

Ferguson v Wesson

2008 NY Slip Op 30996(U)

March 31, 2008

Supreme Court, Kings County

Docket Number: 0028240/2004

Judge: Gerard H. Rosenberg

Republished from New York State Unified Court System's E-Courts Service.
Search E-Courts (<http://www.nycourts.gov/ecourts>) for any additional information on this case.

This opinion is uncorrected and not selected for official publication.

At an IAS Term, Part MMTRP, of the Supreme Court of the State of New York, held in and for the County of Kings, at the Courthouse, at Civic Center, Brooklyn, New York, on the 31st day of March, 2008.

P R E S E N T:

HON. GERARD H. ROSENBERG,

Justice.

-----X

MARGARET FERGUSON,

Plaintiff,

-against-

JONATHAN WESSON, M.D., JAY MEHTA, M.D., NEW YORK CITY HEALTH AND HOSPITALS CORPORATION and CONEY ISLAND HOSPITAL,

Defendants.

-----X

DECISION & ORDER

Index No. 28240/04

Cal. No. 2007-002379T

Motion Seq. No. 004

The following papers numbered 1 to 4 read on this motion.

	Papers Numbered
Notice of Motion, Affirmation(s)/Affidavit(s) and Exhibits Annexed _____	1 - 2
Affirmation(s) in Opposition and Exhibits Annexed _____	3
Reply Affirmation(s)and Exhibits Annexed _____	4

Upon the foregoing papers, and upon oral argument, defendants Jonathan Wesson, M.D., (Dr. Wesson), Jay Mehta, M.D., (Dr. Mehta), New York City Health and Hospitals Corporation and New York City Health and Hospitals Corporation s/h/a Coney Island Hospital (collectively "CIH") move pursuant to CPLR 3212 for an order granting summary judgment and dismissing the complaint.

This is an action alleging medical malpractice, in which plaintiff alleges that during care rendered at CIH from July 11, 2003 through July 16, 2003 the defendants negligently performed cataract surgery on her left eye, causing a posterior capsule tear to the left eye. Plaintiff alleges

that as a result of the posterior capsule tear, debris and fragments were permitted to fall into the vitreous cavity of her left eye, and remained in her eye for twelve days. Plaintiff claims to have sustained injuries including loss of vision in her left eye, the need for corrective surgery (vitrectomy), and repositioning of the intraocular lens which had been placed during the cataract removal surgery on July 11, 2003. At the time of the alleged malpractice, Dr. Wesson was an attending physician at CIH, and Dr. Mehta was a resident and employee of CIH.

In support of the motion, defendants submit the affirmation of Lawrence R. Blum, M.D., a physician board certified in Ophthalmology and fellowship trained in Oculoplastic Surgery and Neuro-ophthalmology. Dr. Blum states that he has reviewed plaintiff's Notice of Claim and Bill of Particulars; the medical records of plaintiff from CIH, Victory Memorial Hospital Ambulatory Surgery, and Maimonides Medical Center's Ophthalmology Retinal Center; the medical records of Dr. Norman Saffra (a non-party retinal specialist who performed corrective surgery on the plaintiff after the events which are alleged in this lawsuit); an IME report by Dr. Blum; the deposition transcripts of plaintiff, Dr. Mehta and Dr. Wesson; and an affirmation by Dr. David Pinhas.

Dr. Blum opines to a reasonable degree of medical certainty that the care and treatment rendered by the ophthalmologists at CIH conformed to good and accepted standards of medical care. Dr. Blum opines that the cataract surgery which was performed by the defendants on July 11, 2003 was indicated. This surgery consisted of phacoemulsification with insertion of anterior chamber intraocular lens (IOL).¹ Dr. Blum opines that there were no departures from good and

¹ Dr. Blum offers these definitions:
"Anterior chamber" - the space normally filled with saline-like aqueous fluid, between the

acceptable standards of care during the surgical procedure or post-operatively. Dr. Blum notes that the Surgical Report documents the occurrence and recognition of a small posterior tear during the surgery with no vitreous coming into the anterior chamber, that a spatula was used to check the anterior chamber for the presence of vitreous, and that no vitreous was noted. Dr. Blum opines that a tear or rent in the posterior capsule during phacoemulsification surgery is a known intraoperative complication encountered by ophthalmic surgeons, and states that the posterior capsule is a very thin and fragile membrane and a rent or tear can develop for a variety of reasons in the absence of negligence.

Dr. Blum next addresses plaintiff's allegation that the defendants' causing of the tear and allowing debris and fragment to fall into the vitreous of the eye and not recognizing this complication was a violation of acceptable medical/ophthalmological care. Dr. Blum opines that the Surgical Report clearly states that the defendants took the necessary steps to ensure that no

cornea and the iris, the colored tissue that makes the pupil.

“Cataract”- opacification of the lens within the eye. Dr. Blum states that the cataract is surrounded by a thin transparent membrane called the capsule of the lens, and opines that surgery is the only way to remove a cataract.

“Phacoemulsification” - a surgical procedure in which the cataract is removed through an incision with a small ultrasonic hollow needle by vacuum. Also referred to as “phaco.”

“Cornea” - the clear watch-crystal-like tissue which is the front window of the eye.

“Lens” - the internal lens of the eye which is positioned just behind the iris and in front of the vitreous.

“IOL” - artificial lens inserted into the eye to replace a cataract which has been surgically removed.

“Posterior capsule” - the posterior part of the lens capsule that is intended to remain after phacoemulsification surgery and which serves as a barrier to the forward movement of vitreous through the pupil into the anterior portion of the eye.

“Retina” - the tissue that lines the back wall of the eye behind the vitreous that takes the picture for vision, like film in a camera.

“Vitreous” - viscous or semiliquified gel which fills the back two-thirds of the eye behind the lens and in front of the retina.

vitreous material had entered the anterior chamber, including the use of the spatula, but none was noted. Additionally, the Report noted that the pupil was round and regular and that there was no distortion to the pupil, indicative of no vitreous material. Despite these precautions, the tear caused pieces of the lens to fall into the vitreous, necessitating a posterior vitrectomy (performed by non-party Dr. Saffra on July 23, 2003). Dr. Blum opines that this was a well-known risk of the procedure and is a complication for which plaintiff gave her informed consent.

With respect to plaintiff's allegation that it was a departure for the defendants to permit the debris and fragments to remain in plaintiff's eye for twelve days, Dr. Blum addresses several follow-up visits by plaintiff at CIH following the surgery, including a visit on July 16, 2003 where 2 fragments of nuclear material in the vitreous were noted and when plaintiff was recommended an evaluation by a retinal specialist. Dr. Blum notes that defendant Dr. Mehta himself scheduled the appointment for the plaintiff with Dr. Saffra, whom plaintiff saw for the first time on July 17, 2003, the next day, and who operated on plaintiff on July 23, 2003. Dr. Blum opines that plaintiff was timely and appropriately referred to Dr. Saffra, the surgical retinal specialist, and was seen and treated within a reasonable period of time for removal of the retained lens material.

Dr. Blum additionally disagrees with plaintiff's allegation that the IOL was not properly positioned. Dr. Blum states that implantation of an anterior chamber IOL rather than a posterior chamber IOL was not a deviation, and is commonly performed in cases where the posterior capsule has a rent or tear. An IOL is usually implanted into the posterior chamber (behind the iris) and is supported by lens capsule. However, when a rent or tear occurs in the posterior capsule, the capsule may not be adequate to provide safe support for a posterior chamber IOL

and may not be adequate to prevent subluxation or dislocation of a posterior chamber IOL. At the discretion of the surgeon, an anterior chamber IOL may be implanted in front of the iris, as was done in this case. There is no indication in the medical records that the position of the left eye anterior chamber was improper, and CIH clinic progress notes dated July 14 and July 16, 2003 indicate that the anterior capsule was noted to be in place.

Dr. Blum concludes that the posterior capsule tear was an inherent risk of the surgery, that phacoemulsification surgery was properly performed, that the complication was appropriately treated by removal of the prolapsed vitreous from the anterior chamber and placement of an anterior chamber IOL, that plaintiff was referred to a surgical retinal specialist and seen within a reasonable period of time for removal of the retained lens material, and that the IOL was properly implanted.

Plaintiff's Opposition

In opposition to the motion plaintiff submits the affirmation of David J. Pinhas, M.D., a board-certified ophthalmologist. Dr. Pinhas states that he has reviewed the medical records of plaintiff from CIH, Victory Memorial Hospital Ambulatory Surgery, Maimonides Medical Center's Ophthalmology Retinal Center, and from Dr. Norman Saffra; a Patient Lens Implant Card; a transcript of plaintiff's testimony at a 50-h hearing; the deposition transcripts of Dr. Mehta and Dr. Wesson, and the affirmation of defendants' expert, Dr. Blum. Dr. Pinhas opines, to a reasonable degree of medical certainty, that the pre-operative, operative, and post-operative care and treatment rendered by the defendants was substandard and departed from the standard of ophthalmologic/medical care, and was a substantial factor in causing injuries to the plaintiff, including complete loss of vision to her left eye. Dr. Pinhas opines that the defendants

committed the following departures:

1. Failing to obtain and/or timely document Ms. Ferguson's informed consent for the July 13, 2003 (sic) cataract operation;
2. Failing to timely document and diagnose the 2 retained lens fragments in the vitreous chamber, which entered via the posterior capsule tear defendants created;
3. Failing to conduct an ultrasound test or DFE (dilated fundus examination) test to rule out retained lens fragments, particularly where Dr. Wesson admitted to Dr. Mehta that he was concerned that they "missed something" in this regard;
4. Failing to timely (immediately within the first or second day) refer Ms. Ferguson to a retinal specialist for 5 days (by Dr. Weistschner) and waiting 12 days to remove the two retained lens fragments in the vitreous chamber (by Dr. Saffra);
5. Failing to recognize Ms. Ferguson's subjective complaints and objective signs of injury as indicating retained lens fragments in the vitreous cavity;
6. Entrusting Ms. Ferguson's immediate post-operative care to an admitted inexperienced resident, Dr. Mehta, who had never dealt with posterior capsular tears before;
7. Failing to properly position the intra-ocular anterior chamber lens; and
8. Failing to document what happened on Ms. Ferguson's July 12, 2003 follow-up visit which leaves this Court and your Affirmant to guess what happened and raises the question as to whether Defendants negligently or intentionally destroyed this record.

Analysis

Summary judgment should only be granted where there are no triable issues of fact (*Sillman v Twentieth Century-Fox Film Corp.*, 3 NY2d 395, 404 [1957]). In order to prevail on a motion for summary judgment, the movant must present a prima facie case demonstrating entitlement to judgment as a matter of law (*Prince v Di Benedetto*, 189 AD2d 757, 759 [1993]; *Zarr v Piccio*, 180 AD2d 734, 735 [1992]). Once the movant has established his or her prima

facie case, the party opposing the motion bears the burden of “produc[ing] evidentiary proof in admissible form sufficient to require a trial of material questions of fact . . . mere conclusions, expressions of hope or unsubstantiated allegations or assertions are insufficient” (*Zuckerman v City of New York*, 49 NY2d 557, 562 [1980]; see also *Romano v St. Vincent’s Medical Center of Richmond*, 178 AD2d 467 [1991]). Stated differently, “the plaintiff must establish the existence of material facts of sufficient import to create a triable issue” (*Shaw v Time-Life Records*, 38 NY2d 201, 207 [1975]). In addition, the evidence presented on summary judgment must be scrutinized in the light most favorable to the party opposing the motion (*Goldstein v Monroe County*, 77 AD2d 232, 236 [1980]). Since summary judgment deprives a party of his or her day in court (*Henderson v City of New York*, 178 AD2d 129 [1991]), it is a drastic remedy that will only be awarded when there is no triable issue of fact and the court can render a decision as a matter of law (*Barclay v Denckla*, 182 AD2d 658 [1992]).

“The requisite elements of proof in a medical malpractice action are a deviation or departure from accepted medical practice and evidence that such departure was a proximate cause of injury or damage” (*Wiands v Albany Med Ctr.*, 29 AD3d 982, 983 [2006]; see also *Furey v Kraft*, 27 AD3d 416, 417- 418 [2006], *lv denied* 7 NY3d 703 [2006]). Accordingly, defendants in a medical malpractice action are able to fulfill “their prima facie burden of establishing their entitlement to summary judgment by adducing expert opinion evidence that they did not deviate from good and accepted medical practice in their treatment of the [plaintiff]” (*Dandrea v Hertz*, 23 AD3d 332, 332 [2005]). “In opposition, the plaintiff must submit a physician’s affidavit attesting to the defendant’s departure from accepted practice, which departure was a competent producing cause of the injury” in order to defeat the defendant’s

motion (*Rebozo v Wilen*, 41 AD3d 457, 458 [2007])

Preliminarily, defendants have in their motion raised the argument that they are entitled to summary judgment with respect to the allegations of negligent hiring and supervision which plaintiff raised in the Bill of Particulars. This issue has not been addressed in any way by the plaintiff in opposing the motion. The failure of a plaintiff's expert to address salient issues with respect to the alleged departure by the defendants from good and accepted medical practice renders such expert's opinion insufficient to defeat the defendants' motion for summary judgment (*see generally, Ross v*, 44 AD3d 923 [2007]; *Wager v Hainline*, 29 AD3d 569, 571 [2006]). Defendants are therefore awarded summary judgment as to the issue of negligent hiring and supervision.

It is well settled that “[s]ummary judgment is not appropriate in a medical malpractice action where the parties adduce conflicting medical expert opinions” as “[s]uch credibility issues can only be resolved by a jury” (*Feinberg v Feit*, 23 AD3d 517, 519 [2005]; *accord Bengston v Wang*, 41 AD3d 625, 626 [2007]; *Graham v Mitchell*, 37 AD3d 408, 409 [2007]; *Barbuto v Wintrop Univ. Hosp.*, 305 AD2d 623, 624 [2003]; *Fotinas v Westchester County Med Ctr.*, 300 AD2d 437, 439 [2002]; *Halkias v Otolaryngology-Facial Plastic Surgery Assocs.*, 282 AD2d 650, 651 [2001]). Here the court finds that issues of fact exist which preclude the granting of summary judgment, and these medical issues are set forth in the affirmations of the parties' respective experts. Plaintiff's expert's opinions that the defendants departed from accepted standards of medical practice and that such departures were a substantial factor in causing the plaintiff's injuries are not “[m]ere conclusory statements, expressions of hope, or unsubstantiated allegations [which are] insufficient to defeat the motion” (*Gilbert Frank Corp. v Federal Ins.*

Co., 70 NY2d 966, *supra*). When considered against defendants' expert's narratives and findings of an absence of departures and proximate cause, issues of fact have been raised which require resolution by a jury.

For example, Dr. Pinhas opines that defendant failed to obtain an informed consent to perform the cataract removal surgery using phacoemulsification. The plaintiff was known to have pre-existing diabetic retinopathy where the blood cells in the retina die off due to a lack of blood supply. Dr. Pinhas opines that a known risk of phacoemulsification is worsening of diabetic retinopathy which can and did in plaintiff's case lead to blindness. Dr. Pinhas further opines that "[m]erely reciting that loss of vision is a risk of this operation without specifically pointing this out to the patient prohibits the patient from making an informed decision as to whether to have surgery," and notes plaintiff's sworn statement that she was never informed of the risk of blindness or subsequent surgery when she signed the generic informed consent form.

This position is at odds with that of defendants' expert, and defendants point to the testimony from the defendant doctors that the complicating factor of diabetic retinopathy was discussed with the plaintiff. However, Dr. Pinhas points out the admitted alteration of the informed consent form which was prepared in this case. While plaintiff testified that she signed an informed consent prior to the date of the surgery (it is dated May 13, 2003), Dr. Mehta admitted that he altered the informed consent form by adding language to it on the day of the surgery, i.e., July 11, 2003, months after plaintiff had signed it. Dr. Mehta testified that the language which he added pertained to placement of an intraocular lens. Plaintiff's expert opines that Dr. Mehta "saw that the 'risks, benefits, and alternatives' were not written in on May 13, 2003", which raises questions about the propriety of the informed consent in light of plaintiff's

sworn account to the contrary. While this latter statement by Dr. Pinhas is not entirely accurate, insofar as it appears that risks of the surgery were indicated on the informed consent form at the time plaintiff signed it, questions of fact exist as to the nature of the alteration to the form by Dr. Meha, as well as whether the added factor of diabetic retinopathy was discussed with the plaintiff which precludes the granting of summary judgment.

Plaintiff's expert also opines that defendants departed in the performance of the surgery. Drs. Wesson and Mehta admit that a posterior capsular tear was iatrogenically made by Dr. Wesson during the surgery. Dr. Pinhas opines that while a posterior capsular tear does not in and of itself constitute a departure from acceptable ophthalmologic care², "the particular circumstances surrounding the subject surgery raise questions." For example, Dr. Pinhas states that Dr. Mehta was extremely inexperienced, having participated in no more than 10 cataract surgeries prior to the plaintiff's surgery. The surgery was commenced by Dr. Mehta, under the supervision of Dr. Wesson, but Dr. Wesson stepped in and took over the surgery at the point of phacoemulsification. Dr. Pinhas opines that Dr. Mehta's inexperience was revealed when Dr. Wesson determined that the surgery "was proceeding too slowly" and took over the surgery at the phacoemulsification stage. Dr. Wesson admitted that he was concerned because patients begin to move over time. Plaintiff's expert opines that the posterior capsular tear was caused either by Dr. Wesson hurrying to make up time or the plaintiff moving because too much time had elapsed due to Dr. Mehta's inexperience.

² Dr. Pinhas does indicate however that this is not a common occurrence, citing his personal experience. Dr. Pinhas states in his affirmation that posterior capsular tears have occurred in approximately 50 out of the approximately 6000 cataract operations in which he has been involved.

Dr. Pinhas contends that once the tear had been noted everything possible should have been done to ensure that no lens/nuclear fragments entered the vitreous cavity, and if that occurred it should have been immediately noted and plaintiff referred to a retinal specialist no later than the next day. Dr. Pinhas notes that the defendants did not do this, and opines that while defendants' expert has pointed out the steps which were taken by defendants to ensure that no vitreous material had prolapsed forward, Dr. Blum fails to address how defendants failed to note on the operative report that 2 lens/nuclear fragments had traveled posteriorly through the posterior capsular tear on the operative report or otherwise. Dr. Pinhas takes issue with Dr. Mehta's description of the 2 fragments as "small", as this characterization is not found in the records. In addition, Dr. Pinhas believes that the fragments were large, as customarily a cataract lens is only broken into 2 - 4 pieces during the emulsification process. While defendants claim that this belief is speculative, it is in fact based upon the experience of plaintiff's expert as an ophthalmologist who has performed or participated in some 6000 cataract surgeries.

Dr. Pinhas also opines that the defendants failed to use tests such as an ultrasound machine, pointing to Dr. Mehta's testimony that swelling prevented him from seeing the back part of plaintiff's eye during his followup examination on July 12, 2003, the day after the surgery, or a DFE (dilated fundus examination) which was ultimately used by a Dr. Weitschner, a retinal specialist, on July 16, 2003 when the fragments were found in plaintiff's eye.

With respect to the July 12, 2003 visit, Dr. Pinhas states that the loss or destruction of these records "raises serious questions about what important(adverse)information was contained in that record." He cites Dr. Wesson's statement to Dr. Mehta that he had "missed something"with respect to the surgery, and opines that when coupled with the fact that plaintiff


had diabetic retinopathy, the plaintiff should have been immediately referred to a retinal specialist. Instead Dr. Wesson had plaintiff return on the day after the surgery to Dr. Mehta, an inexperienced resident who had never before dealt with a posterior capsule tear, and the records of that visit are missing.

Dr. Pinhas also opines that the delay of 12 days until the performance of the corrective surgery was not reasonable, as claimed by defendants' expert. While defendants contend that there was no evidence of the fragments until July 16, 2003, which the Court believes was the third post-operative visit, and that plaintiff was then referred to the retinal specialist, plaintiff's expert has set forth his expert opinion that the fragments should have been diagnosed and addressed earlier.

With respect to Dr. Mehta's application to be granted summary judgment because he was a resident and did not exercise independent medical judgment, plaintiff's expert again has raised questions of fact, among them Dr. Mehta's examination of the plaintiff following the surgery, the nature of which is clouded by the loss or destruction of the pertinent records.

Plaintiff has, therefore, created the necessary questions of fact as to departures from accepted standards of medical practice and proximate cause which mandate denial of the summary judgment motion, except as to the extent indicated.

This constitutes the decision and order of the court.

ENTER 

HON. GERARD H. ROSENBERG

J. S. C.