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SHORT FORM ORDER

INDEX No. 09-4554
CAL. No. 10-02624MM

SUPREME COURT - STATE OF NEW YORK
I.A.S. PART 43 - SUFFOLK COUNTY

COPY

PRESENT:

Hon. ARTHUR G. PITTS
Justice of the Supreme Court

MOTION DATE 4-11-12
ADJ. DATE 4-26-12
Mot. Seq. # 004 - MD

THERESIA CICALI, as Executrix of the Last Will and Testament of Nick J. Cicali, Deceased, Plaintiff, - against - ROBERT HONKANEN, M.D., FADI EL BABA, M.D., and UNIVERSITY PHYSICIANS AT STONY BROOK, Defendants.	ROSENBERG, MINC, FALKOFF & WOLFF, LLP Attorney for Plaintiff 122 East 42nd Street, Suite 3800 New York, New York 10168 KAUFMAN BORGEEST & RYAN, LLP Attorney for Defendants 1205 Franklin Avenue, Suite 200 Garden City, New York 11530

Upon the following papers numbered 1 to 23 read on this motion for summary judgment ; Notice of Motion/ Order to Show Cause and supporting papers (004) 1 - 17 ; Notice of Cross Motion and supporting papers _; Answering Affidavits and supporting papers 18-21; Replying Affidavits and supporting papers 22-24 ; Other _; (~~and after hearing counsel in support and opposed to the motion~~) it is,

ORDERED that motion (004) by the defendants, Robert Honkanen, M.D., Fadi El Baba, M.D., and University Physicians at Stony Brook, pursuant to CPLR 3212 for summary judgment dismissing the complaint is denied.

In this action premised upon the alleged medical malpractice of the defendants, the plaintiff, Theresia Cicali, on behalf of the decedent, Nick J. Cicali, alleges that the defendants, Robert Honkanen, M.D., Fadi El Baba, M.D., and University Physicians at Stony Brook, negligently departed from good and accepted standards of medical care and treatment of the decedent, in and about October 2007 and thereafter, while performing a cataract extraction from his left eye with insertion of an intraocular lens, causing him to sustain a giant retinal tear and hemorrhage, and then delaying in calling a consult with a retinal specialist, performing an inadequate vitrectomy, failing to provide corrective surgery for two weeks, and failing to perform an iridectomy. As a result of these alleged departures, it is further alleged that the plaintiff's decedent's vision deteriorated from 20/60 to loss of vision in his left eye, he had retained lens fragment, high myopia with intraocular inflammation and ocular hypertension, severe phacolytic reaction of the left eye with secondary glaucoma, and further reparative surgery which was not successful in treating the decedent. The plaintiff has asserted causes of action for negligence, and lack of informed consent, and asserts that University Physicians at Stony Brook is vicariously liable for the negligence of defendants Honkanen and El Baba.

The proponent of a summary judgment motion must make a prima facie showing of entitlement to judgment as a matter of law, tendering sufficient evidence to eliminate any material issues of fact from the case. To grant summary judgment it must clearly appear that no material and triable issue of fact is presented (***Friends of Animals v Associated Fur Mfrs.,*** 46 NY2d 1065, 416 NYS2d 790 [1979]***; Sillman v Twentieth Century-Fox Film Corporation***, 3 NY2d 395, 165 NYS2d 498 [1957]). The movant has the initial burden of proving entitlement to summary judgment (***Winegrad v N.Y.U. Medical Center***, 64 NY2d 851, 487 NYS2d 316 [1985]). Failure to make such a showing requires denial of the motion, regardless of the sufficiency of the opposing papers (***Winegrad v N.Y.U. Medical Center***, *supra*). Once such proof has been offered, the burden then shifts to the opposing party, who, in order to defeat the motion for summary judgment, must proffer evidence in admissible form...and must "show facts sufficient to require a trial of any issue of fact" (CPLR 3212[b]; ***Zuckerman v City of New York***, 49 NY2d 557, 427 NYS2d 595 [1980]). The opposing party must present facts sufficient to require a trial of any issue of fact by producing evidentiary proof in admissible form (***Joseph P. Day Realty Corp. v Aeroxon Prods.***, 148 AD2d 499, 538 NYS2d 843 [2d Dept 1979]) and must assemble, lay bare and reveal his proof in order to establish that the matters set forth in his pleadings are real and capable of being established (***Castro v Liberty Bus Co.,*** 79 AD2d 1014, 435 NYS2d 340 [2d Dept 1981]).

The requisite elements of proof in a medical malpractice action are (1) a deviation or departure from accepted practice, and (2) evidence that such departure was a proximate cause of injury or damage (***Holton v Sprain Brook Manor Nursing Home***, 253 AD2d 852, 678 NYS2d 503 [2d Dept 1998], *app denied* 92 NY2d 818, 685 NYS2d 420). To prove a prima facie case of medical malpractice, a plaintiff must establish that defendant's negligence was a substantial factor in producing the alleged injury (*see,* ***Derdiarian v Felix Contracting Corp.***, 51 NY2d 308, 434 NYS2d 166 [1980]; ***Prete v Rafla-Demetrious,*** 221 AD2d 674, 638 NYS2d 700 2d Dept 1996]). Except as to matters within the ordinary experience and knowledge of laymen, expert medical opinion is necessary to prove a deviation or departure from accepted standards of medical care and that such departure was a proximate cause of the plaintiff's injury (*see,* ***Fiore v Galang***, 64 NY2d 999, 489 NYS2d 47 [1985]; ***Lyons v McCauley,*** 252 AD2d 516, 517, 675 NYS2d 375 [2d Dept 1998], *app denied* 92 NY2d 814, 681 NYS2d 475; ***Bloom v City of New York,*** 202 AD2d 465, 465, 609 NYS2d 45 [2d Dept 1994]).

To rebut a prima facie showing of entitlement to an order granting summary judgment by the defendant, the plaintiff must demonstrate the existence of a triable issue of fact by submitting an expert's affidavit of merit attesting to a deviation or departure from accepted practice, and containing an opinion that the defendant's acts or omissions were a competent-producing cause of the injuries of the plaintiff (*see,* ***Lifshitz v Beth Israel Med. Ctr-Kings Highway Div.***, 7 AD3d 759, 776 NYS2d 907 [2d Dept 2004]; ***Domaradzki v Glen Cove OB/GYN Assocs.***, 242 AD2d 282, 660 NYS2d 739 [2d Dept 1997]). "Summary judgment is not appropriate in a medical malpractice action where the parties adduce conflicting medical expert opinions. Such credibility issues can only be resolved by a jury" (***Bengston v Wang,*** 41 AD3d 625, 839 NYS2d 159 [2d Dept 2007]).

In support of motion (004), the defendants have submitted, inter alia, an attorney's affirmation; copies of the summons and complaint, defendants' respective answers, and the plaintiff's verified bills of particulars; uncertified medical records; and copies of deposition transcripts of Robert Honkanen, M.D. dated February 26, 2010, Fadi El Baba, M.D. dated June 15, 2010, and Nick J. Cicali dated December 18, 2009, Theresia Cicali dated August 25, 2010; and the affidavit dated March 2, 2011 of defendants' expert physician David M. Fastenberg, M.D. None of the deposition transcripts are in proper sized print and fail to comport with CPLR 2101 (a). The uncertified

medical records submitted by the defendants in support of this motion are not in admissible form pursuant to CPLR 3212 (*see*, ***Friends of Animals v Associated Fur Mfrs.***, *supra*). Expert testimony is limited to facts in evidence. (*see also*, ***Allen v Uh,*** 82 AD3d 1025, 919 NYS2d 179 [2d Dept 2011]; ***Hornbrook v Peak Resorts,*** Inc. 194 Misc2d 273, 754 NYS2d 132 [Sup Ct, Tomkins County 2002]; ***Marzuillo v Isom,*** 277 AD2d 362, 716 NYS2d 98 [2d Dept 2000]; ***Stringile v Rothman***, 142 AD2d 637, 530 NYS2d 838 [2d Dept 1988]; ***O'Shea v Sarro***, 106 AD2d 435, 482 NYS2d 529 [2d Dept 1984]).

In any event, even if the deposition transcripts comported with CPLR 2101 (a), and the medical records were certified in admissible form, there are factual issues which preclude summary judgment from being granted to the moving defendants.

David M. Fastenberg, M.D., the defendants' expert physician, averred that he is licensed to practice medicine in New York and is board certified in opthamology. He set forth his education and training and the records and materials which he reviewed. He opined with a reasonable degree of medical certainty that at all times the defendants acted in accordance with good and accepted medical care and practice and did not proximately cause any of the decedent's alleged injuries and damages.

Dr. Fastenberg stated that the decedent, at age 71, first presented to Stony Brook Opthamology on April 30, 2002 with complaints of photo sensitivity, distorted vision, and presumed cataracts. Upon examination by Dr. Honkanen, his visual acuity was 20/40 in his right eye and 20/50 in his left eye. Cataracts were noted in both eyes. Dr. Honkanen continued to see the decedent on subsequent visits. Through July 8, 2004, visual acuity was stable in the right eye and was improved with corrective lenses for the left eye. On July 13, 2006, Dr. Honkanen saw the decedent again, at which time, he stated he could only drive during the day and had intermittent blurriness for periods of up to thirty minutes. On June 14, 2007, he advised Dr. Honkanen that he had been hospitalized in February for pneumonia and had elevated blood sugars. He noted his vision had worsened. Upon examination, visual acuity in the right eye was 20/30 and in the left eye was 20/60. Dr. Honkanen indicated that in September 2007, he planned surgery for cataract removal, with the plaintiff agreeing to the same. The left eye was to be operated on first.

Dr. Fastenberg stated that according to his deposition testimony, Dr. Honkanen told the plaintiff that the surgery is elective, that cataracts do not improve, and, if fixed, his vision would improve. He advised that local anesthesia by eye drops would be used. He explained the risks of surgery, including bleeding, infection, loss of vision, the need for more surgery, the lens falling into the back of the eye requiring a second surgery, and corneal cloudiness. Preoperative testing was conducted on October 23, 2007, at which time the decedent signed the consent form which indicated that a cataract extraction and implantation of an intraocular lens of the left eye would be done. The form also indicated that he was advised of the potential benefits and risks and side effects, including bleeding, infection, glaucoma, loss of vision, droopy lid, double vision, loss of eye, retinal detachment, risk of anesthesia, corneal clouding, and the need for additional surgery.

Dr. Fastenberg continued that Dr. Honkanen conducted the surgery on October 29, 2007 consisting of left eye phacoemulsification with posterior chamber lens implant and anterior vitrectomy. According to the operative report, prior to the phacoemulsification, an initial groove was started, and when a deeper grove was attempted, it was noted that the lens was not stable. The entire nucleus moved into the subincision area and tilted vertically, with

a significant portion of the nucleus posterior to the lens capsule. Dr. Honkanen attempted to rotate the lens to a more stable position without success, believing that a posterior levitating technique to remove the old lens would be ineffective. He planned to have subsequent surgery performed on the decedent by a retinal specialist. He inserted the new lens into the left eye to avoid a third procedure.

Dr. El Baba, a retinologist, was notified that the lens dropped into the back of the eye, it required removal and that the decedent's eye was stable. Dr. El Baba stated that it was appropriate to wait a week before seeing the patient. The decedent was discharged and saw Dr. Honkanen the following day. The decedent saw Dr. El Baba on November 7, 2009 at which time it was noted that the vision in his left eye was 1/200, and that the left eye had a severe phacolytic reaction with secondary glaucoma. Dr. Fastenberg stated that Dr. El Baba prescribed oral medication to help reduce the inflammation in the eye, and eye drops were administered to help reduce the pressure from the glaucoma in his left eye. He wanted to see how the decedent responded to treatment before deciding when to recommend surgery. Medical clearance was necessary for a determination concerning whether his Coumadin could be stopped.

Dr. Fastenberg stated that the decedent signed a consent form on November 9, 2007, authorizing Dr. El Baba to perform a pars plana vitrectomy, membrane dissection, endolaser cryotherapy of the left eye, and to treat the retina and remove the retained lens fragment. The risks contained on the consent form included loss of vision, loss of eye, need for further surgery, and retinal detachment. Dr. Honkanen re-checked the intraocular pressure of left eye and found it elevated at 36 mm Hg on November 13, 2007. On November 15, 2007, Dr. El Baba performed surgery using a fragmatome to aspirate and fragment the retained lens, however, the lens was hard and did not fragment. Thereafter, Dr. El Baba used a 2-hand technique to break up and remove the pieces of lens, however, the larger pieces fell onto the posterior pole and caused hemorrhages in the retina, as well as retinal tears in the temporal midperiphery and interior midperiphery. The temporal retina then began to detach from a superotemporal dialysis. As Dr. El Baba used a foreign body forceps to extract pieces of lens fragments, the retina continued to detach causing a supranasal choroidal detachment. Thereafter, Dr. El Baba stopped recovery of the fragments. An air fluid exchange was performed to stabilize the eye and maintain the retina, leaving the retina detached at an inferior location. The following day, the decedent's intraocular pressure in his left eye was decreased to 6 mm/Hg, with evidence of possible persistent detachment of the retina. A scan of the left eye on November 19, 2007, revealed no gross choroidal detachment, but showed an hyphema, or hemorrhage into the anterior chamber of the left eye. The decedent was advised of a guarded visual prognosis. It was suggested that he have a second opinion from Dr. Repucci, a retinal specialist, without urgency as the eye was stable.

Dr. Repucci saw the decedent on November 19, 2007 and noted that there had not been a successful removal of the retained lens, and that there was corneal edema and an hematoma. Dr. Repucci recommended additional surgery to remove the lens. On December 5, 2007, at New York Presbyterian Hospital, Dr. Repucci performed a vitrectomy with membrane peel, endolaser and silicone oil injection of the decedent's left eye, and removed the remaining lens fragment using a cutter and fragmatome. It was noted that there was a moderate amount of blood inside the eye, and the retina was detached inferotemporally with linear breaks noted. The macular area showed multiple posterior breaks with subretinal blood.

When Dr. El Baba examined the decedent on December 6, 2007, the vision in the decedent's left eye was 1/200, pressure was 22 mm/Hg, the anterior chamber remained formed, the posterior capsule intraocular lens was

centered, and the retina was flat with good silicone oil fill. Dr. El Baba saw the plaintiff several more times, thereafter. On January 4, 2008, the decedent had only light perception with his left eye.

Dr. Fastenberg continued that it is his opinion that Dr. Honkanen appropriately determined the decedent was a candidate for cataract surgery, that the dropped lens is a well known and described complication of cataract surgery and not indicative of malpractice, and that the decedent was advised of that potential complication prior to surgery. He continued that dropping the lens into the posterior chamber is not in and of itself evidence of malpractice, and can happen under the best of circumstances. However, Dr. Fastenberg's opinion is conclusory and he does not state what if anything Dr. Honkanen did or did not do to help avoid such occurrence, and how he comported with good and accepted procedure during the surgery. Dr. Fastenberg continued that it was appropriate for Dr. Honkanen not to further attempt to retrieve the lens, as a pars plana vitrectomy should be left to a retina specialist. He stated that it was proper for Dr. Honkanen to thereafter perform a vitrectomy to clean up around the lens and to place a new lens into the sulcus, thus avoiding an additional surgery. He adds that it would not have been appropriate for Dr. Honkanen to perform an iridectomy as it could have caused further bleeding. Any delay in further treatment did not proximately cause any damage to the plaintiff's left eye. Dr. Fastenberg also opined that the decedent was properly provided with informed consent for this elective surgery.

Dr. Fastenberg stated that Dr. El Baba made a reasonable judgment call to wait for medical clearance prior to performing the second surgery, and to reduce the Coumadin levels prior to surgery. Dr. Fastenberg stated that Dr. El Baba's use of the fragmatome to aspirate the lens was reasonable and appropriate, and when the hard lens failed to fragment, it was also appropriate for him to use a 2-hand technique to break up the lens, and then use a foreign body forceps to extract pieces of the lens fragments. This, he stated, did not increase the damage to the decedent's eye. He continued that a detached retina is a known complication of a pars plana vitrectomy for dislocated lens fragments, of which the plaintiff was advised prior to surgery pursuant to informed consent. He stated that Dr. El Baba's technique in performing the pars plana vitrectomy was reasonable and not indicative of malpractice. However, Dr. Fastenberg's opinion is conclusory as he does not state what technique was used, how it comported with the standard of care, and what steps were taken to avoid the complication of a detached retina and hemorrhage.

Based upon the foregoing, the defendants have not established prima facie entitlement to summary judgment dismissing the complaint. Moreover, the plaintiff has raised factual issues which preclude the granting of summary judgment.

The plaintiff's expert is licensed to practice medicine in New York and is board certified in opthamology. He set forth his education, training and experience, and the records and materials which he reviewed. It is plaintiff's expert's opinion with a reasonable degree of medical certainty that there were departures from the standard of care by the defendants in the treatment rendered to the plaintiff's decedent, and that those departures were a substantial factor in causing the loss of vision in his left eye. The plaintiff's expert stated that cataract surgery is not without significant risk of complications, and the risk of such complications increases in a patient of advanced age, such as the decedent, who was eighty years old when the cataract surgery was performed on October 29, 2007 by Dr. Honkanen. He continued that it should be clearly documented in the record that the decedent was having visual difficulty with the activities of daily living important to him, that the cause of the difficulties is due to cataracts, and that there is substantial expectation that the improvement of vision with cataract removal and lens placement will correct these visual difficulties with the activities of daily living.

The plaintiff's expert opined that defendant Robert Honkanen, M.D. failed to conduct a meaningful informed consent discussion with the decedent prior to performing the cataract surgery. The deposition testimony of the decedent and that of his wife states that there was absolutely no discussion by Dr. Honkanen of any potential risks or complications, and that Dr. Honkanen guaranteed that the decedent would have 20/20 vision after the surgery. The expert continued that it is not sufficient to have a patient, especially an elderly patient, sign a consent form which only lists potential complications without a clear discussion and acknowledgment by the patient of an understanding of the risks. When Dr. Honkanen first saw Mr. Cicali in 2002, he reported a history of heart disease (angina, arrythmia, congestive heart failure), and that he was taking Coumadin, Amiodarone, Coreg, and other medications. Given this history, Dr. Honkanen should have had a discussion, which encompassed the risk/benefit analysis with the decedent and his wife who attended every visit with the decedent. The plaintiff's expert stated that had Mr. Cicali been advised that he could lose vision in his eye as a result of the cataract removal, through a complication such as a dropped nucleus, or retinal detachment, which would require one or more subsequent surgeries, he would have declined to undergo the surgery. The plaintiff's expert opined that it was a breach of the prevailing standard of care for Dr. Honkanen not to have conducted a detailed discussion of the risks with the decedent, proximately causing the need for subsequent repair surgery.

The plaintiff's expert opined that prior to the surgery by Dr. El Baba on November 15, 2007, the decedent still had a very good chance of visual recovery to his left eye. However, he continued, Dr. El Baba caused damage to the decedent's eye by virtue of excessive, continued, and unnecessary manipulation of the eye during the surgical repair procedure. Dr. El Baba, as noted from his operative report, was aware of retinal hemorrhages starting once he switched to a two-handed technique to crush the pieces of lens. Prudence required him to stop the procedure. The plaintiff's expert continued that it was not a question of judgment whether to continue or to stop, and further attempts at crushing the lens with the powerful instrument were sure to cause further tears in the retina, thus virtually guaranteeing that the decedent would be blind in his left eye. The plaintiff's expert opined that it was a breach of the standard of operative care for Dr. El Baba to have continued attempts to crush the lens, and that he should have stopped at the first sign of retinal hemorrhage. The decedent's eye could then have been salvaged by permitting another surgeon to treat the condition. The plaintiff's expert opined that the failure to stop the procedure when the hemorrhage was first noted was the proximate cause of the decedent's loss of vision.

Accordingly, motion (004) by the defendants for summary judgment dismissing the complaint is denied.

Dated: June 19, 2012

J.S.C.

____ **FINAL DISPOSITION** __X__ **NON-FINAL DISPOSITION**