Elkin v Lee
2014 NY Slip Op 33588(U)
September 4, 2014
Supreme Court, New York County
Docket Number: 800272/11
Judge: Joan B. Lobis

SUPREME COURT OF THE STATE OF NEW YORK
NEW YORK COUNTY: IAS PART 6

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MICHAEL ELKIN,

Plaintiff,

Index No. 800272/11

-against-

Decision and Order

STEVE K. LEE, M.D., JORGE ROMAN, M.D., and NEW YORK UNIVERSITY HOSPITAL FOR JOINT DISEASES,

Defendants.

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JOAN B. LOBIS, J.S.C.:

This action arises out of Plaintiff Michael Elkin's nerve decompression surgery, which was performed by Defendant Steve K. Lee, M.D., a board certified orthopedic surgeon and an employee of Defendant NYU Hospitals Center s/h/a New York University Hospital for Joint Diseases ("NYU").[1] Mr. Elkin alleges medical malpractice and lack of informed consent. Defendants Steve K. Lee, M.D., and NYU now move pursuant to Section 3212 of the Civil Practice Law and Rules for summary judgment. For the following reasons, the motion is denied.

On August 10, 2010, Michael Elkin first presented to Dr. Steve K. Lee. Mr. Elkin complained of pain and tenderness in his right hand, wrist, arm, and shoulder. Dr. Lee diagnosed him with radial tunnel syndrome, and prescribed a wrist splint to "unload the muscles of the radial tunnel." Dr. Lee prescribed non-steroidal anti-inflammatory medications. He advised Mr. Elkin to have a follow-up appointment within four to six weeks.

[1] Defendant Jorge Roman, M.D., has not appeared.

Ten days later Mr. Elkin returned to see Dr. Lee due to worsening pain in his forearm, tingling in his small and ring fingers, and grip weakness. Dr. Lee noted the tenderness over both the radial tunnel and cubital tunnel with radiation down the ulnar side of the forearm to the small and ring fingers. Mr. Elkin had a "positive Tinel's sign" – a test performed to detect irritated nerves by tapping lightly on the nerve. Dr. Lee noted that there was worsening radial tunnel syndrome and cubital tunnel syndrome, which is also known as ulnar neuritis or the compression of the ulnar nerve.

Dr. Lee prescribed an elbow extension brace to be worn at night, in addition to the wrist split that Mr. Elkin was already using. Dr. Lee also discussed surgery to release the posterior interosseuous nerve within the radial tunnel, an ulnar nerve decompression, and sub-muscular transposition. After the discussion, Mr. Elkin decided to continue conservative treatment while considering the option of surgery.

The brace did not relieve Mr. Elkin's pain, and his pain moved across the hand and up to his elbow. By mid-September 2010 Mr. Elkin could no longer open a jar or hold a pen. He scheduled surgery with Dr. Lee to address the dysfunction in his right arm. On September 13, 2010, Mr. Elkin had pre-admission testing at NYU's Hospital for Joint Diseases, at which time he complained of continuous pain in his right hand, forearm, and elbow; limited range of motion and difficulty using his right arm; severe weakness in his right hand, wrist, and fingers; and tingling in his fingers.

Mr. Elkin received surgery on September 20, 2010. Prior to the surgery, Mr. Elkin received a note documenting his progress ("progress note"), and signed a "Consent for Surgery and/or Interventional Procedures and Medical Treatment" form. Dr. Lee performed a right radial nerve decompression at the forearm, right extensor carpi radialis brevis (ECRB) tendon release, right supinator tendon release, ulnar nerve decompression at the medial elbow, tendon release, repair flexor pronator, and long arm splint.

After the surgery, Mr. Elkin experienced throbbing pain and pins and needles in his thumb, forefinger, and middle finger, which radiated to the back of his arm. He saw Dr. Lee for a follow-up appointment on October 1, 2010, during which he complained of swelling and pain. Dr. Lee removed the wrist splint. He noted that Mr. Elkin had normal post-operative swelling. He determined that Mr. Elkin was doing well, and instructed him to begin occupational therapy.

Two weeks later Mr. Elkin returned to Dr. Lee for complaints of tingling in the area of the superficial radial nerve. Dr. Lee noted that the wounds were well-healed, but Mr. Elkin was experiencing superficial radial nerve neurapraxia. Dr. Lee informed Mr. Elkin that neurapraxia tends to resolve in time and instructed him to continue occupational therapy. Mr. Elkin returned again on November 12, 2010. Dr. Lee noted that Mr. Elkin stated that his superficial radial nerve tingling was improving, and that he had full range of motion of the bilateral shoulders, elbows, wrists, and hands. He instructed Mr. Elkin to return in six weeks. On December 17, 2010, Mr. Elkin had another follow-up appointment, at which Dr. Lee noted the patient still had superficial radial nerve neurapraxia, which was resolving, and instructed Mr. Elkin to return in six weeks.

On February 22, 2011, Mr. Elkin began treating with Otis Alton Barron, M.D., an orthopedist and hand surgeon. Dr. Barron diagnosed Mr. Elkin with a lesion of the radial nerve, and referred him for a motor/sensory nerve conduction study or electromyography ("EMG"). The study was performed on March 4, 2011, by Ramon Valderamma, M.D., a neurologist. Dr. Valderamma concluded that Mr. Elkin had right radial sensory neuropathy, consistent with possible chronic regional pain syndrome. Dr. Valderamma recommended that he see a pain management specialist.

Mr. Elkin saw pain management specialist Michael Weinberger, M.D., on March 28, 2011. Dr. Weinberger noted that the patient complained of pain, swelling, and color changes to his right hand. He determined that Mr. Elkin had cervicobrachial syndrome, but needed further evaluation to check for problems with the cervical spine and brachial plexus. Dr. Weinberger ordered an MRI for Mr. Elkin.

Several days later, Mr. Elkin returned to see Dr. Lee, who suggested that he may need additional surgery. Dr. Lee assessed that Mr. Elkin had possible neuroma of the superficial radial nerve and possible complex region pain syndrome. He referred Mr. Elkin to a pain specialist, and discussed the possibility of decompressing the superficial radial nerve. Mr. Elkin decided not to return to Dr. Lee after this visit.

On April 11, May 16, June 13, and July 11, 2011, Mr. Elkin returned to see Dr. Weinberger. The MRI Dr. Weinberger ordered revealed that Mr. Elkin had "multilevel degenerative changes cervical spine with disc osteophyte complexes. . . ." Dr. Weinberger

diagnosed Mr. Elkin with reflex sympathetic dystrophy, which is another name for complex regional pain syndrome. Another MRI was performed in September 2013, which indicated degenerative disc disease and disc protrusion in Mr. Elkin's cervical spine. At this visit, Dr. Weinberger again diagnosed him with reflex sympathetic dystrophy.

Plaintiff commenced this action on August 10, 2011. In the complaint, Plaintiff alleges two causes of action: medical malpractice and lack of informed consent. The verified bill of particulars alleges that Dr. Lee failed to timely diagnose Mr. Elkin with reflex sympathetic dystrophy/complex regional pain syndrome, and improperly treated him for nerve compression by performing nerve decompressions and tendon releases. He also alleges that Dr. Lee did not disclose all risks and dangers of treatment, or the alternatives to the treatment. Defendants Dr. Lee and NYU now move for summary judgment.

Defendants argue that they have established a prima facie case for summary judgment. They contend that there were no departures from the standard of care in Dr. Lee's treatment of Mr. Elkin, and that proximate cause cannot be shown. In support of the motion for summary judgment, Defendants provide the expert medical affirmation of Roy G. Kulick, M.D., a New York licensed physician who is board certified in orthopedic surgery.

Dr. Kulick avers that during the preoperative management of the Plaintiff, Dr. Lee properly assessed and diagnosed the patient's radial tunnel syndrome of the right arm. Dr. Kulick opines that the standard of care does not require performing an EMG study for this condition, and that such a study would offer little diagnostic reliability. He contends that the surgery performed

by Dr. Lee was planned and performed appropriately, and that Mr. Elkin was appropriately monitored following the surgery.

Defendants' expert further opines that Dr. Lee correctly diagnosed Mr. Elkin with a neuroma on April 1, 2011. He affirms that a neuroma is a known and accepted risk of any nerve surgery. He contends that if Plaintiff developed reflex sympathetic dystrophy or complex regional pain syndrome, then it is not evidence of a departure by Dr. Lee. He claims that these conditions are "completely unpredictable" and "not fully understood in the medical community." Nonetheless, Dr. Kulick opines that Plaintiff does not have reflexive sympathetic dystrophy, and that Plaintiff's symptoms are consistent with neuroma development of the superficial radial nerve.

Defendants also contend that Mr. Elkin was made aware of the risks, benefits, and alternatives to the procedures performed by Dr. Lee. Defendants claim that Dr. Lee's Operative Report, dictated the same day as Mr. Elkin's surgery, and a Progress note from September 20, 2010, indicate that Dr. Lee informed the patient of the alternatives to treatment and the potential risks. Defendants argue that Mr. Elkin was informed, both by Dr. Lee prior to the procedure and through independent research, regarding his condition and alternative treatment options. Defendants also assert that Mr. Elkin signed a consent form stating that he was aware of the risks, benefits, and alternatives to surgery.

In opposition to the motion for summary judgment, Plaintiff argues that the motion must be denied because triable issues of fact exist both with regard to the medical malpractice and lack of informed consent claims. In support of the opposition, Plaintiff provides the expert

affirmation of a physician whose name has been redacted. An unredacted version of the expert affirmation has been provided for the Court. The physician is licensed to practice medicine in the State of New York, and is board certified in orthopedic surgery.

Plaintiff's expert opines that the Defendants departed from good and accepted medical practice by failing to prescribe sufficient non-operative care and treatment for Mr. Elkin. Additionally, they departed from good and accepted medical practice by prematurely deeming non-operative measures as having failed after only one month. He avers that Defendants failed to rule out alternative etiologies for Mr. Elkin's complaints by not performing an EMG or a "work-up of potential cervical/brachial injury."

The expert opines that Mr. Elkin's complaints were not caused by ulnar or radial nerve compression. He affirms that the Plaintiff was symptomatic of cervical disc injury, which was seen in Mr. Elkin's post-operative MRIs of the cervical spine. The expert asserts that the Defendants departed from good and accepted medical practice by performing an unnecessary surgery on the Plaintiff, and that this surgery was a proximate cause of his complex regional pain syndrome. He disagrees with Dr. Kulick's statement that an EMG was not necessary pre-operatively.

The expert also argues that Mr. Elkin's symptoms after surgery indicated complex regional pain syndrome, and Dr. Lee should have considered this diagnosis. He contends that due to Plaintiff's pain post-operatively, Dr. Lee should have referred Mr. Elkin for an MRI and to a neurologist for an EMG. Plaintiff's expert opines that the diagnosis of neuroma has no medical

basis. He avers that the Defendants' departures from good and accepted practice were a substantial contributing factor to Mr. Elkin's injuries, including complex regional pain syndrome and right radial sensory neuropathy.

Plaintiff contends that summary judgment should also be denied for the claim of lack of informed consent. He argues that Dr. Lee failed to disclose all risks, benefits, and alternatives, and that surgery should not have been performed. He argues that Dr. Lee failed to obtain an objective diagnosis by performing a pre-operative EMG, and adopts the argument of his expert "that a reasonable person would not have undergone the surgical procedure had they been informed that a pre-operative EMG would aid to the determination in an objective diagnosis."

In considering a motion for summary judgment this Court reviews the record in the light most favorable to the non-moving party. E.g., Dallas-Stephenson v. Waisman, 39 A.D.3d 303, 308 (1st Dep't 2007). The movant must support the motion by affidavit, a copy of the pleadings, and other available proof, including depositions and admissions. C.P.L.R. Rule 3212(b). The affidavit must recite all material facts and show, where the defendant is the movant, that the cause of action has no merit. Id. This Court may grant the motion if, upon all the papers and proof submitted, it is established that the Court is warranted as a matter of law in directing judgment. Id. It must be denied where facts are shown "sufficient to require a trial of any issue of fact." Id. This Court does not weigh disputed issues of material facts. See, e.g., Matter of Dwyer's Estate, 93 A.D.2d 355, 363 (1st Dep't 1983). It is well-established that summary judgment proceedings are for issue spotting, not issue determination. See, e.g., Suffolk County Dep't of Soc. Servs. v. James M., 83 N.Y.2d 178, 182 (1994).

In a medical malpractice case, to establish entitlement to summary judgment, a physician must demonstrate that he did not depart from accepted standards of practice or that, even if he did, he did not proximately cause injury to the patient. Roques v. Noble, 73 A.D.3d 204, 206 (1st Dep't 2010). In claiming treatment did not depart from accepted standards, the movant must provide an expert opinion that is detailed, specific and factual in nature. E.g., Joyner-Pack v. Sykes, 54 A.D.3d 727, 729 (2d Dep't 2008). Expert opinion must be based on the facts in the record or those personally known to the expert. Roques, 73 A.D.3d at 195. The expert cannot make conclusions by assuming material facts not supported by record evidence. Id. Defense expert opinion should specify "in what way" a patient's treatment was proper and "elucidate the standard of care." Ocasio-Gary v. Lawrence Hosp., 69 A.D.3d 403, 404 (1st Dep't 2010). A defendant's expert opinion must "explain 'what defendant did and why.'" Id. (quoting Wasserman v. Carella, 307 A.D.2d 225, 226 (1st Dep't 2003)). Conclusory medical affirmations fail to establish prima facie entitlement to summary judgment. 73 A.D.3d at 195. Expert opinion that fails to address a plaintiff's essential factual allegations fails to establish prima facie entitlement to summary judgment as a matter of law. Id. If a defendant establishes a prima facie case, only then must a plaintiff rebut that showing by submitting an affidavit from a medical doctor attesting that the defendant departed from accepted medical practice and that the departure proximately caused the alleged injuries. Id. at 207.

The Court first turns to Defendants' summary judgment motion in regards to the medical malpractice claim. Defendants establish a prima facie case for summary judgment. Defendants' expert established the standard of care, and how Dr. Lee's treatment of Mr. Elkin met the standard. Plaintiff's opposition raises triable issues of fact. Plaintiff's and Defendants' experts

disagree over the exact diagnosis of Mr. Elkin's injuries, the causes of the injury, the diagnostic methods necessary to determine if surgery were necessary, and the appropriate post-operative treatments. That branch of the motion for summary judgment as to medical malpractice is, therefore, denied.

Claims of lack of informed consent are statutorily defined. Pub. Health Law § 2805-d. The law applies a reasonable practitioner standard to the duty to disclose: a defendant providing treatment or diagnosis must disclose to the patient alternatives and reasonably foreseeable risks and benefits involved as a reasonable physician under similar circumstances would have provided. See id. § 2805-d(1). The disclosure, moreover, must permit "the patient to make a knowledgeable evaluation." Id. To prevail in a summary judgment motion on a lack of informed consent claim, the movant must establish as a prima facie case that proper disclosure was done and a reasonably prudent person in the patient's position would have undergone the treatment had the patient been fully informed of the alternatives to treatment and its reasonably foreseeable risks and benefits. See, e.g., Schilling v. Ellis Hosp., 75 A.D.3d 1044, 1046 (3d Dep't 2010); see also Pub. Health Law § 2805-d(3). Or, even assuming a reasonably prudent person in the patient's position would not have undergone the treatment had that patient been fully informed, a movant may show that the lack of informed consent did not proximately cause the injury alleged. See 75 A.D.3d at 1046; Pub. Health Law § 2805-d(3). Consent forms that have been signed by a plaintiff by themselves are not dispositive of claims for lack of informed consent. See, e.g., Wilson-Toby v. Bushkin, 72 A.D.3d 810, 811 (2d Dep't 2010).

Defendants fail to establish a prima facie case of summary judgment for lack of informed consent. Defendants support their argument with medical records where Dr. Lee notes

he informed the patient, a signed informed consent form, and deposition testimony where Mr. Elkin states he signed the form. Based on the record, however, including deposition testimony and the verified complaint, there are still triable issues of material fact. While deposition testimony indicates that Mr. Elkin signed the form, it also indicates that he had no memory of signing it or discussing the contents. Furthermore, a signed consent form is not dispositive of informed consent. Id. Nor is it relevant that the Plaintiff researched his condition on the internet and spoke with family and friends. The adequacy of Dr. Lee's disclosure, not Mr. Elkin's independent research, is the basis of a knowledgeable evaluation by the Plaintiff. See Pub. Health Law § 2805-d(1). Accordingly, it is

ORDERED that the motion for summary judgment is denied; and it is further

ORDERED that the parties appear for a pre-trial conference on October 7, 2014, at 9:30 am.

Dated: September 4, 2014

ENTER:

JOAN B. LOBIS, J.S.C.