be taken prior to her next appointment due to a heart murmur. He stated that he saw the plaintiff on February 6, 2003 and noted that she was sensitive to grinding on the lower right side. Upon examination, he noted no abnormal findings. On the left side, there had been a root canal at tooth #4 and a crown had been placed. His diagram showed missing teeth in the lower left front. Periodontal charting was done, light interproximal plaque was noted, flossing was stressed, and she was advised to return in six months. He reviewed the x-rays on February 10, 2003 and stated that there were no abnormalities found. He consulted with the plaintiff on March 7, 2003 regarding the x-rays.

Appointments for February 20, 2003, and October, 2003, were cancelled by the plaintiff. She was seen again on August 14, 2003 and February 17, 2004 for prophylaxis and examination by the hygienist, but not by Dr. Gerdis. She was recalled on August 10, 2004 at which time she saw Dr. Gerdis who indicated that bite wing and periapical x-rays were taken. At the October 5, 2004 appointment, the plaintiff underwent a tooth # 5 (upper right first premolar) distal occlusion for which she received a silver filling, a two-sided restoration due to decay. No x-rays were taken on that date. She had a recall on April 19, 2005, at which time x-rays consisting of four bite wings and two periapicals were taken. She was given instruction to use Rota Points for cleaning her teeth instead of a toothpick. When told that his office billing record indicates that an additional periapical was taken that day, Dr. Gerdis testified that he did not know why an additional periapical would have been necessary or why it would not have been documented in the chart. Dr. Gerdis further testified, when shown the periodontal charting, that it was filled out by someone other than him, and that there were entries made beyond the initial exam date of February 6, 2003. It is noted, however, that the entry of October 5, 2004 on the chart indicated that there was slight bleeding of the upper right #4 crown, second premolar, not in the area which is the subject of this action. On October 11, 2005, the plaintiff had prophylaxis and was seen by Dr. Gerdis. There were no issues or problems presented, and the note was not in his handwriting.

Dr. Gerdis testified that if there were any problems with receding gumline or loose teeth, that the same would have been entered by him in the plaintiff's chart. A note after October 11, 2005 indicated that the plaintiff was apparently pregnant and due on February 28, 2006. The plaintiff was seen thereafter on April 18, 2006 for prophylaxis. No x-rays were taken. On September 26, 2006, the plaintiff was examined

and prophylaxis was given. Four bite wings plus two periapicals were taken which revealed nothing abnormal. On October 3, 2006, there was mesial occlusal distal at # 19, the lower left first molar. On October 9, 2006, the high spot at #19 was polished. On June 8, 2007, Dr. Gerdis was notified that the plaintiff no longer required pre-medication for dental work. Prophylaxis was given and one bite wing was taken, however, Dr. Gerdis did not know why one bite wing was taken. He did not recognize the handwriting on that note which was not entered by him. He stated either he or his hygienist would have ordered the x-ray, and did not know if it was taken in response to a complaint. Eleven months later, the plaintiff was seen on May 5, 2008, at which time four bite wings and two periapicals were taken, and prophylaxis was given. She was seen again on May 23, 2008, at which time distal occlusal of tooth #30, the far side and topside of the right lower first molar, was treated with a filling. On May 27, 2008, #30 was polished.

It is noted that the office record dated February 6, 2003 indicates that the upper teeth #1 and #16, and the lower anterior teeth #17, 18, and 19 are missing from the plaintiff's mouth.

Dr. Faina Bram, D.D.S. testified that she took over Dr. Gerdis' practice in June 2008, which included taking over the records of his patients, his patients, as well as having her own patients. She testified that when the plaintiff came into the office in 2008, the secretary, Carol Fisher, was present and gave the films to the plaintiff without telling her or Dr. Gerdis. Dr. Bram testified that she never treated the plaintiff. The only other person in the office who would have provided treatment besides Dr. Gerdis was Carmella, the hygienist. The last date of plaintiff's treatment with Dr. Gerdis was May 27, 2008.

Carol Fisher testified to the extent that she worked as office manager for Dr. Gerdis since January 1991. She stated that the plaintiff came into the office and told her that she was going to a specialist and needed her x-rays that were on file. She believed she gave the plaintiff a copy of whatever records were available.

Carmella Sansanelli testified to the effect that she has been a registered dental hygienist since June 1964. She worked full-time for Dr. Gerdis from 1991 until 2008 when the practice was sold. She testified that upon presentation of a new patient to the office, a full series of eighteen x-rays would be taken by her or the assistant. A thorough history is obtained, and a cleaning (prophy-prophylaxis) is done at the initial visit. She would also do an examination and look for anything abnormal. Scaling, and peridontal probing to take measurements is also done to measure the depth of a pocket that the patient may or may not have. She also looks for mobility or movement of any teeth, and any bleeding or pus. Missing teeth, or teeth which need restoration are recorded. Full mouth series of x-rays are taken every three to five years, depending upon the need. Then, if not every year, seven films consisting of four wing bites and two anteriors, are taken as follow-ups to compare and contrast with the full mouth series already in the file.

Ms. Sansanelli testified that if a particular complaint about a tooth were made, that tooth would be x-rayed. If a patient complained of a loose tooth, an x-ray would be done. If there was a complaint about a receding gumline, the patient would be examined, the home care would be reviewed to try to get the soft tissue to grow back, and re-evaluation in four to six weeks would be done. If necessary, a periodontal referral would be made. If mobility is an issue, a referral is made to a specialist as well. These referrals and findings would be noted in the record. Ms. Sansanelli also testified that the front desk fills out the insurance

forms. She also testified that she did not remember Ms. Miccio, but vaguely remembered mobility and that she came in more often. Apart from the patient's record, Ms. Sansanelli testified that she also kept an index card for each patient, but did not testify what information, if any, was contained on a card for the plaintiff, or if any card were maintained for the plaintiff. Such index cards have not been provided to this court.

Based upon the foregoing, it is determined that there are factual issues which preclude summary judgment from being granted on the issue of continuous treatment. While Dr. Gerdis testified, and his office records demonstrate that the plaintiff did not complain of mobility of any teeth, particularly tooth # 21 or any lower anterior teeth, or of a receding gumline, the plaintiff testified that she told Dr. Gerdis once a year, and no one else in the office, that she was experiencing mobility of tooth # 21 along with a receding gumline in that area. The plaintiff testified that she first noticed the receding gum in 2004 around the front and back of the "eye tooth and the tooth next to it towards the front of the eye tooth," and that the tooth in front of the eye tooth was loosening, followed by loosening of the eye tooth. Due to the conflicting testimonies, there are factual issues concerning the plaintiff's condition which is the subject of this action, whether or not Dr. Gerdis was apprised of the complaints relative to the lower anterior teeth and gum, the date of presentation of such symptoms, whether informed consent was properly given, thus precluding summary judgment. It is additionally noted that there was no testimony or affirmation submitted establishing the findings on the x-rays, particularly those of May 5, 2008, which had been given to the plaintiff by Dr. Gerdis' office manager. There are factual issues concerning whether or not the tumor was present on those films, its size and location, and whether or not the plaintiff's symptoms were consistent with such tumor, further precluding summary judgment.

The plaintiff's chart does not reveal any particular treatment or complaints concerning teeth 21, 22, and 23 or a receding gumline. Carmella Sansanelli further testified that while she did not remember the plaintiff, she had a vague recollection of mobility concerns. Sansanelli maintained index cards upon which she entered the complaints and problems and follow-up plan for the patients she provided care to, but those cards have not been submitted to demonstrate whether or not the plaintiff complained to her of the loose tooth and receding gumline. Thus, without a complete record, there are factual issues which preclude summary judgment.

Plaintiff's expert, Dr. Wu, set forth that Sansanelli treated the plaintiff as periodontically compromised from April 19, 2005 based upon her suggesting the use of Rota Points, which Sansanelli testified were used to prevent or to treat periodontic disease. Additionally, the area in plaintiff's mouth for which Sansanelli allegedly recommended the plaintiff use the Rota Points on has not been identified, raising further factual issue concerning whether plaintiff's entire mouth, or just a section, was to be addressed with the use of the Rota Points. Dr. Wu does not identify the area either. While Dr. Wu opined that despite Ms. Miccio's worsening clinical findings and radiographic changes, Dr. Gerdis did not refer the plaintiff to a specialist, Dr. Wu does not indicate what x-ray films and radiographic changes she is referring to, the date of such changes, and what clinical findings were noted, thus rendering her opinion conclusory and unsupported.

All of the foregoing factual issues are to be determined by the trier of fact and preclude summary judgment dismissing the complaint for dental malpractice allegedly arising on or before April 1, 2008. Consequently, in that it has not been demonstrated prima facie that the plaintiff did have mobility of tooth

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#21 and a receding gumline while under Dr. Gerdis' care and treatment, any issue determining whether or not there was informed consent cannot be determined either as to any dental treatment on or before April 1, 2008. Additionally, no expert testimony has been submitted opining as to when the plaintiff's benign neoplasm first presented, and whether or not it was demonstrated on the x-rays of May 5, 2008, raising further factual issue concerning the statute of limitations, the onset of the condition complained of, and the applicability of the continuous treatment doctrine. Further factual issues exist concerning the delay in diagnosing the plaintiff's condition from plaintiff's last date of treatment with Dr. Gerdis on May 27, 2008, and the diagnosis of the tumor. Ms. Miccio testified that the biopsy was not done until March 26, 2010 and revealed a benign squamous odontogenic tumor.

Accordingly, motion (002) by the defendants for, inter alia, summary judgment dismissing the complaint is denied.

The foregoing constitutes the Order of this Court.

**Dated: March 6, 2013**  
**Riverhead, NY**

  
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**HON. HECTOR D. LASALLE, J.S.C.**

\_\_\_\_\_ FINAL DISPOSITION      X   NON-FINAL DISPOSITION