Babli v Sen
2016 NY Slip Op 31460(U)
July 29, 2016
Supreme Court, New York County
Docket Number: 150594/2011
Judge: Joan B. Lobis

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

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JENNIFER BABLI,

Plaintiff,

Index No. 150594/2011

-against-

Decision and Order

CHANDRANATH SEN, M.D.,

Defendant.

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In this medical malpractice action, defendant currently moves for summary judgment. Plaintiff opposes the motion. For the reasons below, the Court denies the motion.

Plaintiff first presented to defendant, a neurosurgeon, on November 4, 2008. In the previous year-and-a-half prior, she had been treated for vertigo, facial twitching on the right side, and slight hearing loss in her right ear. Only the hearing loss remained. Dr. John Ferro of ENT and Allergy Associates (ENT), who treated plaintiff's twitching and hearing problems, ordered MRIs in September and October 2008 which revealed a lesion in the right internal auditory canal (IAC). Dr. Ferro opined that plaintiff had a neuroma or possibly neuritis and referred her to defendant.

At the November 4 appointment, defendant reviewed the MRI results and discussed the treatment options of continued observation, stereotactic radiation, or a surgical resection. On April 22, 2009, a follow-up hearing test revealed a slight decrease in the hearing in her right ear. Her April 27, 2009 MRI indicated that her lesion had grown from 5 x 3 mm to 6 x 4 x 2 mm, which defendant noted to be a slight growth. At her May 12, 2009 appointment with defendant, plaintiff complained of worsening hearing in her right ear. Defendant allegedly informed plaintiff she likely

had a schwannoma tumor, or tumor located on the nerve sheath, and told her that absent surgery she probably would lose the hearing in her right ear. He advised her that the stereotactic procedure might stop the tumor's growth but would not remove it. Defendant alleges he informed plaintiff of the risks of surgery, including hearing loss and nerve damage, but told her that a successful operation would remove the tumor altogether. Plaintiff then consulted with Dr. Won Taek Choe at ENT. His notes indicate he discussed treatment options with plaintiff and that she was leaning toward selecting surgery. Shortly thereafter, she opted for surgery.

During plaintiff's surgery on July 16, 2009. Defendant took a biopsy which showed that plaintiff did not have a schwannoma tumor but a hemangioma tumor, a noncancerous growth along the blood vessels. As a result of the surgery, plaintiff sustained partial facial paralysis and a total loss of hearing in her right ear which both persist to this day. Subsequently, plaintiff began this lawsuit, alleging defendant committed malpractice in diagnosing her with the wrong type of tumor, improperly performing invasive surgery when noninvasive treatments would have sufficed, and failing properly explain the extent of the risks he described when he obtained her consent.

Defendant supports his summary judgment motion with the affidavit of Dr. Raphael P. Davis, a New York licensed physician with experience teaching and performing neurosurgery. To a reasonable degree of medical surgery, Dr. Davis opines that defendant did not depart from the standard of care. He explains that a neurosurgeon cannot determine "the manner in which the insult to the nerve is occurring . . . pre-operatively," Davis Aff. ¶ 12, and that the doctor can make an educated guess intraoperatively but cannot reach a definitive conclusion until the postoperative pathological examination. He states that an "overwhelming majority of tumors in the IAC are

'schwannomas," Id. ¶ 13, and the type of lesion which plaintiff had, a hemangioma, is extremely rare.

Further, the expert explains, if the auditory nerve is partially damaged hearing loss can be reversible but once the nerve is dead the patient's hearing cannot be restored. Although the tumor's growth can be documented, he states, a doctor cannot know whether irreversible damage has occurred without operating and must base his or her assessment on the size of the tumor. He claims the treatment options of observation, stereotactic radiation, and neurosurgery all have potential risks and benefits. He contends that in cases such as this one, in which the tumor was growing, the loss of hearing was increasing, and the thirty-seven-year-old patient was in good health, surgery was indicated for either type of tumor and it was not a deviation to recommend it. He states it was not a deviation for defendant to state plaintiff's hearing might be restored as the result of surgery. Finally, he states, the doctor's notes confirm he discussed alternatives to surgery with plaintiff, her husband, and her mother and informed plaintiff of the risks and benefits of surgery. He points out that plaintiff also consulted with Dr. Choe at ENT and therefore clearly was informed when she consented. Defendant argues that, legally, the ENT consultation would render plaintiff's consent "informed" even if defendant had not done an adequate job.

Plaintiff counters with the expert affirmation of Dr. Elliot G. Gross, a New York licensed doctor certified in psychiatry and neurology. Dr. Gross has experience treating patients with IAC disorders and has often determined whether referral to a surgeon is appropriate. Dr. Gross states defendant departed from the standard of care by recommending and performing plaintiff's surgery. He opines that the surgery in question carries a fifty percent risk of hearing loss

and a substantial risk of facial injury. Surgery was not indicated, he states, because the lesion was tiny and the one millimeter growth was insignificant,[1] it was confined to the IAC and did not carry an increased risk of growth, and it did not reach vital structures and put plaintiff's life and basic health at risk. He contends defendant is incorrect that conservative treatment would fail eventually. Instead, he states, given plaintiff's situation, there was a ninety percent chance conservative treatment would be successful and there would be no need for surgery. Thus, he states, it was a departure to recommend surgery. The expert opines there was a lack of informed consent because defendant did not properly allocate the risks and benefits of the various procedures and he overstated the significance of the lesion's negligible growth. Further, he states, because a lesion this small doesn't normally impact a patient's hearing and cause facial twitches, it was likely the lesion was adherent to the nerves, which increases the risk of nerve injury. As for proximate cause, the expert states that a reasonable patient with a full and accurate understanding of the above would not have undergone surgery and sustained these injuries. The expert states defendant deviated from the standard of care by not stopping the surgery once he realized the tumor adhered to IAC nerves.

In reply, defendant objects that plaintiff's expert is unqualified because he is a neurologist and not a neurosurgeon and he does not indicate that he is acquainted with pertinent literature about neurosurgery. He argues that Dr. Gross does not address Dr. Davis' comments concerning plaintiff's increased risk of vascular damage or the risk of insult to a blood vessel, and thus he does not properly evaluate the risk to plaintiff absent surgery. He states Dr. Gross has a simplistic understanding of plaintiff's condition because he is not a surgeon. He challenges the

[1] Plaintiff's expert contends the standard of care would require surgery where the growth was five millimeters or more a year, or the overall size was at least twenty millimeters. He states that if plaintiff actually had a hemangioma, it is unlikely that there would be any growth.

expert's contention that surgery was not necessary because, contending that plaintiff's facial spasms, dizzy spells, and hearing loss showed she was already symptomatic. As the expert ignored the record, he argues, his affirmation should be ignored. Because surgery was in conformance with the standard of care, he states, plaintiff's informed consent argument also fails. Moreover, he argues, a reasonable person in plaintiff's position would opt for the surgery, and this vitiates plaintiff's argument as to proximate cause.

To prevail on summary judgment in a medical malpractice case, 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 the patient's injury. 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). The opinion must be based on facts in the record or personally known to the expert. Roques, 73 A.D.3d at 195. The expert cannot make conclusions by assuming material facts which lack evidentiary support. Id. The defense expert's opinion should state "in what way" a patient's treatment was proper and explain the standard of care. Ocasio-Gary v. Lawrence Hosp., 69 A.D.3d 403, 404 (1st Dep't 2010). Further, it must "explain 'what defendant did and why.'" Id. (quoting Wasserman v. Carella, 307 A.D.2d 225, 226 (1st Dep't 2003)).

Once the defendant makes a prima facie showing, the burden shifts to the plaintiff "to produce evidentiary proof in admissible form sufficient to establish the existence of material issues of fact which require a trial of the action." Alvarez v. Prospect Hosp., 68 N.Y.2d 320, 324 (1986). To meet that burden, a plaintiff must submit an expert affidavit attesting that the defendant

departed from accepted medical practice and that the departure proximately caused the injuries. See Rogues, 73 AD.3d at 207. "Summary judgment is not appropriate in a medical malpractice action where the parties adduce conflicting medical expert opinions." Elmes v. Yelon, 140 A.D.3d 1009, - (2nd Dep't 2016)(citations and internal quotation marks omitted). Instead, the conflicts must be resolved by the factfinder. Id.

Here, defendant set forth a prima facie case in favor of dismissal, thus shifting the burden of proof to defendant. In particular, Dr. Davis, who is experienced in the field of neurosurgery, stated that defendant's failure to properly identify the hemangioma preoperatively was not a deviation given the rarity of this type of lesion and the impossibility of examining the lesion until a postoperative pathology report has been made. He claims it was not a deviation to recommend surgery because the lesion was evolving. He argues that each of the treatment options carried their own benefits and risks, and defendant fully informed plaintiff of them all. Even if he had not, the expert points out, plaintiff consulted with another doctor who also informed her of the risks and benefits of the treatments. Thus, he argues, her consent was informed.

In opposition, Dr. Gross' expert affirmation raises triable issues of fact. Dr. Gross states that the risks of permanent facial nerve damage and of hearing loss are much higher than defendant indicated. He argues that, contrary to defendant's position, surgery was not required in light of the size and relative lack of growth of the lesion and the fact that there was no immediate risk to plaintiff. Moreover, he disputes that surgery was within the standard of care because he contends that there was a ninety percent likelihood that less invasive treatment options would be successful. He also raises an issue as to whether defendant should have recognized the increased

risk of nerve damage and hearing loss because of the likelihood that the lesion adhered to plaintiff's nerve. Because defendant did not adequately address these facts, the expert states, there was no informed consent and, in addition, there was proximate cause.

Defendant's challenges to Dr. Gross' expertise have no merit. Although not a neurosurgeon, as a neurologist who has seen patients with IAC and determined whether referrals to neurosurgeons are indicated, Dr. Gross established that he has the necessary experience to qualify him as an expert. See Walsh v. Brown, 72 A.D.3d 806, 806 (2nd Dep't 2010). His alleged lack of knowledge as to when surgery is indicated merely raises a credibility issue defendant can raise at trial. Similarly, their comments that Dr. Gross has a simplistic understanding of the medical issues at hand and that he does not grasp the nuances of plaintiff's situation are arguments regarding his credibility and are trial issues.

Accordingly, it is

ORDERED that the motion is denied.

Dated: July 29, 2016

ENTER:

JOAN B. LOBIS, J.S.C.