Boyd v NYU Coll. of Dentistry
2022 NY Slip Op 33654(U)
October 24, 2022
Supreme Court, New York County
Docket Number: Index No. 805213/2019
Judge: Judith N. McMahon

SUPREME COURT OF THE STATE OF NEW YORK
NEW YORK COUNTY

PRESENT: **HON. JUDITH MCMAHON** **PART** **30M**

Justice

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THOMAS BOYD, ORALEE WACHTER,

Plaintiff,

- v -

NYU COLLEGE OF DENTISTRY, BRUCE BRANDOLIN, STEVEN FISHER

Defendant.

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INDEX NO.	805213/2019
MOTION DATE	10/19/2022
MOTION SEQ. NO.	001

DECISION + ORDER ON MOTION

The following e-filed documents, listed by NYSCEF document number (Motion 001) 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57

were read on this motion to/for JUDGMENT - SUMMARY.

Upon the foregoing documents, it is ordered that the motion for summary judgment of defendants NYU College of Dentistry (hereinafter "NYUCD"), Bruce Brandolin, D.D.S. and Steven Fisher, D.D.S. is granted to the extent that the complaint is severed and dismissed as against defendant Drs. Bandolin and Fisher, as is plaintiffs' second cause of action for lack of informed consent.[1] The balance of the motion is denied.

This matter arises out of alleged dental malpractice which occurred while plaintiff, Thomas Boyd, was a patient of NYUCD between April 17, 2017 and March 8, 2018. Mr. Boyd claims that the NYU defendants departed from the applicable standard of care by failing to consider plaintiff's medical (cardiological) history (*i.e.*, atrial fibrillation, valvular disease, abnormal EKG, and steroid medication therapy) and in that regard, by failing to prescribe

[1] Plaintiffs have withdrawn their claims of dental malpractice against the individual defendants, together with all claims arising from defendants' failure to consider plaintiff Thomas Boyd's prior spinal fusion surgery as part of his medical history (*see* NYSCEF Doc. No. 52, para 1.

prophylactic antibiotics prior to rendering treatment, which increased plaintiff's risk for developing endocarditis. Plaintiff was ultimately diagnosed with infectious endocarditis that he alleges seeded in his bloodstream[2] in conjunction with gingival manipulation performed on March 8, 2018. It must be noted that none of plaintiff's experts refer to any sequalae suffered by plaintiff as a result of endocarditis. As such, the damages in this case are limited to infectious endocarditis and its treatment.

Plaintiffs maintain that it was defendants' failure (in early 2018) to inquire of and update changes to Mr. Boyd's medications, prior to rendering the March 8, 2018 dental treatment (*i.e.*, plaintiff had recently started a course of steroids and Methotrexate—known to weaken the immune system and to mask symptoms of infection), that resulted in his eventual diagnosis of endocarditis. Defendants argue in the first instance, that pursuant to all applicable guidelines of the American Heart Association, and the American Dental Association, Mr. Boyd was not a member of the category of patients who required premedication, because he did not have underlying cardiac valve disease or a previous bout of infectious endocarditis and, secondly, that given (1) the incubation period of endocarditis is seven to fourteen days, (2) plaintiff's final dental treatment was on March 8, 2018, and (3) plaintiff exhibited no signs and symptoms of infection until June of 2018, then defendants' failure to premedicate plaintiff is not a proximate cause of his illness, which more likely came from bacteria that seeded his bloodstream from a later episode of diverticulitis.

Plaintiffs' complaint lists three causes of action: dental malpractice, lack of informed consent, and loss of consortium on behalf of his spouse, the plaintiff, Oralee Wachter.

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[2] Laboratory tests performed during plaintiff's hospitalization in July of 2018 disclosed the presence of Strep Mitis/Oralis.

FACTUAL BACKGROUND

On April 17, 2017 plaintiff presented to NYU College of Dentistry (hereinafter "NYUCD") for replacement of a crown on tooth #9. During the initial visit, a comprehensive examination was performed which included a thorough review of Mr. Boyd's medical conditions and prescription medications, inclusive of cardiovascular and heart conditions. Plaintiff was seen again on May 4, 2017, at which time the comprehensive examination was continued, periodontal probing completed, radiographs taken, and a treatment plan formulated. Mr. Boyd presented for treatment five more times during 2017 in connection with the replacement of the crown on tooth #9. No manipulation of the gingival tissue was associated with the several treatments in 2017.

On October 18, 2017, a medical consult was sent to Dr. Adam Skolnick, plaintiff's cardiologist, requesting recommendations for medical management in consideration of Mr. Boyd's diagnosis of atrial fibrillation and medication regimen. Dr. Skolnick's response merely stated that Mr. Boyd should refrain from taking Eliquis for 24 hours prior to extractions, without further limitations. On the two occasions plaintiff was treated in 2018, the temporary crown was removed, and the final porcelain crown was placed with the occlusion and margins checked.

During plaintiff's last dental visit on March 8, 2018, a large occlusal decay was found in the gold inlay of tooth #31, and the dentist recommended that the tooth be extracted. A periodontal consultation was written, and the decay was removed. Thereafter plaintiff never returned to the clinic for the tooth extraction.

Plaintiff testified that he began experiencing fatigue and weakness during late March and early April of 2018 but did not seek medical attention for these symptoms. However, plaintiff

denied feeling fatigued during his May 21, 2018 visit with Dr. Skolnick relative to his diagnosis of atrial fibrillation.

On June 22, 2018 plaintiff presented to California Pacific Medical Center (CPMC) with complaints of persistent abdominal pain and tachycardia. He had no fever and again denied fatigue and weakness. An abdominal CT scan was indicative of sigmoid diverticulitis, and plaintiff was given Cipro and Flagyl and released from the hospital.

On June 23, 2018, plaintiff again presented to CPMC with recurrence of severe lower abdominal pain. A repeat abdominal CT scan was performed which was consistent with a likely micro bowel perforation. During his admission he was started on Ciprofloxacin and was advanced from a clear diet. He was discharged on June 27, 2018 with instructions to continue the antibiotic medication for five more days. During this hospitalization Mr. Boyd did not demonstrate signs or symptoms consistent with endocarditis.

On July 6, 2018, plaintiff presented Dr. Lester Jacobson, a cardiologist, for an evaluation of weakness, fatigue, history of atrial fibrillation, hypertension, interstitial lung disease, psoriatic arthritis, and diverticulitis. On physical examination he demonstrated varying pulse rates from 80 and regular to 150. He was readmitted to CPMC for comprehensive cardiac testing and lab work, and a diagnosis of atrial fibrillation with rapid ventricular response. Blood cultures, an electrocardiogram and a trans-esophageal electrocardiogram were ordered, and based upon the results of the cardiac testing and one positive blood culture, a diagnosis of endocarditis was suspected. A TEE performed on July 9, 2018 showed a probably vegetation on one of the aortic valve leaflets.

SUMMARY JUDGMENT AND EXPERT OPINIONS

In support of their motion defendants attach, *inter alia*[3], the affirmation Bruce F. Farber, M.D., an infectious disease specialist (*see* NYSCEF Doc. No. 47), who sets forth that (1) "at risk" patients include those with cardiac valve disease, congenital heart defects, IV drug users and those with a history of endocarditis; (2) development of bacterial endocarditis in valve disease patients is statistically one in 3000, and the American Dental Association has indicated that there are relatively few patient subpopulations for whom prophylactic antibiotics are indicated prior to certain dental procedures, and (3) "given the length of time between his dental care and the putative diagnosis it is highly unlikely to nearly impossible that Mr. Boyd's dental care could be considered the precipitating event" since the signs and symptoms of endocarditis generally manifest within 2 to 3 weeks of a precipitating event. Finally, based upon his review of the hospital records, laboratory analysis and radiographs, Dr. Farber is not convinced that a definitive diagnosis of endocarditis was even made during plaintiff's July 6, 2018 to July 13, 2018 hospital admission.

Also attached is the affirmation of defendants' expert cardiologist, Jerry Gliklich, M.D., (*see* NYSCEF Doc. 48), who confirms the seven-to-fourteen-day incubation period, and agrees that the diagnosis of endocarditis was questionable, and the affirmation of a dentist, Allan Kucine, D.D.S. (*see* NYSCEF Doc. No. 49) who opines that Mr. Boyd did not have any medical condition which required antibiotic prophylactics for his routine dental treatment under the applicable AHA and ADA guidelines since, according to his medical records, plaintiff did not have cardiac valve disease.

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[3] A recitation of the findings and opinions of defendants' expert neurologist, John K. Houten, M.D., *(see* NYSCEF Doc. No. 46) will not be discussed herein, as plaintiffs have withdrawn all claims related to defendants' failure to consider his prior spinal fusion surgery as part of his medical evaluation before performing the dental work.

Finally, defendants maintain that plaintiff is unable to demonstrate that non premedicated dental treatment was a proximate cause of his alleged injuries, since there is no evidence that the bacteremia came from the oral cavity, and given the timing of the events, it more likely seeded from his diverticulitis.

In opposition to the motion, plaintiffs attach, *inter alia,* the July 8, 2019 affidavit of his treating infectious disease specialist, David F. Busch, M.D. (*see* NYSCEF Doc. No. 54) who attests that he treated plaintiff in July of 2018, that the plaintiff was "found to have Streptococcus mitis/oralis," that plaintiff's history suggests that the bacteria could have been seeded to the blood stream in conjunction with dental work, and that Dr. Busch had a "significant suspicion for the possibility of endocarditis, which was then detected." Dr. Busch is unequivocal in his opinion that "dental work without antibiotics was one possible cause of Mr. Boyd's endocarditis" (*id.,* para 7).

Plaintiffs also attach the affirmations of a dentist, Charles Kaner, D.D.S. (*see* NYSCEF 55), and a pulmonologist, Dr. David Goldstein (*see* NYSCEF Doc. No. 57), who confirm that defendants' failures to obtain updated medical information prior to rendering treatment in 2018 was inconsistent with the accepted standard of care and was a proximate result of plaintiff's injuries. Plaintiff's experts explain that "the missing consultation would have shown an indication for prophylactic antibiotics prior to any gingival manipulation by Dr. Beard, a failure which…competently caused or contributed to Mr. Boyd coming down with endocarditis" (*see* Affirmation of Charles Kaner, D.D.S./NYSCEF Doc. No. 55).

Plaintiffs do not submit any evidence whatsoever in opposition to that branch of defendants' motion to dismiss the second cause of action for lack of informed consent.

LEGAL STANDARD AND ANALYSIS

The standards for summary judgment are well settled. The proponent "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" (*Winegrad v. New York Univ. Med. Ctr.*, 64 NY2d 851, 853 [1985]; [*internal citations omitted*]). The motion must be supported by evidence in admissible form (*see Zuckerman v. City of New York*, 49 NY2d 557, 562 [1980]), and the facts must be viewed in the light most favorable to the nonmoving party (*see Vega v. Restani Constr. Corp.*, 18 NY3d 499, 503 [2012]). "In determining whether summary judgment is appropriate, the motion court should draw all reasonable inferences in favor of the nonmoving party and should not pass on the issues of credibility" (*Garcia v. J.D. Duggan, Inc.*, 180 AD2d 579, 580 [1st Dept. 1992]).

Once the movant has met his or her burden on the motion, the nonmoving party must establish the existence of a material issue of fact (*see Vega v. Restani Constr. Corp.*, 18 NY3d 499, 503 [2012]). A movant's failure to make a *prima facie* showing requires denial of the motion, regardless of the sufficiency of the opposing papers (*Winegrad v. New York Univ. Med. Ctr.*, 64 NY2d 851 [1985]; [*internal citations omitted*]). It has been held that merely "pointing to gaps in an opponent's evidence is insufficient to demonstrate a movant's entitlement to summary judgment" (*Koulermos v. A.O. Smith Water Prods.*, 137 AD3d 575, 576 [1st Dept. 2016]).

"The drastic remedy of summary judgment, which deprives a party of his day in court, should not be granted where there is any doubt as to the existence of triable issues or the issue is even 'arguable'" (*DeParis v. Women's Natl. Republican Club, Inc.*, 148 AD3d 401 [1st Dept. 2017]; [*internal citations omitted*]).

To sustain a cause of action for dental malpractice, the plaintiff must prove two essential elements: (1) a deviation or departure from accepted practice, and (2) evidence that such departure was a proximate cause of the claimed injury.

A defendant moving for summary judgment in a dental malpractice action must make a *prima facie* showing of entitlement to judgment as a matter of law by showing "that in treating the plaintiff there was no departure from good and accepted [dental] practice or that any departure was not the proximate cause of the injuries alleged" (*Roques v. Nobel,* 73 AD3d 204, 206 [1st Dept. 2010]; [citations omitted]). To satisfy the burden, a defendant in a dental malpractice action must present expert opinion testimony that is supported by the facts in the record and addresses the essential allegations in the bill of particulars (*id.*). The expert cannot make conclusions by assuming material facts not supported by record evidence (*id.*). A defendant's expert opinion must "explain 'what defendant did and why'" (*Ocasio-Gary v. Lawrence Hosp.*, 69 AD3d 403, 404 [1st Dept. 2010]; [*quoting Wasserman v. Carella*, 307 AD2d 225, 226, 1st Dept. 2003]).

If the movant makes a *prima facie* showing, the burden then shifts to the party opposing the motion "to produce evidentiary proof in admissible form sufficient to establish the existence of material issues of fact which require a trial of the action" (*Alvarez v. Prospect Hosp.*, 68 NY2d 320, 324 [1986]). Specifically, a plaintiff must produce expert testimony regarding the specific acts of malpractice, and not just testimony that alleges "[g]eneral allegations of medical malpractice, merely conclusory and unsupported by competent evidence" (*Alvarez v. Prospect Hosp.*, 68 NY2d at 325). In most instances, the opinion of a qualified expert that the plaintiff's injuries resulted from a deviation from relevant industry or medical standards is sufficient to defeat summary judgment (*Frye v. Montefiore Med. Ctr.,* 70 AD3d 15, 24). The plaintiff's expert must

address the specific assertions of the defendant's expert with respect to negligence and causation (*see Foster-Sturrup v. Long*, 95 AD3d 726, 728-729 [1st Dept. 2012]).

Where the parties' conflicting expert opinions are adequately supported by the record, summary judgment must be denied. "Resolution of issues of credibility of expert witnesses and the accuracy of their testimony are matters within the province of the jury" (*Frye v. Montefiore Med. Ctr.*, 70 AD3d 15, 25; *see also Cruz v. St. Barnabas Hospital*, 50 AD3d 382 [1st Dept. 2008]).

This Court finds that defendants have established entitlement to judgment as a matter of law dismissing plaintiffs' complaint through, *inter alia*, the factually based affirmations of their experts who opine that the defendants adhered to the standard of care, and as to proximate cause, that it was not possible for infectious endocarditis to result from un-premedicated gingival manipulation four months earlier.

In opposition, however, plaintiffs have met their burden in rebutting defendants' *prima facie* showing by submitting, *inter alia,* the affirmation of his treating infectious disease specialist, Dr. Busch, who specifically opines that "dental work without antibiotics was one possible cause of Mr. Boyd's endocarditis" (*see* NYSCEF Doc. No. 54, para 7), and the affirmation of board certified periodontist Charles Kaner, D.D.S. (*see* NYSCEF Doc. No. 55), who relates defendants' failure to update Mr. Boyd's medication history (*i.e.*, use of steroids) prior to rendering treatment on March 8, 2018, as a likely cause of his infectious endocarditis.

While the evidence of injury alone does not mean that the defendants were negligent (*see Landau v. Rappaport*, 306 AD2d 446 [1st Dept. 2003]), the facts in this record together with plaintiffs' experts' opinions as to the departures from good and accepted medical practice mandates a trial on whether the defendant's failure to obtain an updated history of medications in

2018 and to consult with a cardiologist before performing the March 8, 2018 treatment was a proximate cause of plaintiff's contracting infectious carditis and resulting injuries.

Accordingly, it is

ORDERED that defendants' motion for summary judgment in favor of and dismissing the complaint against the defendants Dr. Bruce Brandolin and Dr. Steven Fisher is granted; and it is further

ORDERED that the Clerk is directed to enter judgment severing and dismissing plaintiffs' complaint against the individually named defendants, Dr. Bruce Brandolin and Dr. Steven Fisher; and it is further

ORDERED that defendants' motion for summary judgment dismissing plaintiffs' second cause of action for lack of informed consent is granted as unopposed; and it is further

ORDERED that the Clerk is directed to enter judgment severing and dismissing the second cause of action; and it is further

ORDERED that all of plaintiffs' claims relating to defendants' failure to consider plaintiff's prior surgical fusion are severed and dismissed; and it is further

ORDERED that the balance of the motion is denied; and it is further

ORDERED that the parties shall appear for a virtual pre-trial conference by Microsoft Teams on **January 11, 2023 at 12:45 p.m.**

10/24/2022
DATE

HON. JUDITH N. MCMAHON

Hon. Judith N. McMahon
J.S.C.

CHECK ONE:		CASE DISPOSED			[X]	NON-FINAL DISPOSITION	
		GRANTED	[ ]	DENIED	[X]	GRANTED IN PART	[ ] OTHER
APPLICATION:		SETTLE ORDER				SUBMIT ORDER	
CHECK IF APPROPRIATE:		INCLUDES TRANSFER/REASSIGN				FIDUCIARY APPOINTMENT	[ ] REFERENCE

805213/2019 BOYD, THOMAS vs. NYU COLLEGE OF DENTISTRY
Motion No. 001