Rozon v Schottenstein
2020 NY Slip Op 31938(U)
April 21, 2020
Supreme Court, New York County
Docket Number: 805014/2016
Judge: Eileen A. Rakower

SUPREME COURT OF THE STATE OF NEW YORK — NEW YORK COUNTY

PRESENT: Hon. EILEEN A. RAKOWER PART 6
Justice

CAROLA ROZON,
Plaintiff,
- against-

EDWIN M. SCHOTTENSTEIN, M.D.,

Defendant.

INDEX NO. 805014/2016
MOTION DATE
MOTION SEQ. NO. 4
MOTION CAL. NO.

The following papers, numbered 1 to _____ were read on this motion for/to

	PAPERS NUMBERED
Notice of Motion/ Order to Show Cause — Affidavits — Exhibits ...	
Answer — Affidavits — Exhibits _____	
Replying Affidavits	

Cross-Motion: Yes X No

Presently before the Court is Defendant Edwin M. Schottenstein, M.D.'s ("Defendant" or "Dr. Schottenstein") motion pursuant to CPLR Rule 4404(a) to set aside the verdict, and to direct that judgment be entered in favor of Defendant who is entitled to judgment as a matter of law for Plaintiff Carola Rozon's ("Plaintiff" or "Ms. Rozon") failure to prove a *prima facie* case of medical malpractice as to all elements including liability, causation, and damages. In the alternative, Defendant moves pursuant to CPLR Rule 4404(a) setting aside the verdict and any judgment entered thereon and ordering a new trial as the jury's verdict is contrary to the weight of the evidence and in the interest of justice.

Plaintiff opposes Defendant's motion. For the reasons set forth below, Defendant's motion is denied.

Relevant Background

Plaintiff commenced this medical malpractice action by summons and complaint in January 7, 2016. On December 13, 2013, Defendant performed right eye cataract surgery using a phacoemulsification technique to "emulsify the cataract inside the lens of the eye, leaving the lens capsule behind and sucking the cataract nucleus out through an aspiration point while at the same time irrigating the eye to maintain pressure and shape." (Defendant's Affidavit in Support at 8-9). Two complications that arose during the surgery, the first complication called "posterior rupture" and the second complication called "dropped nucleus." (Defendant's Affidavit in Support at 9).

"The posterior capsule ruptured, leaving a hole, at the beginning of the operation; this can cause the nucleus to fall back into the vitreous cavity, requiring a vitreoretinal surgeon to remove it." (Plaintiff's Affirmation in Opposition at 7-8). "[A] quadrant of the cataract fell into the back of the eye." (*Id.* at 8). Defendant "tried to insert an IOL [Intraocular Lens] into the sulcus of the plaintiff's eye but decided to remove it because it was improperly positioned towards the back of the eye." (*Id.*).

The jury trial commenced on November 12, 2019. The Verdict Sheet had "one departure question and a companion causation question." (Defendant's Affidavit in Support at 4). The departure question required the jury to decide, "[d]id Edwin M. Schottenstein, M.D. depart from accepted standards of care in removing the Intraocular Lens (IOL) from plaintiff Carola Rozon's eye through the original 2.7-millimeter incision on December 31, 2013?" The jury answered yes and the causation question required the jury to decide, [d]id this departure cause injury to Ms. Rozon?" (*Id.*). The jury answered yes. On November 26, 2019, the jury rendered a verdict against Defendant in the amount of $650,000.00 for past pain and suffering, $500,000.00 for future pain and suffering and $1,680.00 for lost earnings.

Pending Motion

Defendant argues *inter alia* that Plaintiff's expert witness, David Montesanti, M.D.'s ("Montesanti"), expert opinion was "too speculative" to support the verdict, therefore the complaint should be dismissed for Plaintiff's failure to establish a *prima facie* case. Defendant argues that,

> [Montesanti's] testimony was speculative and insufficient for many reasons: Dr. Montesanti admitted that his opinion that Dr. Schottenstein's removal of the intraocular lens caused a retinal detachment in Ms. Rozon's eye was one he had never given before, or heard about or read about; … that it was admittedly "speculative"; that it was based on facts not in the record (that there was vitreous in the anterior chamber that no doctor saw and would see, and that there was no immediate retinal tear or detachment allegedly caused by Schottenstein's removal of the IOL seen by anyone according to the record); … that it was a "risk" of indefinite quality as opposed to a "substantial factor; … that the standard of care he applied was his own personal standard of care as opposed to a national or community standard; … and that he "could be wrong"…

> Dr. Montesanti never explained how the IOL removal through an incision in the cornea at the front of the eye was a "risk" let alone a "cause" of a retinal tear or detachment in the back of the eye, and where there was no retinal tear or retinal detachment found by Schottenstein or the subsequent treater Dr. Uri Shabto."

(Defendant's Affidavit in Support at 6).

Plaintiff opposes, arguing *inter alia* that,

> there was more than sufficient evidence on this record to establish the propriety of the jury's finding that Dr. Schottenstein's professional negligence in removing plaintiff's intra-ocular lens through the original 2.7mm incision during his December 31, 2013 surgery was a proximate cause of the injuries plaintiff sustained.

(Plaintiff's Affirmation in Opposition at 7).

On direct examination, the relevant portions of Montesanti's testimony are as follows:

> A: So from the reading, it appears that Dr. Schottenstein did not like the position of the lens, and decided to remove the lens through the wound. In his deposition, but not in the op report, he states that he removed it by grasping the lens with the holding forceps and pulling it through the original wound site.
>
> Q: Do you have an opinion within a reasonable degree of medical certainty whether or not Dr. Schottenstein's decision to remove, to explant that sulcus lens out of her eye was a departure from good and accepted standards of medical practice?
>
> A: So the question is a good one. It is a departure from what I teach, and a departure from what I do, and a departure from what my colleagues do. Beyond that, I can't say. But I can describe what I think the scenario was.

Q: Well, Doctor, let me ask you the question, which is just yes or no, do you have an opinion, yes or no, whether or not it was a departure – strike that. Do you have an opinion within a reasonable degree of medical certainty whether it was a departure to decide to explant that lens at the moment in time by Dr. Schottenstein? Do you have an opinion?

A: My opinion is yes.

Q: And, Doctor, explain why that would be a departure from the standard of care.

A: I can -- once a complication in a case, a cataract surgery case occurs, it is our job as physicians to minimize the risk for further complication or further damage. And one way to minimize that risk is to decrease or minimize the number of manipulations, steps performed inside an eyeball that has already had a compromise -- the barrier to the vitreous. Placing an intraocular lens is certainly not a departure from the standard of care and certainly not something that I would teach against and I have done myself. Removing a lens, however is, and this is why: To remove that lens, there would be what I consider an undue amount of manipulation inside the eyeball. That lens we talked about before has a six-millimeter optic. The incision site is 2.75 millimeters, much smaller. To remove that lens through that 2.75-millimeter opening would cause some physical stress on the eyeball. The lens could be folded inside the eyeball, albeit again with more manipulation and this would create a somewhat -- is merely half the size of the lens but still would involve manipulation through the wound site. One could enlarge the wound site and that is what I would teach to do, enlarge the wound site to six millimeters. Then the lens could be removed from the eyeball without undue stress on the eye itself. The wound could be closed at [a] later date -- I am sorry at a later time during the surgery, without undue astigmatism. Back to my opinion is that removing the lens, even though it was displaced posteriorly somewhat and not in a good position, is not what I would teach or what I would perform myself.

Q: Now, Doctor, when you indicated that you can remove a lens through the wound site by extending it to a six millimeters, would that be in the scenario of a posterior capsule bag tear or not?

***

A: So, yes. That is the quick answer.

THE COURT: Yes what?

Q: Yes, it would be in the face of a posterior bag tear?

A: Yes. You can remove the lens in the face of a communication between the vitreous and the anterior chamber, if manipulation is done at a minimum and the wound is extended in continuity with keeping the manipulation to a minimum.

Q: Was the wound extended in this case?

A: The Wound was not. Or better said, there was no report of the wound being extended.

Q: So the operative report does not document Dr. Schottenstein's extending the wound from the 2.5 or 5.5 -- 2.75-millimeter size to a six-millimeter incision?

A: Correct.

Q: The forceps that were used by Dr. Schottenstein, are those the proper forceps to use in this scenario?

A: Well, they are the proper forceps to use when removing a lens through an open wound. These forceps will not fold the lens in the eye. These forceps will grasp the lens at the optic once the lens is grabbed and pulled to the wound site. Further pulling on that lens would deform it or fold the lens as it pulls out through the wound. So the lens is folded

only as it exiting the wound and to do that, there are pulling forces that need to have occurred.

***

Q: Thank you. Dr. Montesanti I want you to -- I want to direct your focus to Dr. Schottenstein's deposition testimony.

A: Yes.

Q: He was asked this question at his deposition and gave this answer. Yes. At page 134, line 25. Question: Could you explain to me how you explanted the lens? Answer: I have a forceps that is typically for this purpose. It folds the implant inside the eye, and then it is explanted through the same incision that I implanted it with." (*Sic.*) Okay.

A: Yes.

Q: Can that forceps, Defendant's Exhibit H, fold the lens inside the eye as testified to at Dr. Schottenstein's deposition?

***

A: Correct. It cannot fold the lens by itself. Correct.

(Court Hearing Tr. November 18, 2019 at 683-689).

***

Q: What, if any, risks were increased by the pulling out of the lens through this same 2.7-millimeter incision?

A: Two big risks for that would be alteration and position of the vitreous leading to a retinal tear and damage to the endothelial cells on the back of the cornea.

(Court Hearing Tr. November 18, 2019 at 693).

***

Q: You had indicated, doctor, that pulling the lens out of the same size incision without folding it first and having it fold upon itself increased her risk of a retinal tear?

A: Yes, I indicated that.

Q: How does that increase the risk? What happens?

A: So, retinal tear comes about or arises from usually forces, shearing forces we call them, on the retinal surface. So the retina is very thin, a Saran wrap thin. And this is this vitreous as attached to it, several areas, not everywhere in the retina but certain spots like along the blood vessels or the optic nerves. Movement of the vitreous can pull or cause shearing forces on the retina at those spots where it's attached. So if we manipulate the eyeball, change its shape, distort it in any way, it will cause movement of the vitreous and increase the risk for these shearing forces on the retina.

Q: Is a retinal tear a big deal?

A: It is.

Q: Why?

A: Because it can lead to what we call a retinal detachment. Where the retina is pulled from its choroidal, from the blood supply and the nutrients that feed the retina. And when it's pulled away from the choroidal and the blood supply the retina can effective (*sic.*) die or become nonfunctional.

(Court Hearing Tr. November 18, 2019 at 696).

***

Q: Do you have an opinion within a reasonable degree of medical certainty whether it was a departure from the

> standard of care for Dr. Schottenstein to pull the sulcus lens through the same incision without enlarging it, do you have an opinion?
>
> A: My opinion is that, yes, that is a deviation from that standard of care.
>
> Q: Do you were (*sic.*) have an opinion within a reasonable degree of medical certainty whether Dr. Schottenstein's pulling out of the intraocular lens without making that incision larger, was a factor in causing Ms. Rozon harm?
>
> ***
>
> A: It increase the risk for that scenario to occur.
>
> Q: What scenario?
>
> A: The scenario by which Ms. Rozon developed a retinal tear and subsequent retinal detachment.

(Court Hearing Tr. November 18, 2019 at 698).

On cross-examination, the relevant portions of Montesanti's testimony are as follows:

> Q: Dr. Schottenstein testified at trial that by gripping it with these tweezers and bringing it into the incision, he can cause it to curl up some more and move it right through the opening, the 2/7-millimeter keratome incision?
>
> A: Correct.
>
> Q: Now, I think that you said that that (*sic*.) caused trauma to the eye to such an extent that it might cause a giant retinal tear and detachment, is that what you're claiming?
>
> A: I don't know that I said it that way, but I can say it.

Q: No, I'll ask a question so let me see if I can get this straight now. So you're saying that it did not directly cause a giant retinal tear and a detachment?

A: No, I'm not saying that.

Q: All right. So, the removal of the IOL from the eye -- let me see if I can get this straight, caused trauma to the eye generally which in turn caused a higher risk for retinal detachment and a giant retinal tear?

A: Correct.

Q: Okay. When you said it caused a higher risk for that purpose, isn't it also true that removing that IOL through that incision may have absolutely nothing to do with the giant retinal tear and retinal detachment that are diagnosed later on?

A: Correct.

Q: So, giant retinal tears a phenomenon put aside for a second. They can be caused by a few different mechanisms, correct?

A: Correct.

Q: Retinal detachment, they can be caused by a few different mechanisms, correct?

A: Correct.

(Court Hearing Tr. November 18, 2019 at 742-743).

CPLR 4404 Standard

CPLR 4404(a) provides in relevant part,

After a trial of a cause of action of issue triable of right by a jury, upon the motion of any party or on its own initiative, the court may set aside a verdict or any judgment

> entered thereon and direct that judgment be entered in favor of a party entitled to judgement as a matter of law or it may order a new trial of a cause of action or separable issue where the verdict is contrary to the weight of the evidence, in the interest of justice or where the jury cannot agree being kept together for as long as is deemed reasonable by the court.

The First Department of the Appellate Division has stated that "[a] trial court is empowered under CPLR 4404 (a) to set aside a jury verdict and grant judgment in favor of the losing party where it determines that there is no valid line of reasoning and permissible inferences that could possibly lead a rational person to the conclusion reached." *Cahill v. Triborough Bridge & Tunnel Authority*, 31 A.D.3d 347, 349 [1st Dept 2006]. Furthermore, "[t]he question of whether a verdict is against the weight of the evidence is discretion-laden, and the critical inquiry is whether the verdict rested on a fair interpretation of the evidence." *Rose v Conte*, 107 AD3d 481, 483 [1st Dept 2013].

"[T]he overturning of the jury's resolution of a sharply disputed factual issue may be an abuse of discretion if there is any way to conclude that the verdict is a fair reflection of the evidence." *Torricelli v Pisacano*, 9 AD3d 291, 293 [1st Dept 2004]. The weight to be accorded to the conflicting testimony of experts is "a matter 'peculiarly within the province of the jury.'" *Id.*

Medical Malpractice

To establish a *prima facie* case of medical malpractice, "a plaintiff must show not only that the doctor deviated from accepted medical practice but also that the alleged deviation proximately caused the patient's injury." *Koeppel v Park*, 228 AD2d 288, 289 [1st Dept 1996]. "To carry the burden of proving a prima facie case, the plaintiff must generally show that the defendant's negligence was a substantial cause of the events which produced the injury." *Derdiarian v Felix Contracting Corp.*, 51 NY2d 308, 315 [1st Dept 2017]. The plaintiff "need not eliminate entirely all possibility that defendant's conduct was not a cause, but only offer sufficient evidence from which reasonable [persons] may conclude that it is more probable that the injury was caused by defendant than that it was not." *Lo Presti v. Hospital for Joint Diseases*, 275 AD2d 201, 203 [1st Dept 2000].

The plaintiff must make this showing "via the presentation of expert testimony." *Rivera ex rel. Hernandez v Jothianandan*, 100 AD3d 542, 543 [1st Dept 2012]. The expert's "opinion evidence must be based on facts in the record or

personally known" to the expert. *Guzman ex rel. Jones v 4030 Bronx Blvd. Associates L.L.C.*, 54 AD3d 42, 49 [1st Dept 2008]. "In the absence of record support, an expert's opinion is without probative force." *Id.*

When opining as to causation, the expert must exhibit a degree of confidence in her conclusions sufficient to satisfy accepted standards of reliability. *Matott v Ward*, 48 NY2d 455, 459-460 [1979]. The expert's whole opinion must reflect an acceptable level of certainty. *Id.* at 461. "This does not mean that the door is open to guess or surmise . . ." *Id.*

Discussion

Preliminarily, Montesanti's opinion evidence was based on facts in the record because Montesanti testified that he "reviewed the original operative report of the surgery in question and all of the hospital and physician notes that were available." (Court Hearing Tr. November 18, 2019 at 618); *See Guzman ex rel. Jones*, 54 AD3d at 49. Montesanti also testified that he reviewed the "transcripts and [ ] the deposition of Dr. Schottenstein." (Court Hearing Tr. November 18, 2019 at 619). Because Montesanti reviewed the medical records, depositions, and transcript, he testified with probative force. *Guzman ex rel. Jones,* 54 AD3d at 49.

Through Montesanti's testimony, Plaintiff demonstrated that Defendant deviated from accepted medical practice by removing a 6 millimeter lens from a 2.75 millimeter incision. *Koeppel*, 228 AD2d at 289 [1st Dept 1996]. Specifically, Montesanti opined that "pulling the lens out of the same size incision increased the risk of a retinal tear" and a "retinal tear comes about or arises from usually forces, shearing forces we call them, on the retinal surface… if we manipulate the eyeball, change its shape, distort it in any way, it will cause movement of the vitreous and increase the risk for these shearing forces on the retina." (Court Hearing Tr. November 18, 2019 at 696). Montesanti opined within a reasonable degree of medical certainty that pulling the lens "through the same incision without enlarging it" was "a deviation from the standard of care." (Court Hearing Tr. November 18, 2019 at 698).

Plaintiff also showed, via Montesanti's testimony that Defendant improperly pulled a 6 millimeter lens from a 2.75 millimeter incision which proximately caused Plaintiff's injuries. *Koeppel v Park*, 228 AD2d at 289. Montesanti was asked whether Defendant's "pulling out of the intraocular lens without making the incision larger, was a factor in causing Ms. Rozon's injury," Montesanti testified, "It increase[d] the risk for that scenario to occur… The scenario by which Ms. Rozon developed a retinal tear and subsequent retinal detachment." (Court Hearing

Tr. November 18, 2019 at 698). Montesanti testified to Defendant's departure and explained how the departure "was a substantial cause of the events which produced" Plaintiff's injury. *Derdiarian*, 51 NY2d at 315; *Koeppel*, 228 AD2d at 289.

Montesanti's opinion reflected an acceptable level of certainty. *Matott*, 48 NY2d at 461 [1979]. When Montesanti opined as to the deviation of the standard of care, he exhibited a degree of confidence in his conclusions sufficient to satisfy accepted standards of reliability. *Id.* at 459-460. For instance, when Montesanti was asked, "[d] o you have an opinion within a reasonable degree of medical certainty whether it was a departure from the standard of care for Dr. Schottenstein to pull the sulcus lens through the same incision without enlarging it, do you have an opinion?, Montesanti testified, "[m]y opinion is that, yes, that is a deviation from that standard of care." (Court Hearing Tr. November 18, 2019 at 698).

Consequently, Plaintiff made the showing required to establish a *prima facie* case of medical malpractice. *Rivera ex rel. Hernandez*, 100 AD3d at 543. Montesanti conveyed to the jury that a "retinal tear comes about or arises from usually forces, shearing forces we call them, on the retinal service… So if we manipulate the eyeball, change its shape, distort it in any way, it will cause movement of the vitreous and increase the risk for these shearing forces on the retina." (Court Hearing Tr. November 18, 2019 at 696). Montesanti testified that force that caused the retinal tear was from pulling the 6 millimeter lens from the 2.75 millimeter incision. Montesanti supported his opinion that Defendant's malpractice caused a retinal tear with evidence of post-operative trauma. Montesanti stated that,

> Defendant's 2+ injection of the conjunctiva meant that the sclera was very dilated and reddish in appearance (700-701); tear breakup, the presence of anterior chamber cells +2 and flare-up +2 were findings consistent with eye trauma (701-703). On January 2nd , there was a finding of 2+ corneal edema, which showed trauma and disruption of the endothelial cells in the cornea itself (804-805). All evidence of intraoperative trauma.

(Plaintiff's Affirmation in Opposition at 15).

Montesanti also testified that Dr. Shabto was not able to diagnose Plaintiff's retinal tear on his first post-operative appointment could have been because there was poor visibility in Plaintiff's eye from the retinal hemorrhage. Montesant further testified that over time a retinal tear could progress into a giant retinal tear and retinal detachment. The jury could have found that by improperly pulling the 6 millimeter

lens from a 2.75 millimeter incision, Plaintiff suffered a detached retina. The weight to be accorded to Montesanti's testimony was "a matter 'peculiarly within the province of the jury.'" *Torricelli*, 9 AD3d at 293. The jury was also entitled to consider Defendant's testimony and evidence to resolve matters of credibility. The jury's verdict was based on the testimony and evidence presented at trial and should not be overturned. *Torricelli*, 9 AD3d at 293. The jury weighed the conflicting testimony of the experts in rendering the verdict. *Id.*

Accordingly, the Court finds a valid line of reasoning and permissible inferences that could possibly lead a rational person to the conclusion that Defendant committed malpractice. *Cahill*, 31 A.D.3d at 349. Setting aside the verdict and overturning the jury's resolution is therefore improper. *Torricelli*, 9 AD3d at 293. Additionally, these permissible inferences and valid line of reasoning also serve as "a rational process by which the fact trier could base a finding in favor of" Plaintiff. *Pinto*, 109 AD3d at 426. Here, the verdict rests on a fair interpretation of the evidence and is therefore not against the weight of the evidence. *Rose*, 107 AD3d at 483.

Wherefore it is hereby

ORDERED that Defendant's motion is denied in its entirety.

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

Dated: April 21, 2020

ENTER: _____ J.S.C.

HON. EILEEN A. RAKOWER

Check one: X FINAL DISPOSITION NON-FINAL DISPOSITION