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SUPREME COURT OF THE STATE OF NEW YORK — NEW YORK COUNTY

PRESENT: ALICE SCHLESINGER PART IA PART 16

Index Number : 103102/2008

FISHMAN, GARY

INDEX NO. _____

VS

STEWART, MICHAEL G.

MOTION DATE _____

Sequence Number : 003

MOTION SEQ. NO. _____

SUMMARY JUDGMENT

MOTION CAL. NO. _____

The following papers, numbered 1 to _____ were read on this motion to/for _____

	PAPERS NUMBERED
Notice of Motion/ Order to Show Cause — Affidavits — Exhibits ...	
Answering Affidavits — Exhibits	
Replying Affidavits	

Cross-Motion: ☐ Yes ☒ No

Upon the foregoing papers, It is ordered that this motion for summary judgment is granted as to defendant New York - Presbyterian Hospital - New York Weill Cornell Medical Center and the Clerk is directed to sever and dismiss all claims against that defendant. The motion is denied with respect to defendant Michael G. Stewart, M.D.

FILED

MAR 15 2012

NEW YORK COUNTY CLERK'S OFFICE

Dated: MAR 14 2012

ALICE SCHLESINGER J.S.C.

MOTION/CASE IS RESPECTFULLY REFERRED TO JUSTICE FOR THE FOLLOWING REASON(S):

Check one: ☐ FINAL DISPOSITION ☒ NON-FINAL DISPOSITION

Check if appropriate: ☐ DO NOT POST ☐ REFERENCE

☐ SUBMIT ORDER/ JUDG. ☐ SETTLE ORDER/ JUDG.

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NEW YORK

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GARY FISHMAN and MONA WAKELEY-FISHMAN,

Plaintiffs,

Index No. 103102/08
Motion Seq. No. 003

-against-

MICHAEL G. STEWART, MD., M.P.H., and NEW YORK-PRESBYTERIAN HOSPITAL-NEW YORK WEILL CORNELL MEDICAL CENTER,

Defendants.

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SCHLESINGER, J.:

The medical malpractice action now before the Court on a motion for summary judgment brought by all defendants, Dr. Michael G. Stewart an otolaryngologist (ENT) and New York-Presbyterian Hospital-New York Weill Cornell Medical Center (the Hospital), concerns a modified Caldwell-Luc procedure performed by Dr. Stewart on the plaintiff Gary Fishman on May 16, 2007.

Mr. Fishman claims that he was not properly informed by Dr. Stewart of the possible consequences of this procedure; namely, permanent, painful nerve damage in his mouth, including a neuropathic condition known as stomatodynia or burning mouth syndrome, as well as the exacerbation of his existing facial/oral pain. But Dr. Stewart contends that Mr. Fishman was informed about this procedure in great detail, that he signed a consent form, and most important, that he was not informed of the consequences referred to in his papers because they were "not a reasonably foreseeable anticipated consequence of this procedure" (¶12 of Dr. Stewart's August 30, 2010 affidavit attached as Exh Y to the motion). Rather, he says what was discussed were the risks and complications of this

procedure, which included "bleeding, infection, scarring within the sinus, a scar at the gum line under the lip, transient post operative pain/discomfort at the surgical site ... and transient numbness of the lip and teeth" (¶9 of affidavit).

Mr. Fishman also alleges that Dr. Stewart deviated from good and accepted standards of otolaryngological care by performing unnecessary and contraindicated nasal surgery on his maxillary sinus in the absence of a confirmed diagnosis of chronic and/or acute sinusitis and in light of his symptomology, presentation, complaints and medical history. But Dr. Stewart responds that he performed this procedure without any complications, that he performed it "in all respects in accord with accepted standards of care" (¶4), and that the findings on a CT scan which showed a thickened mucosa in the left maxillary sinus provided a reasonable predicate for an exploration of the sinus and evacuation of the thickened mucosa with an endoscopic procedure or, if not feasible, through a Caldwell-Luc approach with endoscopic technique (¶7).

But arguably most important, Dr. Stewart opines, with support from his expert Dr. John Fantasia who is a dentist and oral pathologist at Long Island Jewish Medical Center, that "nor is it recognized and accepted in the otorhinolaryngology community, that BMS [burning mouth syndrome] is caused by or associated with nasal endoscopic or Caldwell-Luc approach endoscopic maxillary sinus surgery" (¶13).

Dr. Fantasia states that he is very familiar with BMS. He explains that there is a triad of symptoms connected with this disorder. They include a painful and/or burning sensation that can affect the tongue or the whole mouth, perceived dryness in the mouth, and taste changes such as metallic or acidic taste. Since Mr. Fishman has testified that he has experienced all three of these symptoms, Dr. Fantasia believes the diagnosis that

Mr. Fishman is suffering from BMS is a correct one. However, as to the cause of this syndrome, this expert states that "it is generally accepted in the medical and dental community that BMS has no known etiology" and that it is a condition that "arises spontaneously" (¶6 of his affirmation).

Dr. Fantasia discusses his own experiences with his patients. The reports by them as to the onset of BMS symptoms are extremely varied. Some say the symptoms began after eating certain foods or undergoing certain dental procedures. Others say the symptoms began after various surgical or medical procedures, not necessarily related to the mouth or face. He says that "most develop BMS without any apparent temporally related event". Therefore, he opines "within a reasonable degree of medical and dental surgery that nothing Dr. Stewart or NYPH did or allegedly did not do caused Mr. Fishman to develop BMS and its associated symptoms" (¶6).

Further, Dr. Fantasia then provides the predicate for defense counsel's argument, that plaintiff's claim that Dr. Stewart's Caldwell-Luc procedure caused BMS here, is not generally accepted in the medical and dental community. The argument is that because of this lack of acceptance, there is a lack of proximate cause on this issue and the claims should be dismissed. Alternatively, counsel asks the Court to order a *Frye* hearing to assess whether plaintiff's "theory" that Dr. Stewart's procedure caused this syndrome has gained general acceptance.

Dr. Fantasia says that BMS is an idiopathic condition, where the cause is uncertain or not yet determined. He elaborates on this point by saying that neither the medical nor dental community accepts that BMS is caused by any one particular event. Moreover, regarding the claims here, Dr. Fantasia states that surgery, including Caldwell-Luc surgery,

is not accepted in those communities as a primary or contributing cause of BMS. "Therefore, plaintiff's claim that the Caldwell-Luc procedure performed upon him by Dr. Stewart caused his BMS is not scientifically meritorious" (¶7).

It is on the basis of these two opinions by defendant Dr. Stewart and dental expert Dr. Fantasia, together with extensive medical and dental records describing a wide array of doctors and dentists that Mr. Fishman consulted both before and after receiving treatment from Dr. Stewart, that defendants argue they are entitled to summary judgment on all claims. Further, with regard to the hospital defendant, counsel urges, in addition to the arguments made on behalf of Dr. Stewart, that the fact that Dr. Stewart was not an employee of the Hospital relieves the Hospital of any vicarious responsibility for his actions.

In reviewing Mr. Fishman's extensive history relevant to his mouth, moving counsel names all the care providers the plaintiff saw and the treatment he received from each, beginning in November 2006 and continuing through December 2008. Plaintiff's relationship with Dr. Stewart began on April 10, 2007. At that time, Mr. Fishman decided to seek a second opinion from an ENT doctor because of his then six-month history of continuous pain that he had been experiencing in the upper left part of his mouth. This was after he had seen multiple dentists, Dr. Seiden, Dr. Fine, Dr. Pollack (an endodontist), Dr. King and Dr. Miles, and after two teeth in that region had been extracted, numbers 14 and 16. He had also seen his own ENT Dr. Katz and a neurologist Dr. Korenman.

It was Dr. Katz who had ordered a CT scan of Mr. Fishman's head and sinuses, which scan was later reviewed by the defendant and relied upon by him when he recommended an endoscopic procedure to explore and remove mucosal thickening at the bottom of the left maxillary sinus cavity that he saw on the scan.

The surgery was agreed to by the plaintiff after he had asked and had answered a number of questions regarding his understanding of why a Caldwell-Luc approach might be necessary, rather than a nasal approach. During the procedure on May 16, 2007 Dr. Stewart removed the mucosa from the maxilla and sent it for analysis. No infection was found. The defendant has acknowledged that he did not believe the mucosa was the source of Mr. Fishman's pain and that he told the plaintiff of this belief.

The plaintiff saw the defendant on May 21, 2007 and reported that his pain was unchanged. They saw each other again on June 5, 2007. At this visit, Mr. Fishman expressed concern that the Caldwell-Luc procedure had made the discomfort worse. There was one final visit to Dr. Stewart on July 30, 2007. At that time, Mr. Fishman reported that his gums were generating slightly less saliva under his lip near the incision and that he was experiencing cheek pain and tooth numbness. Dr. Stewart responded that he had not anticipated such a complaint.

While he was seeing Dr. Stewart and after, plaintiff also saw Dr. Mintz, a neurologist, who ordered a head MRI on May 25, 2007. She also prescribed Amitriptylene and Neurontin to treat his pain. On July 15, 2007, he also saw Dr. Bassiur a dentist specializing in oral pain, and two other doctors who ruled out any fungal disease.

On October 1, 2007, Mr. Fishman returned to see Dr. Katz, an otolaryngologist, with complaints of burning and numbness on the left side of his tongue. Several days later, on October 4, he again saw dentist Bassiur where he reported experiencing an acidic taste in his mouth and dry mouth and burning. She made a tentative diagnosis of BMS and referred the plaintiff to another dentist and oral pain specialist, Dr. Sirois, in October 2007. He prescribed a number of medications in addition to the Neurontin. Mr. Fishman treated

with him until January 2008 on a bi-weekly basis and then to early June 2008 on a monthly basis.

Finally, in December 2008 plaintiff saw two neurosurgeons. On the 18th of December, he saw Dr. Jeffrey Brown and later, on December 29, for a second opinion he saw Dr. Ramesh Babu. During this period, he was given MRI's of his head.

I find that the defendants' submissions, specifically Dr. Stewart's affidavit and the affirmation from Dr. Fantasia, are sufficient to establish a prima facie case in defendants' favor. Therefore, the burden shifts to plaintiff to address the arguments and convince the Court that neither the law nor the facts compel granting this motion.

As stated at the beginning of this decision, Mr. Fishman claims that Dr. Stewart's surgery of May 16, 2007, was not only unnecessary but was contraindicated as well. He also claims that Dr. Stewart failed to properly and adequately inform him of the risks, benefits and alternatives to this procedure. His counsel supports this position and opposes the motion by submitting sworn statements from two experts and an affidavit from the plaintiff. First, on the issues of departures from accepted medical practice and informed consent, there is an extensive affidavit from a board certified otolaryngologist (the same specialty as Dr. Stewart's) who practices in Massachusetts. Additionally, there is an affidavit from Mr. Fishman. Then, on the issue of causation, there is an affirmation from a dentist who practices in New York, and who is also a Diplomat of the American Board of Oral Medicine and the holder of a PhD in Neuroscience from the University of Pennsylvania.[1]

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[1]Both of these affidavits have omitted the names of the professionals in accordance with accepted practice in medical malpractice actions.

With regard to the informed consent issue, the Massachusetts otolaryngologist (revealed later in a supplemental affidavit to be Dr. John Bogdisarian) opines with a reasonable degree of medical certainty that Dr. Stewart failed to properly and adequately inform Mr. Fishman of the risks attendant to Caldwell-Luc surgery, as well as alternatives to that surgery. Dr. Bogdisarian first indicates that in preparing his affidavit he reviewed relevant records, which included the deposition transcripts of the parties and the medical reports and records. He then states "specifically, Dr. Stewart failed to advise Mr. Fishman that permanent nerve damage could result from Caldwell-Luc surgery and failed to inform him of other, more conservative and less invasive treatments" (¶51).

On this point, there is sharp disagreement with Dr. Stewart. As explained more fully by plaintiff's expert in the early part of his affidavit, he believes that Caldwell-Luc surgery (even of the "mini" or "moderate" version, discussed later) comes with a significant risk of nerve damage and therefore it is reasonably foreseeable that injuries such as "permanent damage to the facial, oral and/or cranial nerves as well as trauma to the roots of the teeth" could occur and it follows that a patient, such as Mr. Fishman, must be told of these possibilities (¶52) But clearly, by Dr. Stewart's own testimony, Mr. Fishman was not so informed. Rather, the defendant emphasized that any post-operative symptoms would be short-lived, in other words, not permanent. Also, Dr. Stewart acknowledges that he never warned this patient of nerve damage.

As to alternatives, this doctor points out that Dr. Stewart never informed the patient that there were, in fact, alternatives, which included "continued observation and monitoring, continued treatment with neuropathic pain medication, different pain medication regimes, nerve blocks, and/or referral to an oral surgeon for further evaluation for persistent pain

that was basically dental/oral in nature, and not related to sinus disease" (¶55). These alternatives were particularly important because, in Dr. Bogdisarians' opinion based on Mr. Fishman's history, presentation and symptoms, the plaintiff was never a suitable candidate for Caldwell-Luc surgery.

Mr. Fishman in his own affidavit briefly discusses his treatment by various health care providers before he "saw Dr. Stewart for a second ENT opinion". Because of some mucosal thickening that might have been causing his persistent pain at or near tooth #14, the defendant suggested that he look inside his sinuses to see if there was anything abnormal or inflamed (¶6).

The plaintiff goes on to say that the defendant advised him that Caldwell-Luc surgery was minimally invasive and would not cause any type of permanent injury, except for a small scar above the gum line. He emphasizes that he was never told that this procedure exposes facial/cranial nerves to significant risk of injury or that it was used primarily for chronic and/or acute sinusitis, which he never had (¶9). He says clearly that he "would have never undergone Caldwell-Luc surgery had he known that the risks of Caldwell-Luc surgery included permanent, irreversible nerve damage" (¶15). He insists that he would have chosen less radical and less invasive remedies for his oral/facial pain and would have "definitely sought a second opinion from another ENT surgeon" (¶'¶ 15-16). Finally, he says that if he had known that Caldwell-Luc surgery was primarily treatment for chronic sinusitis, from which he did not suffer, he would not have risked undergoing this procedure (¶17).

With regard to departures, here again Dr. Bogdisarian (in his first statement in which he is still anonymous) sets down his opinions and the rationale for them very clearly. He

first reviews the relevant history and points out the absence of any symptoms connected with BMS. The complaints were rather of localized, intermittent pain in the area around tooth #14. Then he points to the shared opinion by Dr. Katz, an otolaryngologist, and Dr. Koranmen, a neurologist who the plaintiff saw in March, the month before he saw the defendant, that Mr. Fishman was suffering from "nerve pain and/or neuralgia" and essentially ruled out sinus problems as the cause of his persistent pain (¶¶15 -16).

Dr. Bogdisarian then discusses Caldwell-Luc surgery. He does not say that he is talking about mini, moderate or classic Caldwell-Luc. Instead he begins more generally by saying: "By way of background, the Caldwell-Luc operation is used to relieve severe chronic maxillary sinusitis and/or chronic rhinosinusitis when more conservative treatment has failed" (¶34). He says it is more radical and more invasive than other treatments for this condition. He explains in detail why it is highly invasive. He ends this section by explaining how surgical instruments are used to fenestrate or make an opening into the maxillary sinus so as to scrape out the lining of the sinus. Then he says (at ¶37) that:

> In making such a fenestration, the surgeon must be extremely careful to avoid the roots of the teeth comprising the maxillary jaw because teeth may become devitalized if their blood supply or nerves are injured by fenestration. Caldwell-Luc surgery can also cause severe interference with and can result in permanent damage to the facial/cranial nerves and/or the infraorbital nerve.

Again, the doctor does not limit these descriptions to classic or traditional Caldwell-Luc. He then states his opinion "within a reasonable degree of medical certainty that Dr. Stewart deviated and departed from good and accepted standards of otolaryngological care by performing an unnecessary Caldwell-Luc surgery ... in the absence of a confirmed

diagnosis of severe chronic sinusitis". He also departed, according to Dr. Bogdisarian, by performing a procedure "that was contraindicated in light of Mr. Fishman's symptoms consistent with oral and/or facial nerve damage" (¶¶ 38-39).

Dr. Bogdisarian elaborates on these deviations by pointing out that there was "no evidence whatsoever that [Mr. Fishman] had chronic sinusitis, let alone severe and/or acute sinusitis" (¶40). This was confirmed by his lack of any such symptoms, observed clinically by Drs. Katz and Korenman and diagnostically by the March 16, 2007 CT scan. Further, he adds that "In Mr. Fishman's case, none of the diagnostic criteria for diagnosing sinusitis were met" (¶46).

Finally, Dr. Bogdisarian opines that this surgery was contraindicated "because he [Mr. Fishman] was already experiencing localized, intermittent nerve pain at or near #14, an area that would likely be exposed to significant risk for further nerve damage during the Caldwell-Luc surgery". Therefore, the surgery was "ill-advised and in contradiction to good and accepted standards of otolaryngological care and practice" (¶49).

In Reply in ¶ 24 and in Point II beginning with ¶40, defense counsel argues that the opposition given by plaintiff's ENT doctor is based on a "mistaken premise." He states that the procedure by Dr. Stewart was not a traditional Caldwell-Luc procedure and that the defendant made it "abundantly clear that he conducted the subject procedure endoscopically". Therefore, he argues that a difference exists between a traditional Caldwell-Luc procedure and that performed by Dr. Stewart because the level of invasiveness is less and the instruments are different, as is the size of the incision.

But in fact, while Dr. Stewart may have used endoscopic instruments, he did not perform an endoscopy. That is the procedure he tried but was unable to perform because

of Mr. Fishman's anatomy. Instead, Dr. Stewart performed a type of Caldwell-Luc procedure. Defense counsel has no basis to conclude that Dr. Bogdisarian's opinions ignored the actual procedure Dr. Stewart performed and spoke only about a classic Caldwell-Luc.

In Point II beginning with ¶40, counsel urges the same reasoning, this time as it applies to the lack of informed consent claim. Again defendants argue, and point to Dr. Stewart's affidavit in the moving papers (Exhibit Y, ¶12) for support, that because a modified Caldwell-Luc approach was used, the doctor did not have to tell his patient, Gary Fishman, that there could be permanent nerve damage as a consequence of the procedure.

At oral argument, which was vigorous, I asked moving counsel if it was the defendants' position that the distinction between the classic Caldwell-Luc procedure and the type performed by Dr. Stewart was a significant point because, as far as the Court was concerned, the distinction was not emphasized in the moving papers. While the papers did include an assertion that a non-traditional procedure was used and provided a copy of the operating report, the papers also repeatedly referred to the procedure as simply Caldwell-Luc, without any modifying term attached. For example, In counsel's lengthy affirmation in support of the motion, specifically in ¶¶ 24-26, he describes the visits to defendant's office by Mr. Fishman and what was said and done. There, "Caldwell-Luc" is often used without any modification.

Similarly, in ¶7,in his own affidavit, Dr. Stewart says, "Mr. Fishman was advised that if a Caldwell-Luc (emphasis added) approach was necessary that it would include an incision and access to the maxillary sinus under the lip at the top of the gum line..." and in

¶9 where reference is made to the anticipated risks and complications, Dr. Stewart simply says "from the Caldwell-Luc incision". However, relevant to this point, Dr. Stewart does at one point in his affidavit (attached as Exhibit Y to the moving papers) explain the procedure as being a modified or mini Caldwell-Luc and states the following:

> Allegations that there is a high risk of permanent nerve damage from the modified or mini Caldwell-Luc procedure with endoscopic technique I performed is inaccurate. The procedure I performed was a modified, or "mini" Caldwell-Luc procedure in that the incision in the gum line and the size of the access point to the sinus is smaller in the endoscopic Caldwell-Luc surgery I performed as compared to a "classic" Caldwell-Luc surgery which is possible because small endoscopic surgical tools are used to accomplish the procedure. The typically described nerve-related complications of this endoscopic Caldwell-Luc approach are transient numbness of the lip and teeth.

Therefore, while mentioned, the distinction between the traditional Caldwell-Luc and that performed by Dr. Stewart was somewhat buried as part of Exhibit Y to the voluminous papers and was in no way emphasized. Nor did moving counsel draw pointed attention to that distinction in his legal arguments in his own 73-paragraph affirmation provided with the moving papers. That being the case, I directed plaintiff, over defense counsel's objection, to submit a supplemental affidavit from his expert responding to the argument asserted in the Reply that the opinion of plaintiff's ENT doctor had no value and should be disregarded because the expert might be opining solely on the traditional Caldwell-Luc procedure, although such was never really stated.

The supplemental affidavit I received was detailed and valuable to the Court's understanding of the different ways of performing a Caldwell-Luc procedure and how they

compared. But affiant made it clear that his opinions remained the same as to departures and informed consent, no matter what kind of Caldwell-Luc procedure was done. Specifically, he asserted that "exposure of the facial/cranial nerves located in or near the maxillary sinus to damage via retraction, transection, tearing and/or stretching" is inherent to both Caldwell-Luc approaches (¶10).

He then, with great specificity and reference to Dr. Stewart's operative report, compares the steps used in each approach. He then concludes (at ¶21) "with a reasonable degree of medical certainty" that the procedure performed by the defendant on May 16, 2007 "posed the same risk(s) of nerve damage" because:

> (1) both procedures are performed in the exact same location (at or near the maxillary sinus and its attendant nerves); (2) both procedures involve exposing the same cranial/facial nerves to potential damage, and (3) both procedures involve nearly identical surgical steps.

This doctor also explains where the real differences are; that is, endoscopic surgery is through the nostrils with no incision at all, in contrast to any kind of Caldwell-Luc procedure since those always involve an incision into the gum to gain access to the maxillary sinus through the canine fossa, rather than through the nostrils.

But in any Caldwell-Luc approach, according to Dr. Bogdisarian, damage and/or interference with facial/cranial nerves within the maxillary sinus and/or injury to tooth roots of the upper jaw can occur. This can happen at different stages of each of these procedures, when the incision is made above the canine fossa, when the periosteum is elevated, and during fenestration while creating an opening in the maxillary sinus. All three occur in a classic Caldwell-Luc and in a modified or mini one as well. Most important, pursuant to defendant's *operating report*, all three occurred here.

In reviewing all the papers, as I have done several times, I find that with regard to the issues of departures and informed consent the plaintiff has successfully shown the existence of factual issues sufficient to defeat summary judgment. Most important, I find that plaintiff accomplished this showing solely via his opposition papers, even though the supplemental affidavit on the subject of the mini versus the classic Caldwell-Luc approach was useful — useful, but not necessary to this Court's determination.

Defense counsel in his Reply, as discussed earlier, gave an exaggerated and misleading emphasis to the plaintiff's so-called "mistaken premise". He created an impression that these two approaches were vastly different from each other and that Dr. Bogdisarian was limiting his first discussion to the traditional Caldwell-Luc approach. However, both of these contentions were wrong. As stated earlier, Dr. Bogdisarian never limited his discussion of the risks involved in a Caldwell-Luc approach to the classic type, either explicitly or implicitly.

It should be noted that Dr. Bogdisarian swore in his first affidavit that he had read all the relevant material and records, which presumably included Dr. Stewart's operative report as well as his deposition testimony. Therefore, there was no basis to suggest that his comments were limited to a classic approach. The better, more reasonable assumption is that his comments were directed to what Dr. Stewart actually did. Via good advocacy, defense counsel in his Reply created an illusory argument, the "mistaken premise" one, that justified a response from plaintiff's expert. However, while very detailed and informative, as I stated before, the supplemental affidavit proved to be unnecessary and is not what I relied upon in finding that the plaintiff has successfully opposed the motion as to departures and informed consent.

With regard to causation, where the defendants have argued via the affirmation of Dr. Fantasia that there is none, plaintiff submits an affirmation from a dentist, as well. I previously gave his credentials, but it should be added that he is presently an Attending in the Department of Surgery and Neurology at the NYU Medical Center Tisch Hospital. He has also been Mr. Fishman's primary treating dentist since October 2007.

He first opines within the prescribed standard that Dr. Stewart's Caldwell-Luc procedure performed on the plaintiff on May 16, 2007:

> was the proximate cause of Mr. Fishman's injuries, (1) trigeminal neuropathic pain, a severe pain disorder resulting from injury to the trigeminal nerve, (2) stomatodynia, an incurable neuropathic pain disorder often described as a scalding or burning sensation in the tongue, lips, palate, or entire mouth, (3) dry mouth (xerostomia), (4) taste changes (dysgeusia), as well as (5) a significant exacerbation in severity and frequency of his facial dental neuropathic pain, discomfort and paresthesia (¶6).

This expert also introduces a new medical condition, "stomatodynia". It is essentially the same thing as BMS, including the treatment. What makes them different is "the underlying cause of the condition" (¶18). He agrees with defendants' expert Dr. Fantasia that BMS is understood to be idiopathic in origin (of unknown origin). He agrees with Dr. Fantasia that a patient may develop BMS spontaneously with no known correlation to any specific temporal event. But when there is evidence of a causative event involving nerve injury, then stomatodynia is the preferred and accurate term. Stomatodynia, according to this expert, arises "from an identified cause, to wit, nerve dysfunction and/or nerve damage, unlike burning mouth syndrome which is often considered as idiopathic or psychiatric in origin" (¶21).

Further, the expert explains that post-operative nerve damage and resulting nerve dysfunction are associated with the Caldwell-Luc procedure because of the invasive nature of the surgery. Particularly during fenestration or opening up, he explains, nerves may be injured or stretched, leaving the patient with temporary or permanent neurological complications which include symptoms of BMS.

Specific to Mr. Fishman, he points out that before May 16, 2007, he had no such symptoms as burning, dry mouth, decreased saliva or altered taste sensations. But during the period after the surgery (he says weeks, defense counsel in Reply argues months), he did develop all of these conditions. This expert says such timing is not surprising based on his own experience with patients where "the neurological damage manifests immediately after the surgery/traumatic event or it can develop slowly over time, unnoticeable at first then gradually worsening" (¶39).

Finally, Mr. Fishman's dentist opines with a reasonable degree of medical certainty that the May 16, 2007 surgery by the defendant "significantly exacerbated and/or worsened Mr. Fishman's pre-existing neuralgia." Therefore, not only did he develop these new symptoms in his mouth, but his pre-existing facial and/or oral pain significantly worsened in both intensity and frequency (¶41). This expert concludes his statement with four medical journal articles that purport to show a connection between Caldwell-Luc surgery and various kinds of nerve damage. Each one shows a connection between undergoing a Caldwell-Luc procedure and the later development of neuropathic pain.

In Reply on this point, defense counsel submits a second statement from dentist John Fantasia, who not surprisingly takes issue with plaintiff's expert dentist, specifically as to the latter's discussion of stomatodynia versus burning mouth syndrome. He says there really is no difference between the two and that the terms are used interchangeably.

The remainder of his supplemental affirmation sounds more adversarial than scientific. I say that because as to several points, for example Mr. Fishman's intake of certain medications and his emotional condition, Dr. Fantasia essentially parrots defense counsel's arguments.

This then gets us to those arguments. Dr. Fantasia is highly critical of the plaintiff's expert's opinion and dismisses it as circular and insufficient regarding the distinction between Stomatodynia and BMS. However, these medical terms are not the main thrust of the opinion. Rather, it is that a Caldwell-Luc procedure, involving incision into the gum and other invasive techniques, is traumatic and can and often does cause nerve damage to the mouth and face, damage which can sometimes be permanent. He opines that that is what happened to Mr. Fishman and he explains how.

The points counsel raises in the remainder of his Reply are arguments based on his own interpretation of the evidence. These, I believe, are best left for trial.

As mentioned earlier, as alternative relief, moving counsel asks for a *Frye* hearing. *Frye* hearings are held when the moving party is able to make a showing that a particular theory by the plaintiff is a novel one, one not generally accepted in the medical or dental community. But not in situations such as this one. In the concurring opinion by Justice David Saxe in *Marsh v Smyth*, 12 AD3d 307 (1st Dep't 2004), guidance is provided on the limited role the courts should play in controversies such as this one. The following statement in that opinion (at p 312) is applicable here:

> But more important, in a case such as this, where the proposed expert testimony concerns a claim that the plaintiff's injury was caused by the actions taken by defendants, the whole

> concept of the *Frye* analysis is of limited applicability. Plaintiff's experts were not relying on a newly minted procedure or test, or a newly posited behavioral syndrome; they were simply offering their informed opinion that the way in which defendants handled plaintiff's body while she was unconscious resulted in injury to that part of her body. Expert testimony as to whether the asserted conduct of the defendants was the causative agent for the plaintiff's injury does not really involve anything novel or experimental as contemplated by the *Frye* test. Rather, it is exactly that which is often the primary point of contention in a personal injury action, where the plaintiff offers an opinion that the defendant's conduct caused the injury, and the defendant denies any such conduct and counters that the injury resulted from some other causative agent, unrelated to defendant.

In other words, these kinds of competing claims are best dealt with at trial.

In *Lara v. New York City Health & Hospitals Corp.*, 305 AD2d 106 (1st Dep't 2003), a case cited by the defense, it was proper to hold a *Frye* hearing to consider whether a theory propounded by the plaintiff, that a precipitous delivery could cause a slow bleed resulting in cerebral palsy, was a theory that held general acceptance in the medical community. The hearing was proper because in the first place, the defense was able to show that the theory was not generally accepted. But no such showing has been made here. Therefore, on the issue of causation, I find that the opposition opinion submitted by a dentist, informed as to Caldwell-Luc procedure and based on his own experience in treating patients who have undergone the procedure and its aftermath, and his acquaintance with journals showing a connection between the procedure and serious nerve damage, together with treatment of the plaintiff since 2007, does sufficiently put into issue the claim that Dr. Stewart's surgery caused Mr. Fishman's injuries.

Based on my findings, first on departures and informed consent and now on causation, the plaintiff has sustained his burden in defeating the motion, but only vis-a-vis Dr. Stewart. The Hospital is entitled to have the action against it dismissed as it is clear that Dr. Stewart was not its employee. Therefore, there is no vicarious responsibility for his actions. Finally, there are no independent acts of negligence asserted against the Hospital. All claims here exclusively deal with decisions and actions by Dr. Michael Stewart.

Accordingly, it is hereby

ORDERED that the motion for summary judgment by defendant NEW YORK-PRESBYTERIAN HOSPITAL-NEW YORK WEILL CORNELL MEDICAL CENTER is granted and all claims against that defendant are severed and dismissed; and it is further

ORDERED that the motion by defendant MICHAEL G. STEWART, MD., M.P.H., is denied.

Counsel are directed to appear for a pre-trial conference on March 21, 2012 as previously scheduled prepared to select a trial date.

Dated: March 14, 2012

MAR 14 2012

J.S.C.

ALICE SCHLESINGER