SUPREME COURT OF THE STATE OF NEW YORK
NEW YORK COUNTY

PRESENT: **HON. JOHN J. KELLEY** **PART** **56M**

Justice

----------X

JENNIFER ROSENBERG,

Plaintiff,

- v -

ROBERT S. GLICKMAN, D.M.D.,

Defendant.

----------X

INDEX NO. 800036/2011

MOTION DATE 01/27/2025

MOTION SEQ. NO. 008

DECISION + ORDER ON MOTION

The following e-filed documents, listed by NYSCEF document number (Motion 008) 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 159, 160, 161, 162, 163, 164, 165

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

In this action to recover damages for dental malpractice based on alleged departures from good and accepted dental practice and lack of informed consent, the defendant, Robert S. Glickman, D.M.D., moves pursuant to CPLR 3212 for summary judgment dismissing the complaint. The plaintiff, Jennifer Rosenberg, opposes the motion, and cross-moves to strike the defendant's expert's affirmation and the transcript of the deposition testimony of nonparty witness Anthony J. Caruso, D.D.S. She also cross-moves pursuant to CPLR 3124 to compel the defendant to respond to certain discovery demands, or pursuant to CPLR 3126 for the imposition of sanctions, and to strike from the court file records of her dental treatment that the defendant uploaded to the New York State Court Electronic Filing (NYSCEF), or to seal them. The defendant's motion is granted, and the complaint is dismissed. That branch of the plaintiff's cross motion seeking to compel additional discovery is denied as academic, and the remaining branches of her cross motion are denied on the merits.

The plaintiff makes numerous claims against the defendant in connection with the dental treatment that he rendered to her. Specifically, she alleged in her complaint, bill of particulars,

and other court filings that the defendant deviated or departed from the applicable standard of care in dentistry and oral surgery by failing properly to place an implant in the area of tooth #9, destroying her gum tissue, employing an inferior implant, allowing the implant to integrate with bone tissue, taking insufficient measures to preserve bone, teeth, and gums, and failing to abort the procedure when it allegedly was not proceeding as planned. In addition, the plaintiff alleged that the defendant committed malpractice by placing an implant over insufficient bone support. She further alleged that the defendant failed to inform her that the implant had been placed improperly and that he could not satisfactorily complete the treatment plan and properly place the implant, and further departed from good practice by failing to refer her to another oral surgeon or another specialist for the performance and completion of the implant surgery. The plaintiff additionally faulted the defendant for taking insufficient x-rays, taking an insufficient medical and dental history, performing an insufficient periodontal evaluation, and maintaining inadequate records, and, with respect to the latter allegation, for failing properly to chart her periodontal disease, tooth mobility, number of fillings, areas of decay, cavities, and root canal procedures. Moreover, she alleged that the defendant failed to take and maintain molds of her arches. The plaintiff also contended that the defendant "abandoned" her by, among other things, failing to finish her dental treatment.

Furthermore, the plaintiff alleged that the defendant failed to inform her of the reasonable risks and benefits of, and alternatives to, the proposed treatment, to recommend a more conservative treatment plan, and to inform her both that the implant would have to be replaced, and how often it would have to be replaced.

The plaintiff additionally averred that, as a consequence of these allegedly wrongful acts, the defendant caused her to undergo unnecessary implant surgery, permitted the structure of her mouth to become weakened, and caused her lose the support of bone required for implants.

It is well settled that the movant on 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" (*Winegrad v New York Univ. Med. Ctr.*, 64 NY2d 851, 853 [1985] [citations omitted]). The motion must be supported by evidence in admissible form (*see Zuckerman v City of New York*, 49 NY2d 557, 562 [1980]), as well as the pleadings and other proof such as affidavits, depositions, and written admissions (*see* CPLR 3212). The facts must be viewed in the light most favorable to the non-moving party (*see Vega v Restani Constr. Corp.*, 18 NY3d 499, 503 [2012]). In other words, "[i]n 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 issues of credibility" (*Garcia v J.C. Duggan, Inc.*, 180 AD2d 579, 580 [1st Dept 1992]). Once the movant meets his or her burden, it is incumbent upon the non-moving party to establish the existence of material issues of fact (*see Vega v Restani Constr. Corp.*, 18 NY3d at 503). A movant's failure to make a prima facie showing requires denial of the motion, regardless of the sufficiency of the opposing papers (*see id.; Medina v Fischer Mills Condo Assn.*, 181 AD3d 448, 449 [1st Dept 2020]).

"The drastic remedy of summary judgment, which deprives a party of his [or her] 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'" (*De Paris v Women's Natl. Republican Club, Inc.,* 148 AD3d 401, 403-404 [1st Dept 2017]; *see Bronx-Lebanon Hosp. Ctr. v Mount Eden Ctr.*, 161 AD2d 480, 480 [1st Dept 1990]). Thus, a moving defendant does not meet his or her burden of affirmatively establishing entitlement to judgment as a matter of law merely by pointing to gaps in the plaintiff's case. He or she must affirmatively demonstrate the merit of his or her defense (*see Koulermos v A.O. Smith Water Prods.*, 137 AD3d 575, 576 [1st Dept 2016]; *Katz v United Synagogue of Conservative Judaism*, 135 AD3d 458, 462 [1st Dept 2016]).

"To sustain a cause of action for medical [or dental] malpractice, a 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 plaintiff's injury" (*Frye v Montefiore Med. Ctr.*, 70 AD3d 15, 24 [1st Dept 2009]; *see Dykes v Stabile,* 153 AD3d 783, 783-784 [2d Dept 2017];

Alongi v Sutter, 139 AD3d 887, 887-888 [2d Dept 2016]; *McGuigan v Centereach Mgt. Group, Inc.,* 94 AD3d 955, 956 [2d Dept 2012]; *Florio v Kosimar*, 79 AD3d 625, 625 [1st Dept 2010]; *Alvarado v Miles,* 32 AD3d 255, 256-257 [1st Dept 2006]).

Once the applicable burden is satisfied by the defendant, the burden shifts to the plaintiff to demonstrate the existence of a triable issue of fact by submitting an expert's affidavit or affirmation attesting to a departure from accepted dental practice, and opining that the defendant's acts or omissions were a competent producing cause of the plaintiff's injuries (*see Roques v Noble*, 73 AD3d at 207; *Landry v Jakubowitz*, 68 AD3d 728 [2d Dept 2009]; *Luu v Paskowski*, 57 AD3d 856 [2d Dept 2008]). Thus, to defeat a defendant's prima facie showing of entitlement to judgment as a matter of law, a plaintiff must produce expert testimony regarding specific acts of malpractice, and not just testimony that contains "[g]eneral allegations of medical malpractice, merely conclusory and unsupported by competent evidence tending to establish the essential elements of medical malpractice" (*Alvarez v Prospect Hosp.,* 68 NY2d at 325; *see Frye v Montefiore Med. Ctr.*, 70 AD3d at 24). In most instances, the opinion of a qualified expert that the plaintiff's injuries resulted from a deviation from relevant standards in the field of dentistry is sufficient to preclude an award of summary judgment in a defendant's favor (*see Murphy v Conner*, 84 NY2d 969, 972 [1994]; *Frye v Montefiore Med. Ctr*., 70 AD3d at 24). Where the expert's "ultimate assertions are speculative or unsupported by any evidentiary foundation, however, the opinion should be given no probative force and is insufficient to withstand summary judgment" (*Diaz v New York Downtown Hosp*., 99 NY2d 542, 544 [2002]; *see Frye v Montefiore Med. Ctr*., 70 AD3d at 24).

Crucially, "'[e]xpert testimony is necessary to prove a deviation from accepted standards of medical [or dental] care and to establish proximate cause'" (*McAlwee v Westchester Health Assoc., PLLC*, 163 AD3d 549, 551 [2d Dept 2018], quoting *Burns v Goyal*, 145 AD3d 952, 954 [2d Dept 2016]). Thus, "in a dental malpractice action, expert proof is required to establish matters beyond the experience of the average juror" or finder of fact (*McGinn v Sellitti*, 150

AD2d 967, 968 [3d Dept 1989]; *see Bivens v Stern*, 172 AD3d 991, 992 [2d Dept 2019] ["In an action to recover damages for dental malpractice, the plaintiff must submit an affidavit of merit from a dental expert"]; *Kai Lin v Strong Health*, 82 AD3d 1585, 1586-1587 [4th Dept 2011]). Consequently, where a moving defendant in a dental malpractice action makes a prima facie showing that he or she did not depart from good and accepted practice, or that the treatment rendered to the plaintiff did not cause or contribute to the plaintiff's injuries, the plaintiff, to defeat summary judgment, must submit an expert affirmation or affidavit in opposition; a plaintiff's failure to submit such an expert affirmation or affidavit under such circumstances requires the court to award summary judgment to the moving defendant (*see Benedetto v Tannenbaum*, 186 AD3d 1596, 1598 [2d Dept 2020]; *Bethune v Monhian*, 168 AD3d 902, 903 [2d Dept 2019]; *Koster v Davenport*, 142 AD3d 966, 969 [2d Dept 2016]; *Whitnum v Plastic & Reconstructive Surgery, P.C.*, 142 AD3d 495, 497 [2d Dept 2016]; *Roques v Noble*, 73 AD3d at 207; *Bailey v Owens*, 17 AD3d 222, 223 [1st Dept 2005]; *cf. Williams v Sahay*, 12 AD3d 366, 368 [2d Dept 2004] [unsworn affidavit of unnamed expert that was not affirmed under the penalties for perjury is insufficient to raise triable issue of fact as to defendants' alleged malpractice]).

The law does not require a health-care provider to guarantee a good result (*see Saliaris v D'Amelia*, 143 AD2d 996, 996 [2d Dept 1988]), and, although an outcome or result may truly be unfortunate, "'a bad result does not, ipso facto, support a claim for medical malpractice'" (*Saliaris v D'Amelia*, 143 AD2d at 996-997; quoting *Schoch v Dougherty*, 122 AD2d 467, 468 [3d Dept 1988]; *see Nestorowich v Ricotta,* 281 AD2d 870, 871 [4th Dept 2001], *affd* 97 NY2d 393 [2002]; *Bobek v Crystal*, 291 AD2d 521, 523 [2d Dept 2002]; *Nabozny v Cappelletti*, 267 AD2d 623, 628 [3d Dept 1999]; *Zito v Friedman*, 77 AD2d 514, 515 [1st Dept 1980] [jury must be instructed that a bad result by itself is not proof of malpractice]). Rather, a plaintiff ultimately must support his or her claim with an expert opinion that the adverse or bad result or outcome was proximately caused by one or more deviations or departures from the applicable and accepted standard of care in the area of medicine or dentistry that is the subject of the claim.

In support of his motion, the defendant submitted the pleadings, the plaintiff's bill of particulars, transcripts of both party and nonparty deposition testimony, his own dental records and dental records from 17 other dentists who provided treatment to the plaintiff, a statement of allegedly undisputed material facts, an attorney's affirmation, and the expert affirmation of board-certified oral and maxillofacial surgeon, Arthur C. Elias, D.M.D.

Dr. Elias incorporated by reference the defendant's statement of allegedly undisputed material facts, which included a history of the plaintiff's dental care before beginning her treatment with the defendants. As the plaintiff's records revealed, she had, prior to the treatment that is the subject of this action, undergone root canal therapy in 2001 with respect to tooth #9 at Smile Dental in Avon, Colorado, secondary to a motor vehicle accident that resulted in trauma to that tooth. On August 30, 2006, she presented to nonparty dentist Jeffrey D. Yeres, D.D.S., in New York for a dental check-up. Dr. Yeres took a dental history and x-rays, and concluded that the plaintiff had moderate plaque, calculus, and bleeding, after which he performed a cleaning. On April 21, 2008, the plaintiff returned to Dr. Yeres, after which he documented that she evinced general minimum plaque and calculus, with light posterior bleeding, and characterized her condition as "generalized healthy tissue," with minimum posterior proximal inflammation and good oral hygiene. On September 19, 2008, the plaintiff returned to Dr. Yeres, upon which he reported that tooth #9 was "planned for extraction with placement of an implant by 'another surgeon.'"

That same day, the plaintiff began treating with nonparty dentist Jeffrey Shapiro, D.D.S., in New York, for pain over the top of tooth #9, and presented to him for an initial comprehensive oral evaluation and x-rays. According to the plaintiff's deposition testimony, Dr. Shapiro informed her that her prior root canal therapy underneath tooth #9 had failed and that the remaining portion of that tooth had deteriorated, and he recommended that the remainder of that tooth be extracted. He purportedly told the plaintiff that the extraction would resolve an existing infection at tooth #9, and offered to perform the extraction. On September 24, 2008,

the plaintiff returned to Dr. Shapiro, who extracted tooth #9 and placed a graft at the site of the extraction. On October 1, 2008, and October 15, 2008, the plaintiff returned to Dr. Shapiro for postoperative observation. The plaintiff testified that she was informed by Dr. Shapiro about the possibility of placement of an implant at the site of tooth #9 as a restorative option, and he apparently also informed her of the alternatives to placing a dental implant, including the placement of a dental bridge. In any event, the plaintiff declined to undergo an implant procedure with Dr. Shapiro. Instead, according to the plaintiff, she was referred to the defendant for implant placement by someone affiliated with the New York Mets baseball organization.

On December 10, 2008, the plaintiff saw Anthony J. Caruso, D.D.S., in Southampton, New York, for a regular dental checkup. He reported having conducted a comprehensive examination for caries and oral cancer, and concluded that the plaintiff presented with mild posterior periodontal disease, with pocketing greater than 3 millimeters (mm) on her distal molars. Dr. Caruso further reported that a soft tissue examination revealed normal results with respect to the plaintiff's extra-oral head and neck region, lymph chain, lips, labial and buccal mucosa, tongue, floor of the mouth, hard and soft palates, and pharynx.

On May 13, 2009, the plaintiff presented to New York University (NYU) College of Dentistry for an initial consultation with the defendant. According to the defendant, he took a medical and dental history of the plaintiff during this initial consultation, and reported that the plaintiff was not a smoker, was not a diabetic or hemophiliac, had no immune system deficiency, and evinced no indicia of radiation therapy. The plaintiff reported to the defendant that she maintained good dental hygiene habits, and that she had been taking albuterol and Advair for asthma. The defendant testified at his deposition that, during this initial visit, he performed a complete intra-oral and extra-oral head and neck examination of the plaintiff, and reported no underlying pathology. The defendant recommended, and, on May 14, 2009, ultimately took, a

computed tomography (CT) scan of the area in and near tooth #9 to evaluate whether the prior bone graft had healed, and whether the bony tissue was sufficient to support an implant.

As Dr. Elias described the relevant dental records, the defendant found and reported mild loss of bone at the buccal cortical plate, although the defendant testified at his deposition that the height of the buccal plate nonetheless was within normal limits, and that he observed no bony defects at the site of the tooth. The defendant thus determined that the plaintiff had sufficient bone support for an implant, a determination that purportedly was corroborated by the plaintiff's subsequent treating dentists. The defendant referred the plaintiff to prosthodontist Leila Jahangiri, D.M.D., for the development of an overall treatment plan, including aesthetic restoration consisting of an implant-supported crown. As Dr. Elias interpreted the plaintiff's medical records, Dr. Jahangiri similarly concluded that no osseous or cartilage graft was necessary. The defendant thus elected to employ a "Nobel BioCare Replace Select" implant, measuring 3.5 mm by 10 mm, dimensions that he concluded were sufficient in light of the plaintiff's bone structure at the site of tooth #9.

At the plaintiff's first visit with Dr. Jahangiri on May 28, 2009, that prosthodontist took impressions of the plaintiff's teeth. On June 2, 2009, the plaintiff returned to Dr. Jahangiri for a follow-up visit, upon which Dr. Jahangiri noted that the plaintiff had fair oral hygiene practices and a generalized moderate calculus accumulation, and thereafter performed a dental prophylaxis and polishing. Dr. Jahangiri then fabricated the surgical template that the defendant would use for the implantation procedure, and testified at her deposition that she fabricated the stent for the purpose of physically limiting and restricting the defendant's placement of the implant to the position that she determined would be ideal for a restoration. Specifically, she testified at her deposition that the drill burr that was to be used by any oral surgeon performing an implant procedure could not go beyond the angulation dictated by the surgical template. On July 1, 2009, Dr. Jahangiri had the plaintiff try on the surgical template and prosthesis to assure that the fit and occlusion were fashioned to the plaintiff's satisfaction. The defendant performed

the implant procedure on that date, which, according to his description, was performed as scheduled and without complication. The defendant alleged that the plaintiff's postoperative course was managed by Dr. Jahangiri, who, in her own chart, noted no complication of the implant postoperatively, and otherwise reported that the surgical wound and implant were healing well. The plaintiff's visit with Dr. Jahangiri on August 6, 2009 was her last visit with either the defendant or Dr. Jahangiri.

On September 30, 2009, the plaintiff again visited Dr. Caruso in Southampton. According to the plaintiff's chart maintained by that dentist:

> "Pt. came in with emergency stating that she was hit by toddler in the front tooth area #9.
>
> "1PAX shows implant #9 healing well.
>
> "Limited exam reveals no pathology.
>
> "NV-operative."

Dr. Caruso placed a cover screw to close the inside of the dental implant to prevent bacterial ingrowth into the implant, and reported no radiolucency around the abutting teeth. He testified at his deposition that nothing jeopardized the viability of the implant for restoration.

The plaintiff thereafter returned to Colorado, where she previously had resided, for treatment of an unrelated medical condition, and testified at her deposition that she was aware that she left New York without having completed the restorative treatment plan that Dr. Jahangiri had formulated.

On June 7, 2010, the plaintiff presented to oral surgeon H. James Garel, D.D.S., in Colorado, who reviewed the plaintiff's pre-implant CT scan upon which the defendant had relied in performing the implant procedure, and, according to Dr. Elias, similarly concluded that the plaintiff had adequate bone for implant placement. Dr. Garel also wrote that the implant was suitable for a restoration as an option available to the plaintiff. On June 16, 2010, the plaintiff

presented to oral surgeon Alan Z. Pomeranz, D.D.S., M.MSc., in Colorado, who wrote, in a letter to referring dentist Jonathan Haerter, D.D.S., that,

> "the implant is completely in the wrong position in order to restore it. We will need to trephine out the implant and rebuild the site with hopes of eventually replacing the implant. We will need to rebuild not only the hard tissue but the soft tissue around the head of the implant. At the initial visit, I did remove the cover screw to see if we could get some granulation and soft tissue coverage over the top of the implant."

Nowhere in any of his records or letters to Dr. Haerter did Dr. Pomeranz opine that anything that the defendant did or did not do constituted a departure from good dental or oral surgery practice. The plaintiff treated with Dr. Pomeranz and his practice from June 2010 to July 2011. On July 6, 2010, Dr. Pomeranz wrote to Dr. Haerter he planned to graft the site of tooth #9 at the same time as he removed the implant, and asserted that he also had planned to allow approximately five months of healing before the plaintiff returned to obtain a three-dimensional "i-CAT" scan and he would place the new implant. During the next several months, Dr. Pomeranz performed additional work in preparation of implant removal, including a subepithelial connective tissue graft over the implant. Ultimately, however, the plaintiff declined to have the implant removed and, in or about July 2011, she instead had a dental bridge fabricated and placed over both the implant at the site of tooth #9, as well as over teeth #7, 8, and 10.

Dr. Elias opined, in great detail, as to each of the plaintiff's claims of a departure from good practice, and concluded that, contrary those contentions, the defendant did not commit or omit to do any of the acts that the plaintiff enumerated. He expressly opined that there was sufficient bone support for the placement of the implant at the site of tooth #9, inasmuch as the May 14, 2009 cone beam CT (CBCT) of the plaintiff's maxillary bone showed adequate bone support at that site. He averred that this conclusion was reaffirmed by the plaintiff's subsequent treatment providers, noting that Dr. Jahangiri testified that osseous or cartilage grafting was not necessary prior to the implant procedure and that, upon reviewing that scan, Dr. Garel arrived at the same conclusion on June 14, 2010. Dr. Elias expressly rejected the plaintiff's contention

that the defendant employed an inferior implant device, explaining that the defendant had implanted a Nobel BioCare Replace Select device, "which is among one of the standard and well-recognized types of implants used in dentistry," had been used for decades, and were designed to achieve positive primary stability between the implant and bone. He noted, moreover, that the implant device was the proper size, and clearly satisfied the applicable standard of care, and that the implant successfully integrated with the surrounding bone in any event. Dr. Elias also concluded that the defendant properly placed the implant, and comported with the standard of care in this respect. He noted in this regard that the plaintiff had expressed her desire that the edentulous space between teeth #8 and #10 be restored, given that tooth #9 previously had been extracted. After describing the classification of teeth in an around the site for tooth #9, Dr. Elias opined that the defendant, based upon both the plaintiff's directives, the plan and recommendations formulated by Dr. Jahangiri, and the goal of aesthetic and functional restoration, elected and implemented placement and positioning of the implant that was within the standard of care, and noted that the procedure was completed without complications. Dr. Elias further noted that all subsequent x-rays, including those taken on June 7, 2010 by Dr. Garel, reflected that the implant at the site of tooth #9 remained in a suitable position---well within the axial inclination of the alveolar bone---for restoration using an angled abutment.

Dr. Elias explicitly opined that the defendant performed a sufficient periodontal evaluation of the plaintiff in his role as an oral and maxillofacial surgeon. He explained that, as a specialist in oral and maxillofacial surgery, as opposed to other dental specialties, the defendant was obligated by the applicable standard of care to evaluate the plaintiff from a "pathological point of view," that is, "to assess whether the plaintiff had any underlying disease process like infection or abscess." Dr. Elias asserted that the defendant performed appropriate clinical examinations and ordered the appropriate imaging to evaluate the plaintiff with respect to her candidacy for implant therapy. In this respect, he averred that the defendant appropriately obtained the plaintiff's medical and dental history, her history of present illness,

and her chief complaint, that is, her perceived need for a dental implant at the site of tooth #9, as well as her history of asthma and sinus trouble. Dr. Elias further asserted that the defendant properly documented the plaintiff's reported history of the motor vehicle accident in 2001 that caused trauma to tooth #9, consequent root canal treatment of tooth #9, eventual extraction of tooth #9, and bone grafting at that site. He concluded that the standard of care required only that the defendant perform a CBCT scan, and did not require the plaintiff to undergo a preoperative panoramic x-ray of the area of tooth #9 in addition to the CBCT.

Dr. Elias further stated that the defendant satisfied the standard of care by performing a head and neck examination, and an intra-oral examination, which included the examination of the maxillary arch for any evidence of underlying pathology, such as acute infection, abscess, or abnormal mobility of the adjacent teeth, and that none of the findings that he made would have precluded placement of an implant at site #9. He also rejected the plaintiff's allegation that the defendant took insufficient measures to preserve her bone, teeth, and gums, because, at the time when she was treating with the defendant, there was no underlying bone, tooth, or gum pathology, or evidence of structural weakening, and that, as such, he concluded that additional or different treatment was not warranted. Dr. Elias further noted that the defendant relied extensively on the clinical examination undertaken by Dr. Jahangiri on May 28, 2009, prior to implantation, which revealed cavities of no clinical significance in teeth #10 and 31, and good bone support under the teeth adjacent to tooth #9.

In addition, Dr. Elias opined that the defendant was not obligated by the applicable standard of care to take and maintain molds of the plaintiff's arches, since such services were the responsibility of Dr. Jahangiri. He noted that she did, in fact, provide those services on May 28, 2009, and, thus, prior to the implant procedure, "as part of both the development of the surgical template and the patient's prosthetic rehabilitation or restoration."

Dr. Elias also emphatically rejected the plaintiff's claims that the defendant should have aborted the procedure, and was liable in malpractice for his alleged failures to finish the

treatment, to inform her that he could not satisfactorily complete the treatment plan and properly place the implant, and to refer her to a specialist or another oral surgeon for the performance and completion of the implant surgery. He also concluded that the defendant did not abandon the plaintiff. In this respect, Dr. Elias explained that the defendant's clinical involvement was concluded after placement of the implant at the site of tooth #9, and that, once the procedure had been completed without complication, "the notion that the procedure should have been 'aborted'" became meaningless, as did the need to refer the plaintiff to another surgeon or specialist for "completion" of the procedure. With respect to the allegation of abandonment, Dr. Elias opined that the defendant's treatment plan provided for the continuity of care, with Dr. Jahangiri managing the plaintiff postoperatively. He explained that Dr. Jahangiri actually saw the plaintiff on July 9, 2009 and August 6, 2009, and conducted a tele-appointment on July 30, 2009. He reached this conclusion, at least in part, based on Dr. Jahangiri's August 6, 2009 note, which reported that tissue growth was progressing well over the implant site, that there was no evidence of malposition or issues with the implant, and that the plaintiff was "very satisfied" with the outcome of the implant procedure. Dr. Elias further noted that Dr. Jahangiri herself testified that she would have documented any such problems had they been evident.

Moreover, according to Dr. Elias,

> "documentary evidence clearly belies any allegation that Dr. Glickman, or Dr. Jahangiri for that matter, w[as] responsible for the non-completion of the plaintiff's restorative rehabilitation. The records and transcripts indicate that the plaintiff's decision to discontinue care was occasioned by her diagnosis of gallbladder cancer, for which she moved to Colorado to receive treatment. According to the NYU chart, the plaintiff was contacted on January 28, 2010 to schedule an appointment for stage II of her treatment, the restoration of the implant with a crown. However, the plaintiff informed the office that she would call back after she finished gall bladder cancer treatment. At her deposition, that plaintiff conceded that she was aware that she was supposed to return for completion of her restorative treatment after six (6) months elapsed following placement of the implant (i.e., to permit the implant site to properly heal), but made the decision not to return."

In this respect, he opined that standard of care did not require a provider to force a patient to complete a planned restoration.

With respect to the issue of whether the defendant's implant procedure caused or contributed to any of the plaintiff's alleged injuries, Dr. Elias first concluded that the plaintiff sustained no permanent injuries to the site of tooth #9 as a consequence of the implant. He noted that, for more than 10 years, the plaintiff made no documented or clinically supported complaints with respect to that site, nor did she present with clinical symptoms deemed to have been a result of the implant. Dr. Elias personally examined the plaintiff, and he reported that he found no evidence of her alleged complaints. Specifically, during this examination, Dr. Elias noted that the gingiva of the plaintiff's anterior maxillary teeth was pink, firm, and uninflamed, while her maxillary dental midline was consistent with her facial midline. At the time of his examination in 2012, he concluded that the plaintiff had in place what was "otherwise an excellent aesthetic restoration in the form of a dental bridge involving teeth #7-#10," which he concluded was ostensibly a reference of the bridge placed by Dr. Pomeranz in Colorado. He reported that a pontic tooth was affixed to the plaintiff's bridge to fill the site at tooth #9, and he noted no signs of altered speech, altered bite, altered occlusion, or maxillary disfigurement. Dr. Elias concluded that, to the extent that the plaintiff developed any complaints about the tooth site subsequent to the implant, those were due to other medical and dental issues completely unrelated to the placement of the implant, a conclusion that he asserted was corroborated by all of the documentary evidence of the plaintiff's treating dentists long after the implant procedure. He thus averred that the placement of the implant was proper from an oral and maxillofacial standpoint, as reflected, among other things, in its successful osseointegration and longevity over a period of more than 13 years.

The defendant thus established his prima face entitlement to judgment as a matter of law with respect to the medical malpractice cause of action with his submissions, and particularly with Dr. Elias's affirmation.

In opposition to the motion, the plaintiff submitted her own affidavit, in which she simply offered lay opinions as to the departures that the defendant allegedly committed, and focused

on the problems that she has had with tooth #9. She also submitted biographical information of the defendant that had been published on NYU's web site, and later submitted a copy of Dr. Elias's dental license, his National Provider Identification number in the National Plan and Provider Enumeration System (NPPES), and biographical information about Dr. Elias that had been published on the New York-Presbyterian Hospital (NYPH) web site. She alleged that Dr. Elias made fraudulent statements in his affirmation, particularly with respect to when he graduated from dental school, and she expressed doubt as to whether dental implants were taught at the time he graduated from Harvard dental school in 1967. She did not, however, address his decades as a practicing oral surgeon, or any continuing dental education he may have obtained between 1967 and the time he examined her on behalf of the defendant in 2012. Moreover, the plaintiff also pointed to what she alleged were inconsistencies between the specialties that he listed in his NPPES entry, those that are reported on the NYPH web site, and those he identified in his affirmation. She also questioned his apparent age at the time he examined her, and his likely age at retirement. She further alleged that Dr. Caruso made fraudulent statements in the course of his deposition, and that he violated obligations that she claimed he owed her merely by testifying, as a nonparty witness, after being subpoenaed by the defendant, and by appearing at that deposition represented by his own attorney.

None of the plaintiff's submissions demonstrated that the defendant failed to satisfy his burden on this summary judgment motion. Her submissions also failed to raise a triable issue of fact as to whether the defendant departed from good practice, or whether any such departure caused or contributed to any compensable injuries. At most, she has attempted to challenge the credibility of Drs. Elias and Caruso with numerous speculative contentions and otherwise inadmissible documents which, even if accepted as true, would be insufficient to defeat summary judgment or contradict the substance of their respective affirmation and testimony. As noted above, "[t]he rule is clear that a court may not weigh the credibility of the affiants on a motion for summary judgment unless it clearly appears that the issues are not genuine but

feigned" (*Waldenmaier v Jones*, 37 AD2d 828, 828 [1st Dept 1971]; *see Garcia v J.C. Duggan, Inc.*, 180 AD2d at 580). The plaintiff failed to satisfy that high standard, arguing only that the court should not believe Drs. Elias and Caruso. Moreover, contrary to the plaintiff's contention, the defendant was permitted to take the deposition of her treating dentists, but only with respect to those dentists' observations and treatment, and he was entitled to elicit Dr. Caruso's expert opinion, but only with regard to Dr. Causo's own role in the diagnosis, care, and treatment of the plaintiff (*see Slapo v Winthrop Univ. Hosp*., 186 AD3d 1281, 1283-1284 [2d Dept 2020]).

Inasmuch as the plaintiff failed to submit an expert affirmation or affidavit contesting, contradicting, rebutting, or refuting any of the material facts or opinions described and rendered by Dr. Elias, and has failed to submit an admissible, expert opinion contradicting the deposition testimony of the defendant or of any nonparty witness, she has failed to raise a triable issue of fact in opposition to the defendant's prima facie showing of entitlement to judgment as a matter of law in connection with the dental malpractice cause of action. As explained above, the unsworn June 16, 2010 letter report of Dr. Garel, while stating that the implant was in the wrong position for restorative work, never opined that the defendant had improperly placed it, or placed it in the wrong position, provided no explanation as to how it ended up in that position, never concluded that it was in the wrong position for other treatments, and never opined that the implant was in the wrong position due to any malpractice on the defendant's part. In any event, an unsworn letter or report from a professional does not constitute admissible evidence to support or oppose a motion for summary judgment (*see Markiewicz v Jones*, 207 AD3d 1098, 1101 [4th Dept 2022]; *Ulm I Holding Corp. v Antell.* 155 AD3d 585, 585 [1st Dept 2017]). Moreover, the court discerns no basis for the plaintiff's request to strike Dr. Elias's affirmation or the transcript of Dr. Caruso's deposition testimony. Hence, the court denies that branch of the plaintiff's cross motion seeking to strike those items, and concludes that summary judgment must be awarded to the defendant dismissing the dental malpractice cause of action.

The elements of a cause of action to recover for lack of informed consent are:

> "(1) that the person providing the professional treatment failed to disclose alternatives thereto and failed to inform the patient of reasonably foreseeable risks associated with the treatment, and the alternatives, that a reasonable medical practitioner would have disclosed in the same circumstances, (2) that a reasonably prudent patient in the same position would not have undergone the treatment if he or she had been fully informed, and (3) that the lack of informed consent is a proximate cause of the injury"

(*Spano v Bertocci*, 299 AD2d 335, 337-338 [2d Dept 2002]; *see Zapata v Buitriago*, 107 AD3d 977, 979 [2d Dept 2013]; *Balzola v Giese*, 107 AD3d 587, 588 [1st Dept 2013]; *Shkolnik v Hospital for Joint Diseases Orthopaedic Inst*., 211 AD2d 347, 350 [1st Dept 1995]). For a statutory claim of lack of informed consent to be actionable, a defendant must have engaged in a "non-emergency treatment, procedure or surgery" or "a diagnostic procedure which involved invasion or disruption of the integrity of the body" (Public Health Law § 2805-d[2]). "'[T]his showing of qualitative insufficiency of the consent [is] required to be supported by expert medical testimony'" (*King v Jordan*, 265 AD2d at 260, quoting *Hylick v Halweil*, 112 AD2d 400, 401 [2d Dept 1985]; *see* CPLR 4401-a; *Gardner v Wider*, 32 AD3d 728, 730 [1st Dept 2006]). Hence, where a defendant establishes his or her prima facie entitlement to judgment as a matter of law in connection with a lack of informed consent cause of action by submitting an expert affirmation from a dentist, a plaintiff can only raise a triable issue of fact by submitting "an expert affirmation stating with certainty that the information defendant[ ] allegedly provided to plaintiff before the dental procedures at issue departed from what a reasonable practitioner would have disclosed" (*Leighton v Lowenberg*, 103 AD3d 530, 530 [1st Dept 2013]).

According to the defendant, his established practice was to discuss the risks of, and alternatives to, an implant procedure with a patient, as well as the perioperative course associated therewith, and thereafter send that patient home with an informed consent form that he requested to be signed and returned on the day of the procedure. In this respect, the defendant testified at his deposition that he would inform a patient that, if he concluded during the surgery, that there was insufficient bone in which to anchor the implant, the implant either would not be placed and he would instead perform a bone augmentation procedure, or he would

place the implant and perform a bone augmentation procedure around it. The defendant further testified that, whenever an implant is placed at one of the front six teeth, sometimes known as "the aesthetic zone," the patient is informed of the possibility of tissue augmentation, which, under most cases, would be performed by a prosthodontist. He further testified that he informed the plaintiff that he would be using Dr. Jahangiri's surgical template to guide the angulation of the implant. According to the defendant himself, he informed the plaintiff that the alternative to the placement of the implant placement was having no implant, but instead to leave an empty space at the site where the non-viable or infected tooth had been extracted. According to Dr. Elias, if the plaintiff elected that approach, the defendant also informed the plaintiff of the option of placing a dental bridge across the hole left by the extraction of tooth #9, as well as across several adjacent teeth, as an alternative to an implant-supported prosthesis.

Dr. Elias concluded that the defendant properly informed the plaintiff of the risks of and alternatives to the surgical placement of an implant, and that the plaintiff was properly advised of those risks and alternatives. Nonetheless, Dr. Elias opined that the standard of care did not require the defendant to review the various restorative options with the plaintiff. Rather, he asserted that this obligation fell within the purview of a restorative dentist, such as prosthodontist Dr. Jahangiri, whose knowledge and training principally concerned the types of available restorations, and "how best to match a restorative option with a patient's own idiosyncratic aesthetic preferences," and that the plaintiff was informed of these options even prior to treating with the defendant. Dr. Elias further asserted that Dr. Shapiro, as the dentist who treated the plaintiff immediately prior to the defendant, informed her of these restorative options following his extraction of tooth #9.

As Dr. Elias characterized it, the risk associated with the surgical placement of an implant is the risk of that implant failing, i.e., the risk of the implant becoming too loose to support a restoration. Dr. Elias explained that,

"[g]enerally, there are two types of implant failure: short-term implant failure and

> long-term implant failure. Short-term failure typically occurs within the time it takes for the implant to heal and integrate, i.e., within the first 4-6 months. During this period of time, when the implant is not fully integrated with the surrounding bone, the implant is vulnerable to migration in response to certain types of trauma at the site of implantation. The colonization of bacteria around the implant site can similarly cause the implant to fail, which not only highlights the importance of practicing good oral hygiene, but also the importance of the patient maintaining his or her follow-ups to evaluate for any indications of poor oral hygiene, so that oral hygiene instructions can be reinforced to the patient."

He further asserted that the manner in which the bone heals around the implant can contribute to implant failure and that, given the wide biological variation of individual healing capabilities, bone or tissue grafting may be performed to build up areas of bone around the implant to give it additional support as it heals. Dr. Elias contrasted short-term failure with long-term implant failure that usually occurs, if at all, four to sixth months after the procedure, due to load-bearing issues secondary to excessive or improper force being placed on the implant over time. In addition, he explained the condition known as peri-implantitis, or inflammation of the gum tissue, that also can cause an implant to fail, and can arise at any point in time, even after the passage of several years subsequent to the implant procedure. Dr. Elias asserted that this condition can result from a change or diminution in oral hygiene practices, leading to a deterioration of the surrounding gum or gingival tissue, or also can spontaneously arise from the body's rejection of a foreign body.[1]

Dr. Elias opined that the defendant properly informed the plaintiff of the risk of implant failure, as well as her chance of successful implantation given her prior dental history. He concluded that the defendant explained to the plaintiff how the procedure would be performed and her chance of success, and explained to the plaintiff, that during the surgery, if he felt that there was insufficient bone to place the implant, he either would delay the placement

[1] Dr. Elias noted that implant failure secondary to bodily rejection has no causal connection to the manner in which an implant was surgically placed, but can occur non-iatrogenically. He concluded that the fact that the plaintiff's implant remained in place for over a decade suggested the appropriateness of its surgical placement.

of the implant, and instead would perform a bone augmentation before placement, or, alternatively, he would place the implant and perform a bone augmentation around the implant. Based on his review of the defendant's deposition testimony, Dr. Elias stated that the defendant explained the success criteria for implant placement to the plaintiff, specifically, that the plaintiff had an 80-85% chance of success in light of her prior history of root canal therapy, infection, and extraction of tooth #9. According to Dr. Elias, the defendant properly informed the plaintiff that the failure rate of an implant is a function of how the jaw bones atrophy over time, creating different healing possibilities, and also was a function of certain areas of the mouth, with the anterior front teeth more prone to traumatic events. He adverted to the defendant's deposition testimony concerning his custom and practice of noting in a patient's chart that he had engaged in a detailed discussion with the patient as to where the site of implantation would take place, the chance of success, and the available data on implant failure.

Dr. Elias thus emphatically concluded that the defendant "satisfied the informed consent process governing his treatment of the plaintiff," and that, having been properly informed of the risks of, and alternatives to, the implant placement, the plaintiff made an informed decision to proceed with the placement of the implant.

Although, to satisfy his burden on this motion for summary judgment, the defendant may not legally rely upon the qualitative sufficiency of the information provided to the plaintiff by Drs. Shapiro and Jahangiri prior to meeting with him (*see Sangiuolo v Leventhal,* 132 Misc 2d 680, 682-683 [Sup Ct, N.Y. County 1986]), the court concludes that he nonetheless established that the information that he provided to the plaintiff, and the consent that he obtained from her in connection with the implant procedure, was qualitatively sufficient, particularly in light of Dr. Elias's opinion that most of the information that needed to be imparted to the plaintiff in connection with the overall plan of treatment was required to be imparted by other treating dentists and dental specialists. In opposition to that showing, the plaintiff failed to submit an expert affirmation or affidavit opining that the consent that the defendant obtained was

qualitatively insufficient. She thus failed to raise a triable issue of fact, even though she submitted her own lay opinion that a reasonable patient in her situation would not have agreed to undergo the procedure had he or she been fully informed of the relevant risks, benefits, and alternatives. Hence, summary judgment must be awarded to the defendant dismissing the lack of consent cause of action.

Although CPLR 3212(f) permits a court to deny a summary judgment motion where "facts essential to justify opposition may exist but cannot then be stated," the plaintiff here failed to demonstrate how further discovery might lead to relevant evidence (*see Alcor Life Extension Found. v Johnson*, 136 AD3d 464 [1st Dept. 2016]). "The 'mere hope' of [plaintiff] that evidence sufficient to defeat such a motion may be uncovered during the discovery process is not enough" (*Frierson v Concourse Plaza Assoc*., 189 AD2d 609, 610 [1st Dept 1993]). To properly oppose the defendants' motion by invoking CPLR 3212(f), or to obtain further discovery to enable her to oppose the motion, the plaintiff was "bound to show there was a likelihood of discovery leading to such evidence, i.e., that facts may exist but cannot be stated at that time" (*id.*). The plaintiff, however, failed to make such a showing here (*see Gyabbah v Rivlab Transp. Corp*., 129 AD3d 447 [1st Dept 2015]). Hence, CPLR 3212(f) provides no basis upon which the court may deny the defendant's motion for summary judgment, and the plaintiff's continued demands for additional discovery, which, in fact, had been addressed and rejected in several of the court's prior orders in any event, have been rendered academic. Hence, that branch of the plaintiff's cross motion, in effect, pursuant to CPLR 3124 seeking to compel the defendant to produce additional documentation must be denied, as is her request to impose a sanction upon the defendant for failing to produce the additional information that she sought.

Moreover, by placing her dental and medical condition in controversy, the plaintiff has waived both the common-law physician-patient privilege (*see Dillenbeck v Hess*, 73 NY2d 278, [1989]; *Cynthia B. v New Rochelle Hosp. Med. Ctr*., 60 NY2d 452, 456-457 [1983]) and the physician-patient privilege recognized by the Health Insurance Portability and Accountability Act

of 1996 (42 USC §§ 1320d, *et seq*.) (*see generally Poser v Varnovitsky*, 46 AD3d 1295, 1296 [3d Dept 2007]). Thus, issues relevant to the plaintiff's dental health, hygiene, and treatment became discoverable, including all relevant dental and other medical records that would likely have been admitted into evidence in open court had there been a trial of this action (*see Winslow v New York-Presbyterian/Weill-Cornell Med. Ctr.,* 203 AD3d 533, 533 [1st Dept 2022]; *Jones v FEGS-WeCARE/Human Resources, NYC*, 139 AD3d 627, 628 [1st Dept 2016]; *Giustiniani v Giustiniani*, 278 AD2d 609, 611 [3d Dept 2000]; *Monica W. v Milevoi*, 252 AD2d 260, 262 [1st Dept 1999] [medical records]; *Kaplowitz v Borden, Inc*., 189 AD2d 90, 92-93 [1st Dept 1993] [medical records]; *Napoleoni v Union Hosp*., 207 AD2d 660, 662 [1st Dept 1994]).

Crucially, neither a party's embarrassment nor a general desire for privacy is sufficient, of itself, to establish good cause for sealing court records (*see Matter of Holmes v Winter,* 110 AD3d 134, 138 [1st Dept 2013], *revd other grounds* 22 NY3d 300 [2013]; *Mosallem v Berenson*, 76 AD3d 345, 348 [1st Dept 2010]; *Liapakis v Sullivan*, 290 AD2d 393, 394 [1st Dept 2002]; *Matter of Hofmann*, 284 AD2d 92, 93 [1st Dept 2001]; *State of New York ex rel. Aniruddha Banerjee v Moody's Corp*., 54 Misc 3d 705, 708 [Sup Ct, N.Y. County 2016]). This rule frequently has been applied to deny requests for the sealing of medical records, despite a party's contention that the records contained sensitive or embarrassing medical information (*see Kelly D. v Niagara Frontier Tr. Auth*., 177 AD3d 1261, 1264 [4th Dept 2019]; *Ava v NYP Holdings, Inc*., 64 AD3d 407, 416-417 [1st Dept 2009]; *Borek v Seidman*, 2023 NY Slip Op 30617[U], *3-4, 2023 NY Misc LEXIS 854, *4 [Sup Ct, N.Y. County, Mar. 1, 2023] [Kelley, J.]; *Guberman v West*, 2019 NY Slip Op 33508[U], *4-5, 2019 NY Misc LEXIS 6352, *5-6 [Sup Ct, N.Y. County, Nov. 21, 2019]).

Hence, there is no basis upon which to strike the plaintiff's dental and medical records from the court files, and no basis upon which to seal them. Consequently, that branch of the plaintiff's motion seeking to strike or seal her dental and medical records must be denied.

The plaintiff's remaining contentions either are without merit or would not alter this court's legal conclusions.

Accordingly, it is,

ORDERED that the defendant's motion is granted, he is awarded summary judgment dismissing the complaint, and the complaint is dismissed; and it is further,

ORDERED that the plaintiff's cross motion is denied; and it is further,

ORDERED that the Clerk of the court shall enter judgment dismissing the complaint.

This constitutes the Decision and Order of the court.

2/11/2025
DATE

JOHN J. KELLEY, J.S.C.

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