

Berkovits v Wellman
2020 NY Slip Op 30553(U)
February 24, 2020
Supreme Court, New York County
Docket Number: 805123/2017
Judge: Eileen A. Rakower
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SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NEW YORK: PART 6

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ELIEZER BERKOVITS and BONNIE BERKOVITS,

Index No.
805123/2017

Plaintiffs,

**DECISION
and ORDER**

-against-

DAVID WELLMAN, M.D., and NEW YORK
PRESBYTERIAN HOSPITAL,

Mot. Seq. 1

Defendants.
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HON. EILEEN A. RAKOWER, J.S.C.

Defendant David Wellman, M.D. (“Dr. Wellman”) moves pursuant to CPLR § 3212 for an Order granting summary judgment dismissing Plaintiffs Eliezer Berkovits (“Mr. Berkovits”) and Bonnie Berkovitz’s (“Mrs. Berkovits”) (collectively, “Plaintiffs”). Summons and Verified Complaint.

Dr. Wellman filed the motion on April 16, 2019. On July 18, 2019, Plaintiffs’ attorney filed an Order to Show Cause (Motion Sequence 2) to be relieved as counsel. On July 22, 2019, the Honorable Martin Shulman, J.S.C. transferred the case to the Honorable Eileen A. Rakower, J.S.C. Oral argument was scheduled for October 25, 2019. Plaintiffs’ attorney was relieved, the case was stayed for 30 days and opposition was due for Dr. Wellman’s summary judgment motion on February 6, 2020. There is no opposition. For the reasons, discussed below, the motion for summary judgment is granted in its entirety.

This action, sounding in medical malpractice and a derivative cause of action for loss of consortium, arises out of orthopedic surgery and post-operative care rendered by Dr. Wellman to Mr. Berkovits commencing in September 2014 until November 2015. Mr. Berkovits alleges that Dr. Wellman failed to timely diagnose and treat Mr. Berkovits’ post-operative infection.

Background

On September 2, 2014, Berkovits fell into an empty mikvah, a pool used for ritual bathing and was transported by ambulance to NYPH. The Emergency Room

personnel performed Radiological studies which showed that Mr. Berkovits had multiple fractures of his right foot and ankle, including: “distal fibular, posterior malleolar and anterolateral distal tibial fractures of the right ankle; comminuted fracture of the second metatarsal base compatible with a Lisfranc fracture and ligamentous disruption and fracture of the sesamoid of the first metatarsal.”

Dr. Wellman, a Board-Certified Orthopedic Surgeon with specialty training in trauma and fracture management, was called to examine Mr. Berkovits. After examining Mr. Berkovits and reviewing the x-ray and CT scans, Dr. Wellman determined that the ankle fracture could be treated conservatively with casting but the Lisfranc fracture needed surgical management with open reduction and internal fixation. On September 8, 2014, Dr. Wellman operated on Mr. Berkovits foot and explained to Mr. Berkovits that the purpose of the operation “was to create a foot that is stable for weight bearing and which will not deteriorate over time with activity.” Dr. Wellman also provided Mr. Berkovits with a bolus of pre-operative antibiotics to minimize the risk of infection. On September 10, 2014, Mr. Berkovits was discharged from NYPH and was transferred to Village Care Rehabilitation until December 2014. From September 18, 2014 through February 25, 2015, Mr. Berkovits presented to Dr. Wellman for out-patient post-operative visits. During this time there was no record of signs or symptoms of infection.

On April 1, 2015, Mr. Berkovits returned to see Dr. Wellman complaining of pain and soreness of his right foot. A physical examination was performed, and a CT scan was ordered that day. The CT scan showed that the fracture was completely healed, and there was no evidence of a deep, active infectious process, but that a surgical screw had broken and was mostly like the cause of the pain. A second surgery was scheduled for April 20, 2015 to remove the surgical screw.

On April 17, 2015, Mr. Berkovits saw Craig Basman, M.D. (“Dr. Basman”) for pre-operative medical clearance. Mr. Berkovits was cleared and not diagnosed with any type of infection.

On April 20, 2015, Mr. Berkovits went to NYPH for his second surgery. Dr. Wellman stated in the operative report that:

The patient, date of birth ..., suffered right-sided Lisfranc injury. Over the past several weeks the patient has noted increasing pain with increasing swelling and redness about the foot. Today, the patient’s exam is consistent with postoperative infection with symptomatic hardware. In order to treat this, we will need to remove all hardware,

debride the foot, and take cultures today in the operating room.

During the operation, Dr. Wellman took specimens from the bone and surrounding soft tissue for culture. In the operating room, Mr. Berkovits was administered Vancomycin and Zosyn, two broad spectrum antibiotics, to cover both gram-positive and gram-negative bacteria. Barry Hartman, M.D. ("Dr. Hartman"), Board Certified in the specialty of Infectious Diseases attended to Mr. Berkovits following the surgery on April 20, 2015.

On April 23, 2015, the cultures revealed that the organism causing Mr. Berkovits' infection was staphylococcus lugdunensis and the bacteria was sensitive to the antibiotic Oxacillin. On April 23, 2015, Dr. Hartman directed that the Zosyn and Vancomycin be discontinued, and that Mr. Berkovits start receiving Oxacillin. Dr. Hartman planned for Mr. Berkovits to receive IV antibiotics for six weeks. Mr. Berkovits was discharged from NYPH on April 24, 2015.

Mr. Berkovits saw Dr. Wellman for follow-up visits on May 5, 2015 and May 20, 2015 and was doing well. On May 21, 2015, Mr. Berkovits saw Dr. Hartman. Dr. Hartman noted that Mr. Berkovits was doing well, and he would be taken off the IV Oxacillin on June 1, 2015 and Mr. Berkovits would start taking Dicloxacillin orally for six weeks starting on June 2, 2015. Mr. Berkovits saw Dr. Wellman for follow-up visits on June 30, 2015 and July 22, 2015 and was doing well.

On July 28, 2015, Mr. Berkovits went to his primary care physician, Dr. Silverman, for significant pain in his right foot. Mr. Berkovits was prescribed Doxycycline.

On August 25, 2015, Mr. Berkovits saw Dr. Wellman and reported the history of pain and the visit to Dr. Silverman. After an x-ray and a physical examination were performed, Dr. Wellman was concerned that Mr. Berkovits might have a resurgence of his infection and ordered a CT scan of the foot and informed Plaintiffs of the likely need for a further irrigation and debridement procedure as well as another course of IV antibiotics. Dr. Wellman discussed his plan with Dr. Hartman, and they agreed that Mr. Berkovits should remain off antibiotics for two weeks in order to maximize the chances of obtaining "meaningful cultures."

On September 1, 2015, Mr. Berkovits saw Dr. Wellman. Mr. Berkovits was doing well off the antibiotics and was not experiencing a fever or other signs of systematic infection. Mr. Berkovits agreed to stay off the antibiotics and undergo the irrigation and debridement procedure.

On September 15, 2015, Mr. Berkovits was admitted to Hospital for Special Surgery for irrigation and debridement of his right foot infection. During the surgery, Dr. Wellman applied Vancomycin powder into the surgical wound and IV Zosyn was administered. Dr. Wellman consulted an Infectious Disease physician, Andy O. Miller, M.D. (“Dr. Miller”). The cultures from the procedure were positive for staphylococcus lugdunensis.

On September 17, 2015, Mr. Berkovits saw Dr. Miller. Dr. Miller stopped the Vancomycin but continued the Zosyn. On September 18, 2015, Mr. Berkovits saw Dr. Miller. Dr. Miller discontinued the Zosyn and ordered oral antibiotics of Levofloxacin and Rifampin for 42 days and then Mr. Berkovits was to be reevaluated for further treatment. On September 24, 2015, Mr. Berkovits was discharged.

On September 28, 2015, Mr. Berkovits experienced “projectile vomiting.” Mr. Berkovits saw Dr. Miller. Dr. Miller temporarily discontinued the Rifampin. Shortly thereafter, Dr. Miller had Mr. Berkovits restart the Rifampin, but Mr. Berkovits again experienced vomiting. Dr. Miller discontinued the Rifampin. Dr. Miller did not think that oral Levofloxacin would be effective in eradicating Mr. Berkovits’ infection, therefore, on October 14, 2015, Mr. Berkovits was admitted to the Hospital for Special Surgery for treatment with IV Cefazolin. On October 26, 2015, Mr. Berkovits was discharged.

On November 10, 2015, Mr. Berkovits saw Dr. Wellman for the last time. After a physical examination, Dr. Wellman noted that there was “only minimal warmth and swelling” and the “incision was dry, clean and intact with no signs of infection.” There is no evidence provided by Plaintiffs that Mr. Berkovits had any recurrence of the infection.

Summary Judgment Standard

CPLR § 3212 provides in relevant part, that a motion for summary judgment,

“shall show that there is no defense to the cause of action or that the cause of action or defense has no merit. The motion shall be granted if, upon all the papers and proof submitted, the cause of action or defense shall be established sufficiently to warrant the court as a matter of law in directing judgment in favor of any party... [t]he motion shall be denied if any party shall show facts sufficient to require a trial of any issue of fact.”

A defendant moving for summary judgment in a medical malpractice case has the burden of making a *prima facie* showing of entitlement to judgment as a matter of law by showing that “there was no departure from good and accepted medical practice or that any departure was not the proximate cause of the injuries alleged” by introducing expert testimony that is supported by the facts in the record. *Rogues v. Nobel*, 73 A.D.3d 204, 206 [1st Dept. 2010]. Once the defendant has made this showing, the burden shifts to the party opposing the motion “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 Hospital*, 68 N.Y.2d 320, 324 [1986]. Specifically, a plaintiff “must submit an affidavit from a physician attesting that the defendant departed from accepted medical practice and that the departure was the proximate cause of the injuries alleged.” *Rogues*, 73 A.D.3d at 207.

“Although a loss of consortium claim is a separate and distinct cause of action, New York courts have never characterized the loss of consortium as a claim independent from the underlying action instituted on behalf of the injured spouse.” *Bonanno v Mayman*, 2019 N.Y. Slip Op. 33343[U], 9 [N.Y. Sup Ct, New York County 2019] (citation omitted). “Accordingly, with plaintiff’s underlying claims dismissed, his wife cannot advance a claim for loss of consortium.” *Id.*

Defendants’ Pending Summary Judgment Motion

In support of Defendants’ motion for summary judgment, Defendants submit the Affirmation of Alan A. Pollock, M.D.’s (“Dr. Pollock”), a Diplomate of the American Board of Internal Medicine and a Diplomate of the Subspecialty Board of Infectious Diseases.

According to Dr. Pollock’s Affirmation, he reviewed the Bill of Particulars, medical records and deposition transcripts. Dr. Pollock opines within a reasonable degree of medical certainty that there was no delay on the part of Dr. Wellman in the diagnosis of Mr. Berkovits’ infection and that any alleged delay in diagnosis and treatment did not cause or contribute to any of the injuries claimed in this case. Dr. Pollock opines that “a patient who develops a post-operative infection will present with increased redness, increased swelling and markedly increased localized pain, all well in excess of normal and expected post-operative pain and swelling.” Dr. Pollock opines that “[t]he records and testimony in this case, show, unequivocally, that Mr. Berkovits did not present to Dr. Wellman with any signs or symptoms indicative of a post-operative infection until April 2015.” Dr. Pollock further opines that an earlier diagnosis of the infection would not have impacted the required treatment or Mr. Berkovits’ outcome.

Discussion

Defendants make a *prima facie* showing of entitlement to summary judgment. *Alvarez*, 68 N.Y.2d at 324. Defendant, through Dr. Pollock's Affirmation, demonstrates that Dr. Wellman "took all appropriate measures to prevent Mr. Berkovits from developing an infection" and "that Dr. Wellman diagnosed Mr. Berkovits in a timely manner and that he provided entirely appropriate treatment to address the infection including surgery, cultures and prompt consultation with an Infectious Disease specialist." Dr. Pollock states that early diagnosis of the infection would not have changed the course of treatment or minimized the infection.

Since the Defendants have made a *prima facie* showing of entitlement to summary judgment, the burden now shifts to Plaintiffs to demonstrate by admissible evidence the existence of a factual issue requiring a trial of the action. *Lindsay-Thompson*, 147 A.D.3d at 639. Specifically, to repeat, in a medical malpractice claim, a plaintiff "must submit an affidavit from a physician attesting that the defendant departed from accepted medical practice and that the departure was the proximate cause of the injuries alleged." *Rogues*, 73 A.D.3d at 207. Plaintiffs do not submit opposition, despite multiple opportunities to do so.

Dismissal of Mr. Berkovits' direct suit mandates dismissal of Mrs. Berkovits' derivative cause of action for loss of consortium. *Camadeo*, 290 A.D.2d at 356.

Wherefore, it is hereby

ORDERED that Defendant David Wellman, M.D.'s motion for Summary Judgment pursuant to CPLR § 3212 is granted in its entirety and the causes of actions against Defendant David Wellman, M.D. are dismissed, and the Clerk is directed to enter judgment accordingly.

This constitutes the Decision and Order of the Court. All other relief requested is denied.

Dated: FEBRUARY 24, 2020



Eileen A. Rakower, J.S.C.