

Alfieri v Conklin

2021 NY Slip Op 32910(U)

May 21, 2021

Supreme Court, Orange County

Docket Number: Index No. EF001869-2017

Judge: Robert A. Onofry

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SUPREME COURT-STATE OF NEW YORK
IAS PART-ORANGE COUNTY

Present: HON. ROBERT A. ONOFRY, J.S.C.

SUPREME COURT : ORANGE COUNTY

-----X

TERRY ALFIERI,

Plaintiff,

-against-

MICHELE CONKLIN AS ADMINISTRATRIX
OF THE ESTATE OF FRANCIS W. CONKLIN,

Defendant.

-----X

MICHELE CONKLIN AS ADMINISTRATRIX
OF THE ESTATE OF FRANCIS W. CONKLIN,

Third-Party Plaintiff,

-against--

Dr. Thomas A. Piserchia M.D., Dr. Thomas A. Piserchia
M.D., P.C.,

Third-Party Defendants,

-----X

To commence the statutory time
period for appeals as of right (CPLR
5513[a]), you are advised to serve a
copy of this order, with notice of
entry, upon all parties.

Index No. EF001869-2017

DECISION AND ORDER

Motion Date: March 31, 2021

Motion #2

The following papers numbered 1 to 7 were read and considered on a motion by the
Third-Party Defendants, pursuant to CPLR 3212, for summary judgment dismissing the third-
party complaint.

Notice of Motion- Halford Affirmation- Egol Affidavit- Exhibits A-U 1-4
Opposition- Cambareri Affirmations 5
Opposition- Rousseau s Affirmation 6
Reply- Halford Affirmation- Exhibit A..... 7

Upon the foregoing papers, it is hereby,

ORDERED, that the motion is granted.

Introduction

The Plaintiff Terry Alfieri commenced an action against Michelle Conklin, as
Administratrix of the Estate of Francis W. Conklin, to recover damages for personal injuries

allegedly sustained in a fall.

Conklin commenced a third-party action against a doctor who treated Alfieri for such injuries, Dr. Thomas A. Piserchia M.D., and his practice, Dr. Thomas A. Piserchia M.D., P.C. (hereinafter referred to collectively as the "Piserchia Defendants"), alleging that malpractice by the same caused or contributed to Alfieri's damages.

The Piserchia Defendants move for summary judgment dismissing the complaint.

The motion is granted.

Factual/Procedural Background

In the third party complaint, Conklin alleges, *inter alia*, as follows.

"That Third-Party Defendant Dr. Thomas A. Pischeria [sic throughout: Piserchia] did provide medical care and treatment to plaintiff TERRY ALFIERI in a negligent and substandard manner, and did commit acts and omissions which constituted medical malpractice and did thereby cause TERRY ALFIERI to be severely injured and harmed to require treatment, care, and confinement.

That Third-Party Defendant Dr. Thomas A. Pischeria, committed acts or omissions which constituted medical malpractice and medical negligence in connection with the care and treatment of the plaintiff TERRY ALFIERI, such that DR. THOMAS A. PISCHERIA M.D., failed, *inter alia*, to adhere to prevailing standards of good and acceptable medical care and treatment, undertook contraindicated treatment, failed to timely diagnose and detect the signs and symptoms which were evident, failed to give immediate evaluation and proper treatments, failed to insert the appropriate hardware, failed to implement, maintain or abide by appropriate cleanliness and sterilization techniques and standards, failed to Perform/abide by appropriate

surgical techniques, guidelines and standards, failed to request and obtain those tests, consultations and procedures, which were required under the circumstances, all to the permanent damage and detriment of the plaintiff TERRY ALFIERI, and requiring plaintiff TERRY ALFIERI's treatment and care.

That due to the aforesaid medical negligence and medical malpractice, the plaintiff TERRY ALFIERI sustained significant injuries leading to the need for additional surgeries and hardware insertion, as well as an ongoing infection.”

In a bill of particulars, Conklin alleges that, as a result of Dr. Piserchia’s negligence, Alfieri suffered the following injuries:

- Failed hardware and delayed union of fracture site requiring surgery in the form of exploration of extremity with removal of the failed hardware, open reduction and internal fixation of tibial shaft with an intramedullary tibial rod, insertion of demineralized bone substrate material to the tibial shaft and fluoroscopy causing permanent and significant scarring and disfigurement;
- MRSA infection developed at surgical incision site requiring surgery in the form of excision of infected skin and granulation tissue with fluoroscopy causing permanent and significant disfigurement;
- Fractured hardware of right tibial shaft;
- Sepsis;
- Cellulitis and abscess of leg;
- Required use of crutches;
- Continued difficulty with ambulation; scarring and
- Decreased range of motion of right leg continuing to date;
- Permanent total disability for a prolonged period of time and permanent partial disability to present;

- Possibility of future surgery.

The Piserchia Defendants now move for summary judgment seeking dismissal of the third-party complaint. In support of the motion, the Piserchia Defendants submit an affirmation from counsel, Kristen Halford.

As background, Halford asserts as follows.

The litigation at bar arises from a fall sustained by Alfieri on January 16, 2016, while visiting the residence of Francis Conklin, the late father of the Plaintiff Michele Conklin. Alfieri fell on an exterior stairway while leaving the Conklin residence, sustaining severe trauma to her right lower extremity. She was taken by ambulance to Bon Secours Community Hospital where she was diagnosed with comminuted, displaced fractures of the right tibial shaft and fibula. The fractures were surgically reduced and stabilized by Dr. Piserchia at Bon Secours on January 18, 2016.

Halford argues that, as set forth in the detail in the appended affirmation of Dr. Kenneth Egol, an orthopedic trauma surgeon, Alfieri suffered known complications of her fracture repair surgery, including nonunion, hardware failure, and infection, and required various surgeries and treatments. Halford further notes that Alfieri has not alleged any direct cause of action as against Dr. Piserchia. Further, she notes, all parties have been deposed, and a note of issue was filed on November 20, 2020.

Halford argues that, based on the record, and the appended affidavit of Dr. Egol, the Piserchia Defendants should be granted summary judgment dismissing the complaint.

In further support of the motion, the Piserchia Defendants submit an affidavit of Kenneth Egol, M.D.

Dr. Egol avers that he is a physician licensed to practice medicine in the State of New York. He is certified by the American Board of Orthopedic Surgery, and is affiliated with the New York University Langone Orthopedic Hospital, where he presently serves as Chief of the Division of Fracture Surgery and as Vice Chairman of the Department of Orthopedic Surgery.

Further, that he is familiar with accepted standards of care relating to the surgical treatment of fractures, and the management of post-operative complications, including delayed union, hardware failure, and infection.

He has reviewed the pertinent medical records, films, deposition testimony, and pleadings, in the action. Based on the same, it was his opinion, to a reasonable degree of medical certainty, that Dr. Piserchia did not deviate from accepted standards of care in his care and treatment of Alfieri.

As factual background, Dr. Egol notes as follows.

As a result of the fall at issue, Alfieri sustained severe trauma to the right lower extremity with fractures of the right tibial shaft and fibula. The fractures were surgically reduced and stabilized by Dr. Piserchia at Bon Secours Community Hospital on January 18, 2016.

Post-operatively, Alfieri suffered known complications of her fracture repair surgery, including nonunion, hardware failure, and infection. She required a revision surgery on May 9, 2016, to remove and replace her broken hardware. The revision surgery was complicated by post-operative wound infection that necessitated two debridement and irrigation procedures, and a prolonged course of oral and intravenous antibiotics.

Dr. Egol notes that Conklin alleges that Dr. Piserchia failed to properly install and secure Alfieri's hardware during the January 18th surgery, failed to facilitate bone union at the site of the

tibial fracture during the January 18th surgery, and failed to facilitate proper closure of the “surgical opening wound” after the January 18th and/or May 9th surgeries. There are also general allegations of a lack of good care.

However, it was his opinion, to a reasonable degree of medical certainty, that the allegations of malpractice are devoid of merit.

As to the specifics, Dr. Egol avers as follows.

After her fall, Alfieri was transported to the Emergency Room at Bon Secours Community Hospital, where x-rays demonstrated fractures of the right tibial shaft and fibula. The fractures were comminuted, meaning that the bone was broken into more than two pieces, and were displaced, meaning that the fractured bone had moved out of alignment.

An orthopedic surgery consultation was requested of Dr. Piserchia, who saw Alfieri that night. He noted that the fractures would have to be treated surgically, with open reduction and internal fixation (“ORIF”). He documented that he discussed with Alfieri the nature of her injuries, as well as the potential risks and complications of surgical repair, including death, loss of limb, infection, extension of the fracture sites, nonunion, malunion, fibrous union, and neurovascular injury/deficit. Surgery was planned for Monday, January 18th.

On January 18, 2016, Alfieri signed a consent form authorizing Dr. Piserchia to perform insertion of an intramedullary nail/rodding and possible plating of the right tibia and fibula with fluoroscopy. The surgery was performed that afternoon.

The two primary methods for internal stabilization of tibial shaft fractures are intramedullary nailing and plating. The primary advantage of intramedullary nailing is that it is less invasive and can be performed through smaller incisions. During the procedure, a guidewire

is threaded into the central cavity of the bone (the medullary canal). The surgeon then lines up the broken ends of the bone and inserts a nail or rod (these terms are used interchangeably) through the medullary canal to maintain alignment of the bone. Locking screws are placed on both ends to keep the bone from moving around the rod. Prior to rod insertion, the surgeon often uses a device called a reamer (a rotational cutting tool) to hollow out the bone and create room for the rod within the medullary canal.

Plating is a second fixation technique. Tibial plating requires a larger incision for exposure of the fracture site. The surgeon aligns the bone and affixes a plate to the bone with cortical screws.

Intramedullary nailing and plate fixation both carry the risks of infection, delayed union (stalled healing), and nonunion (interrupted healing), all of which are complications that may necessitate additional surgery.

Intra-operatively on January 18th, Dr. Piserchia found that the patient's tibial fracture was very comminuted and unstable. He initially planned to place an intramedullary rod to stabilize the fracture. However, he had difficulty passing the guidewire down into the tibia, and despite multiple attempts, he was unable to pass the guidewire through the segmental fracture site.

He therefore decided to open up the fracture site in order to align the fractures before introducing the intramedullary rod. After manually manipulating the fractures into alignment, he was able to pass the guidewire, but he discovered that a 9 mm rod would have been "very tight" due to the size of the patient's medullary canal. In order to create enough room for the rod, he would have needed to over-ream the medullary canal to about 10 to 10.5 mm. According to his operative report, Dr. Piserchia believed that he could not do this safely, especially across the area

of the segmental fractures.

At his deposition, Dr Piserchia testified that he was concerned that the reamer could shatter the bone further and cause more disruption at the fracture site.

Given such concerns, Dr. Piserchia decided to abandon his attempts at nailing and to stabilize the fracture with a compression plate and screws. Thus, he opened the distal incision more widely, aligned the bone, placed clamps to hold the bone in place, and then placed a 9-hole compression plate over the tibia, bridging the fracture site. He fixed the plate by drilling for and inserting eight bicortical screws. Dr. Piserchia obtained x-rays to confirm satisfactory positioning and stabilization. He then flushed the operative field with sterile saline and closed the subcutaneous tissue and skin with multiple layers of heavy Vicryl and Prolene sutures. The incisional wounds were cleansed and dressed, and an Aircast was applied to the right lower extremity. Dr. Piserchia dictated his operative report on the date of surgery and signed it two days later, on January 20th.

Alfieri testified that she recalled speaking to Dr. Piserchia in the recovery room, and that he explained to her that he had been unable to insert a rod, but that the plate and screws he used were holding well and everything was lined up. She testified that he visited her and examined her right leg every evening while she was in the hospital.

Alfieri was discharged home on January 21st. Prior to discharge, she was seen and examined by Dr. Piserchia, who noted that she was to maintain non-weight bearing status until further notice.

Alfieri presented for her first post-operative visit at the Bon Secours Orthopedics Clinic on January 27, 2016. Dr. Piserchia removed her dressings, noting that her incisions appeared

clean, dry, and healthy. An x-ray demonstrated that the tibial shaft fracture was holding in place with a plate and screws transfixing the fracture site in satisfactory position. Dr. Piserchia instructed Alfieri to elevate her leg intermittently and to continue non-weight bearing status. She was also to use an air cast for immobilization. Dr. Piserchia asked her to return for re-evaluation in one week.

Alfieri continued to see Dr. Piserchia for outpatient follow-up evaluations, initially weekly, and later, every 3 to 4 weeks. X-rays were performed at every visit, and continued to show satisfactory alignment, an intact plate and screws, and callous formation/healing of the fracture site. Alfieri showed no signs of infection in her surgical incisions. She began using a rolling walker with toe-touch status in February, and crutches with partial weight-bearing in March.

Alfieri started physical therapy at Milford Healthcare, her place of employment, on March 17, 2016.

On March 30, 2016, Dr. Piserchia cleared her to increase her weight-bearing as tolerated.

At a clinic visit on April 21, 2016, Dr. Piserchia documented that Alfieri was fully mobile, ambulatory on the right lower extremity, and doing well. She was not having any significant pain. Her surgical incisions had healed. Repeat x-rays demonstrated that her fractures were healing in place with callus formation on both the tibia and fibula. The plate and screws were intact. Dr. Piserchia documented that Alfieri was anxious to return to work. He advised her that she could do so upon condition that she not over-exert herself. He provided her with a written note indicating that she could work for 6 to 8 hours per day, but no more than eight hours per day.

She was instructed to continue intermittently elevating her leg. She was asked to return to the clinic in one month for further evaluation and x-rays.

Alfieri testified that she returned to work on April 26, 2016. She had some pain in her leg, which she graded as a 3 to 4 out of 10 in severity. She testified that the pain was not severe enough to prevent her from completing her eight-hour shift. She took the next two days off and then returned to work on April 29, 2016. While working that day, she heard a “pop,” which was accompanied by increased pain in the right leg. She presented to the Bon Secours Emergency Department at 7 p.m. for evaluation.

An x-ray was obtained in the E.D. and compared with the previous x-ray taken on April 21, 2016, during Alfieri’s most recent visit with Dr. Piserchia. The April 29th x-ray demonstrated minimal medial angulation of the fibula when compared to the April 21, 2016, study, and that a screw in the proximal tibia had broken. According to the history taken by the E.D. attending, Dr. Matthew Pius, Alfieri had started to have pain 3 to 5 hours earlier, and had been walking with an Aircast. While at work, she felt a pull in the right leg, with a sensation of looseness and abnormal movement above her ankle. Upon Dr. Pius’ review of her x-ray, he noted that she had an apparent break of her tibial plate along with nonunion of the fibular fracture, which seemed to be more displaced in comparison with the April 21st x-ray. Dr. Piserchia was contacted. He reviewed the x-ray and agreed that her plate appeared to be cracked. He recommended that the patient be splinted and maintained on non-weight bearing status, and asked to see her at the clinic.

Alfieri had an appointment with Dr. Piserchia on May 4, 2016. Dr. Piserchia documented that the patient had traveled to Arizona and had been putting pressure on her leg during that time.

He further noted that Alfieri had insisted upon returning to work, indicating that she would protect and avoid over-stressing the right leg. During her second day at work, she had felt a pop in the leg and a sensation of a tendon stretching. She was evaluated in the E.D. and found to have a minute crack in her tibial plate. Since then, she had experienced increased pain in the leg and noticeable motion at the fracture site (a complaint that is indicative of a tibia fracture nonunion). There was no appreciable displacement of the fracture or plate. Dr. Piserchia informed Alfieri that the plate had failed and would need to be surgically removed. She would require a revision repair with either re-plating or intramedullary nailing.

Alfieri was admitted to Bon Secours Community Hospital for her revision surgery on May 9, 2016. Dr. Piserchia met with the patient to discuss the nature and severity of her injury as well as his surgical recommendations, which included the use of new hardware and supplemental Vitoss bone graft. According to his admission note, he and Alfieri discussed the possible surgical risks and complications, including infection, neurovascular compromise, inability to implant the rod, loss of limb, and death.

Surgery was begun at 8:30 a.m. Dr. Piserchia incised the skin and subcutaneous tissue down to the level of the tibial plate. He then removed the cortical screws and tibial plate, noting that the second uppermost screw was broken. He had to excavate the bone around the screw insertion site in order to remove the broken fragment of the screw from the tibial shaft. Because significant healing had occurred, Dr. Piserchia was able to advance a guidewire across the fracture site this time, and an intramedullary rod was then inserted into the tibial shaft over the wire. Two screws were used to lock the rod proximally and three screws were used to lock the rod distally to stabilize the construct. A biopsy specimen was taken from the nonunion/delayed

union site for histopathology and the synthetic bone graft was applied at the fracture nonunion site. X-rays demonstrated that the rod was in acceptable position. Dr. Piserchia flushed the incisional areas several times during the procedure. He closed the incisions with multilayer Vicryl sutures and a combination of Prolene sutures and stainless steel staples for the skin. The incisions were dressed and the patient was placed in an Aircast-type support.

Dr. Piserchia saw and examined Alfieri daily through her discharge on May 12, 2016. At discharge, she received instructions to keep her dressings clean and dry and to maintain non-weight bearing status with crutches. She was also told to limit her activities and to contact her surgeon if she observed any swelling, redness, odor, excessive pain, temperature over 100.5°, nausea/vomiting lasting longer than four hours, or any change in color, persistent numbness, tingling, coldness, or increased pain.

Alfieri saw Dr. Piserchia at the orthopedic clinic for her first post-operative check on May 19, 2016. She reported that she was doing well. Dr. Piserchia removed half of her staples alternately, cleansed her incision sites, and re-covered her incisions with dry sterile dressings. She was told to remain non-weight bearing with crutches.

On May 26th, Alfieri informed Dr. Piserchia that she had been having some drainage from her incision site. On examination that day, Dr. Piserchia did not observe any drainage. Alfieri had minimal swelling with tenderness over the mid-incisional area and there was no odor. Dr. Piserchia removed her sutures and remaining staples, noting that the incision sites were intact. He cleansed the incisions with alcohol and betadine and applied Steri-strips.

On May 31st, Alfieri presented to Dr. Gabriel Dassa, a non-party orthopedic surgeon, for an initial evaluation. On examination, she had a well-healed surgical incision over the medial

aspect of the right tibia measuring approximately 14 cm. According to Dr. Dassa's note, the incision was clean with no swelling, erythema, or signs of infection. At the knee, there was a well healed surgical incision from the IM rod with no signs of infection, although the right knee was swollen in comparison with the left.

On June 2, 2016, Alfieri returned to Dr. Piserchia for follow-up. She was doing well but she now had an open area of granulation tissue (new connective tissue that forms on the surface of a wound during the healing process), from which there had been mild drainage. He cleansed the leg with alcohol, noting that there was no active drainage at that time. The area of granulation tissue was at the junction of the mid-to distal incision on the anterior aspect of the right leg. She had one buried, absorbable suture that had worked its way out to the skin. Dr. Piserchia removed this, cleansed the incision, and applied a dry sterile dressing. He prescribed oral antibiotics (Keflex and Cipro) to prevent infection and advised the patient to change her dressings 2 to 3 times per day, applying Curad Silver solution to the open area. She was asked to return for follow-up in one week.

At visits on June 10th and June 17th, Dr. Piserchia documented that there was no significant drainage or odor at the incision. The open area was decreasing in size and the wound was granulating. Dr. Piserchia opined that there was no distinct evidence of infection. He advised Alfieri to continue with local wound care.

On June 23rd, Dr. Piserchia documented that the patient had no pain in the leg, no systemic symptoms, and no redness or erythema. The small area of opening over the anterior tibial area was granulating in and had a droplet of drainage. It did not appear to be infected. Dr. Piserchia found and removed another retained suture. X-rays demonstrated healing fractures and

good alignment.

In follow-up on July 1st and July 7th, Dr. Piserchia documented that there was no redness, ecchymosis, swelling, pain, purulent drainage, or odor in the incisional areas. The small oval-shaped opening at the surgical incision was healing over and getting smaller.

Alfieri was next seen by Dr. Piserchia on July 22nd. At that time, there was a change in the appearance of the wound. He noted that he would be taking Alfieri to the O.R. the following Monday, July 25th; she had two small sinus tracts (a finding that is consistent with infection) along with some clear drainage. A culture was taken and sent to the lab. Dr. Piserchia planned to resect the sinus tract, debride and irrigate the area, and administer IV antibiotics. He discussed the risks and benefits of surgery with the patient.

The next day, July 22nd, Alfieri presented to the Bon Secours E.D. due to pain following Dr. Piserchia's manipulation of her leg the day before. She was already scheduled for surgery due to possible infection, and a culture was pending. She was admitted for treatment with IV antibiotics (vancomycin and piperacillin). Dr. Piserchia saw her in the hospital that night, noting that she was afebrile with stable vital signs. His plan was to continue antibiotics, follow up for her culture results, and proceed with surgery as scheduled on July 25th.

On July 23rd, Alfieri's culture results were reported. The cultures yielded MRSA (methicillin resistant Staph aureus). Surgery was performed by Dr. Piserchia on July 25th. He excised the skin and sinus tract and sent the tissue for histopathology. He also sent another sample of the wound drainage for culture and sensitivity. He irrigated the fracture site with sterile saline, acetic acid, and colloidal silver solution. He placed a surgical drain to prevent collection of fluid and then sutured and dressed the wound. The procedure was well-tolerated,

with no complications. Post operatively, an infectious diseases specialist, Dr. Liu, was consulted. She recommended a six-week course of IV antibiotics. The patient was switched from vancomycin to daptomycin. A PICC line for antibiotic infusions was placed on July 29th. Alfieri was discharged home later that day.

During Alfieri's weekly visits with Dr. Piserchia from August 3, 2016, to September 1, 2016, there were no signs of active drainage or infection. X-rays demonstrated that her hardware was holding and her fractures were healing. There was no evidence of lytic bone destruction. Alfieri was being followed by a wound care nurse and was continuing to receive her antibiotics at an infusion center. A repeat culture was negative for MRSA.

On September 14, 2016, Alfieri presented to the Bon Secours E.D. with complaints of pain in the right calf and redness and a small mid-wound separation on her right tibia. She had recently completed her six-week course of antibiotics. She reported that she had an appointment scheduled to see Dr. Piserchia that evening. An x-ray was performed in the E.D. which showed unchanged alignment of the healing fractures in her right tibia and fibula. A urinalysis was positive for bacteria. Blood cultures taken that day were negative. Dr. Piserchia was contacted by the E.D. attending; and asked to see her in the clinic that night. Alfieri was given a prescription for Macrobid for urinary tract infection.

At the clinic that evening, Dr. Piserchia did not observe any active drainage. However, Alfieri had some redness around the incisional area. She had no redness or specific tenderness over the calf. He advised her to keep the incision clean and dry and to intermittently elevate the leg to reduce swelling. She was to return for follow-up in one week.

On September 29, 2016, Alfieri presented with a "bubble" on the anterior aspect of the

tibia near the mid-incisional area. Dr. Piserchia was able to express some blood and “what appeared to be infected tissue.” Cultures and sensitivities were taken and sent to the lab. Dr. Piserchia felt that she would require a repeat excision and debridement. He noted that the skin was adherent to the underlying bone. The poor soft tissue and vascularity in this area of the leg is notorious for issues with healing and infection. The patient signed a consent for surgery.

On October 3, 2016, Dr. Piserchia performed a deep debridement and irrigation of the right lower extremity at Bon Secours Hospital. According to his operative report, Dr. Piserchia observed what appeared to be a superficial infection of the skin and subcutaneous tissue. Excision was carried through the skin and subcutaneous tissue to the bone, which was exposed and did not appear to be infected. The patient tolerated the procedure well and no complications were noted. Intra-operative cultures revealed scant MRSA.

Alfieri was discharged on October 7, 2016. She was to continue to receive her IV vancomycin from the infusion center across the street from the hospital. As per Dr. Liu, she was prescribed oral rifampin for six weeks. Alfieri was also to receive home nursing care through Celtic Home Services.

Alfieri continued to follow with Dr. Piserchia through December 7, 2016. During her visits, there were no further signs of infection. She left Dr. Piserchia’s care after the December 7th visit.

Two years after her last procedure with Dr Piserchia, in October 2018, Alfieri began treating with Dr. Anthony Infante, an orthopedic surgeon. During the initial visit, Dr. Infante noted that her incisions were well-healed, with no evidence of infection. X-rays showed that her hardware was in a good position with no migration or breakage. Later that month, Dr. Infante

removed the tibial rod and hardware, which was thought to be causing some right lower extremity pain. In a post-op follow-up visit, Alfieri indicated she was doing well, with no pain or other symptoms.

Based on all the above, Dr. Egol avers, it was his opinion, to a reasonable degree of medical certainty, that the allegations of malpractice as against Dr. Piserchia lacked any medical support and were without merit.

That is, Dr. Piserchia exercised appropriate clinical judgment in abandoning a procedure that he felt could not be safely undertaken and could potentially cause more harm to this patient (an intramedullary nailing), and instead opting to place a plate and screws, which is a well-established technique for stabilizing and fixing long bone fractures of this nature.

There was no merit to the claim that Dr. Piserchia failed to facilitate union at the tibial fracture site. Further, the use of a graft was not indicated during the initial surgery.

In addition, Dr. Egol opines, there was no evidence that Dr. Piserchia failed to properly install the hardware. Rather, numerous post-operative x-rays through April 21st showed that the hardware remained in place for several months after the surgery, with an intact plate and no evidence of screw loosening. X-rays also demonstrated that she had early callus formation at the tibial and fibular fracture sites, indicating that her fractures were healing.

Unfortunately, Dr. Egol asserts, when Alfieri returned to work in late April of 2016 (14 weeks after her surgery), she heard a “pop,” which indicated that a broken screw and a crack in her compression plate. This hardware failure occurred due to nonunion (interrupted healing) of her fractures. Dr. Egol asserts that nonunion is complication that occurs in approximately 5% of lower leg fractures and can occur whether a rod or a plate is used. Here, he opines, although the

cause of Alfieri's nonunion is unknown, risk factors include fracture severity, poor nutrition, disease comorbidity, and medication use.

Further, in his opinion, it was appropriate for Dr. Piserchia to permit Alfieri to return to work in late April 2016 (14 weeks post-operatively) upon condition that she worked no longer than 6 to 8 hours, and avoided overstressing the leg. Generally, he asserts, patients with these types of fractures are permitted to walk 14 to 18 weeks after surgery, although there is no set timeframe. In fact, he avers, as long as the patient is not having significant pain, ambulation is actually beneficial in cases of delayed healing because "the bone seeing load" promotes bone healing.

In addition, Dr. Egol opines, when Alfieri was discovered to have broken hardware and a fracture nonunion, Dr. Piserchia took her back to the O.R. in a timely fashion, and appropriately instructed her to maintain non-weight bearing status prior to the surgery.

Further, during the second surgery, he properly found that the fractures were more stable and reduced into a better position, and that he could safely pass the flexible wire, ream the medullary canal, and place an intramedullary rod.

It was also Dr. Egol's opinion that there was no merit to the claim that Dr. Piserchia "failed to facilitate proper closure" of the surgical incisions. Rather, during the initial and revision surgeries, he performed a multi-layered closure with appropriate use of sutures and/or staples to the subcutaneous tissue and skin. Further, during all surgeries, he also used sterile technique and adhered to appropriate infection control protocols, including the administration of appropriate prophylactic antibiotics prior to incision, and the use of antiseptic solutions to irrigate the operative field. Indeed, Dr. Egol avers, although infection control practices reduce the

risk of post-operative infection, the risk cannot be eliminated, and such infections can and do occur despite adherence to proper procedures.

It was also his opinion, to a reasonable degree of medical certainty, that Dr. Piserchia appropriately managed the patient's infection following her revision surgery.

In the initial post-operative period, Alfieri had some non-purulent (*i.e.*, non-infectious appearing) serous drainage from her incision. However, he asserts, this is not an uncommon finding following surgery of this nature. Dr. Piserchia monitored her wounds closely with weekly follow-up visits, prescribed oral antibiotics to stave off infection, and gave her detailed local wound care instructions in an effort to keep her incisions clean, dry, and sterile. Alfieri had no overt signs or symptoms of infection, and the small dehiscence in her incision appeared to be healing over, until July 21, 2016, at which time Dr. Piserchia observed sinus tract formation in the surgical area. At that time, Dr. Egol opines, Dr. Piserchia appropriately obtained a wound culture and scheduled Alfieri for the O.R. to explore the wound. Further, it was his opinion that the July 25th surgery was properly and timely performed; and that there was no need to operate on an emergent basis because Alfieri remained hemodynamically stable, with normal vital signs and no evidence of systemic infection. Otherwise, he opines, Dr. Piserchia removed the infected tissue, irrigated the operative field with antiseptic solution, and left the hardware in place; all of which is acceptable and standard treatment for an early fracture-related infection of this nature. Following the surgery, an infectious diseases consultant was brought into the case to provide guidance with respect to the patient's culture results and long-term antibiotic therapy. Unfortunately, Dr. Egol opines, despite appropriate surgical management, local wound care, and treatment with culture-targeted antibiotics, Alfieri had a recurrence of infection that necessitated

a second incision and debridement procedure in October, with extended utilization of IV and PO antibiotics.

Two years after leaving Dr. Piserchia's care, Alfieri had her hardware removed by another orthopedic surgeon, Dr. Infante. However, Dr. Egol opines, the fact that the hardware was removed does not speak to any negligence or improper surgical technique by Dr. Piserchia. Rather, hardware that is implanted to stabilize tibial shaft fractures can cause pain and stiffness in the leg, and removal is commonly offered to patients who are experiencing such symptoms after their fractures have healed. Here, he notes, the x-rays obtained by Dr. Infante prior to removing the hardware demonstrated that the hardware remained in good position with no migration, and that her fractures were healed and she had no signs of recurrent infection.

In sum, Dr. Egol opines, the third-party claims against Dr. Piserchia should be dismissed, as none of the surgical complications that transpired in this case are attributable to any professional negligence on the part of Dr. Piserchia.

In partial opposition to the motion, Alfieri submits an affirmation from counsel, Mark Cambareri.

Cambareri notes that Alfieri did not file a direct claim as against the Piserchia Defendants. However, he asserts, in order to avoid issues of collateral estoppel, he noted as follows.

The Piserchia Defendants' medical expert, Dr. Egol, did not state why, or explain how, the cortical screw and plate inside Alfieri's ankle broke. Rather, he notes, although there was a reference to Alfieri "insisting" on returning to work, she only did so after being cleared by Dr. Piserchia. Further, she observed all precautions.

Dr. Egol also noted that Alfieri traveled to Phoenix (Arizona) before returning to work. However, Cambareri asserts, Alfieri was just a passenger in a vehicle driven there by her boyfriend, and she engaged in no activities while there. For the return flight home, she used a wheelchair in the airport.

Finally, Cambareri notes, Alfieri testified that, after the second surgery, she cleaned the wound as shown to her by Dr. Piserchia. She was never told that she was cleaning her wound improperly, and recalled being told to stop cleaning the wound after it worsened. She was prescribed antibiotics because of MRSA. Further, he notes, Alfieri subsequently sought an opinion from another orthopedist, who informed her that her bone had not healed sufficiently to have the intermedullary rod removed.

In sum Cambareri argues, there is no evidence that Alfieri contributed to any of the multiple complications that arose after her surgeries.

In opposition to Piserchia Defendants' motion, Conklin submits an affirmation from counsel, Marc Rousseau.

Rousseau argues that the Piserchia Defendants failed to demonstrate a *prima facie* entitlement to judgment as a matter of law because the affidavit of Dr. Egol is "conclusory, speculative, fails to address the allegations as set forth in the pleadings herein, fails to explain the standard of care, fails to explain what PISCHERIA [sic] did and why, and fails to establish a *prima facie* entitlement to summary judgment."

Indeed, he notes, Dr. Egol based his opinion on his review of the relevant medical records, and not on a physical examination of Alfieri.

Rousseau asserts that the potential risk of hardware failure was not discussed with Alfieri,

nor was the risk of further surgery, which was identified by Dr. Egol as a risk of surgical repair of the fracture utilizing either intramedullary nailing or plating. These facts, he argues, belie the assertion that such risks were known by Alfieri, and that there was no departure from the standard of care.

Further, he asserts, although Dr. Egol discusses the alternative methods of surgical repair for comminuted fractures, Dr. Egol, again, does not assert that the risk of hardware failure is among them.

In addition, Rosseau notes, while Dr. Egol states that the post-operative x-rays from the time of the initial surgery until April 21, 2016, showed the hardware “remained in place,” he fails to address the allegation that Dr. Piserchia failed to properly install the hardware and failed “to secure hardware in a sufficient and prudent manner during the first surgery.” Indeed, Rousseau argues, that an improperly installed device has not moved, does not negate the impropriety of the initial installation.

Further, he asserts, Dr. Egol does not explain the standard of care with regard to the installation of the plate.

With regard to the failure of the hardware, Dr. Egol states (without explanation or reasoning) that the hardware failure was due to the nonunion of the fracture site. However, Rosseau argues, there is nothing in the record to support this claim and, without sufficient explanation as to such conclusion, the Court is without the ability to determine if such assertion was personally known to Dr. Egol. Further, Rousseau contends, because the assertion is purely speculative and without support, the statements that nonunion is a known complication of such surgical repair is of no import in relation to the hardware failure.

In response to the allegation of failure to facilitate union at the tibial fracture site, Dr. Egol also states, “summarily, without support, and without explanation, that the use of a bone graft was not indicated during the initial surgery, but was during the second.” This is true, Rousseau notes, despite the fact that Dr. Egol asserts there was no appreciable displacement of the fracture or plate, and significant healing had occurred at the fracture site. Thus, Rousseau argues, this opinion is again “purely speculative and conclusory, fails to benefit from any explanation as to what Piserchia did and why, and fails to explain the standard of care with regard to such allegation.”

Similarly, he asserts, the opinion of Dr. Egol that there is no merit to the allegation that Dr. Piserchia failed to facilitate proper closure of the surgical incisions is based solely upon the “self-serving medical records” of Dr. Piserchia.

Moreover, Rousseau notes, despite an opportunity to do so, Dr. Egol did not examine Alfieri in order to determine if the remaining evidence (*i.e.* scarring and/or condition of skin) at the incision sites support the conclusion that proper techniques and/or materials were utilized in the closure of the incisions. Nor is there any reference to the review of photographs of the surgical scars from either the first or second surgery. As such, Rousseau argues, Dr. Egol’s assertions are conclusory and insufficient to warrant summary judgment.

Dr. Egol also opines that Dr. Piserchia properly managed the infection that occurred after the revision surgery. Rousseau notes that Alfieri first complained of drainage from the incision site on May 26, 2016. However, he notes, despite the same, Dr. Piserchia removed the sutures and remaining staples at that time. No antibiotics were prescribed to prevent infection. A week later, on June 2, 2016, there was an open area of granulation tissue and mild drainage, as well as

a buried suture that had not been previously removed. Rousseau asserts that, despite the contention that the granulation tissue was evidence of the healing process (and presumably not of an infection), antibiotics were prescribed, along with Curad Silver solution. Further, he notes, although Dr. Egol opines that there was no evidence of infection at the visits on June 10th and June 17th, 2016, this opinion is based on Dr. Piserchia's self-serving records.

On June 23, 2016, the incision area was granulating still and had some drainage, but did not appear to Dr. Piserchia to be infected. Another suture left behind was found and removed.

On July 1st and July 7th, 2016, there was no drainage or odor observed.

However, on July 22, 2016, almost one month after Alfieri presented with drainage, she exhibited drainage again, as well as two sinus tracts. Cultures resulted in findings involving MRSA.

On July 25, 2016, surgery to remove the sinus tracts was performed, and it was only then that a consultation with an infectious disease physician was requested.

On September 14, 2016, after completion of a six week course of antibiotics, Alfieri appeared in the emergency room with redness and small wound mid-wound separation, and had a urinalysis positive for bacteria. She was treated for a urinary tract infection, despite the wound separation.

Two weeks later, on September 29, 2016, Alfieri exhibited a bubble in the incision areas and what appeared to be infected tissue.

However, surgery was not performed until October 3, four days later.

Rousseau argues that Dr. Egol's opinion regarding the management of the infection is based solely upon the self-serving records of Dr. Piserchia, as he did not examine Alfieri himself

to determine whether there was any corroborating evidence at the incision sites.

Further, he asserts, Dr. Egol's opinion ignores the fact that, although drainage was claimed by Alfieri, Dr. Piserchia removed the staples and sutures (a gateway against infection) without prescribing antibiotics on May 26, 2016. A week later, on June 2, 2016, granulation tissue was found and a suture not removed was removed. Rousseau notes that, despite an assertion that granulation tissue is a sign of healing, not infection, antibiotics were prescribed. Rousseau asserts that Dr. Egol provides no explanation for this, and makes no effort to explain the timing of the antibiotics and the silver solution usage. Further, he does not comment at all on the failure to remove all sutures, and whether this was a contributing factor to the infection and formation of sinus tracts observed one month after the first complaint and cultures confirmed MRSA present.

In addition, Rousseau asserts, after the surgery for excision and debridement of the sinus tracts (three days later, again with no attempt at an explanation other than a conclusory statement that it was not an emergency despite cultures showing MRSA), then and only then was an infectious disease physician consulted. Moreover, after completing the course of antibiotics, Alfieri exhibited further signs of infection, and wound separation that was treated, not as an infection of the incision site, but as a urinary tract infection, with no explanation from Dr. Egol. Two weeks later, he notes, Alfieri exhibited further signs of infection, "with the tissue at the incision site adhering to the bone, it had gotten so bad."

Rousseau argues that there are clear inconsistencies regarding the management of the post-operative infections, to wit: Dr Egol opines that Dr. Piserchia managed the situation correctly, despite antibiotics being prescribed at certain times and not at others, while at the same

time opining there were no signs of an infection until July 22, 2016. Rousseau asserts that there is no explanation as to why there were delays in intervention and how the progression of the infection developed to such an extreme point on both occasions, without the benefit of an infectious disease consult until after surgery was already performed. Thus, he argues, the opinion of Dr. Egol is inconsistent at best, and conclusory and speculative at worst.

In sum, Rousseau asserts, Dr. Piserchia failed to properly perform the initial surgery and to properly install and secure the hardware on order to facilitate proper union. This resulted in, at least, a hardware failure, which led to the resulting complications and the need for the revision surgery.

Further, he argues, Dr. Piserchia failed to properly facilitate closure of the incision sites and to timely diagnose and properly and timely treat the resulting infections. This resulted in the two excision and debridement procedures, as well as the extended antibiotics course.

Therefore, he asserts, the Piserchia Defendants' motion must be denied in its entirety.

In reply, the Piserchia Defendants submit an affirmation from counsel, Kristen Halford.

Halford argues that Conklin's opposition papers, which are merely "an attorney affirmation unaccompanied by any expert opinion," are comprised of "inadmissible medical assertions by her attorney; references to new and unfounded allegations of malpractice that were never previously pleaded in this case and are unsupported by expert opinion; repetitive, baseless assertions that Dr. Piserchia's records are 'self-serving' and thus unreliable; and frivolous, disingenuous arguments concerning the legal sufficiency of Dr. Egol's detailed, factually supported expert affirmation." Indeed, Halford asserts, the "absence of any supporting expert opinion can only lead to the conclusion that the third-party plaintiff's allegations of malpractice

are non meritorious.”

In general, Halford asserts, expert testimony is necessary to prove a deviation from accepted standards of medical care and to establish proximate cause. Here, she notes, Conklin has not submitted the same.

By contrast, she argues, Dr. Egol’s opinions are detailed and supported by the record.

Further, she asserts, the lack of an independent medical examination of Alfieri does not undermine Dr. Egol’s opinions, as it cannot be credibly argued that a physical examination of Alfieri by Dr. Egol five years after the subject treatment and care would have yielded any information that would have impacted his opinions in this case. Indeed, she opines, in medical malpractice actions, medical examinations are typically only performed where the nature or extent of a plaintiff’s injuries are in dispute.

Moreover, she notes, a medical examination of Alfieri was performed at the behest of Conklin’s attorneys by Dr. Michael Berezin, an orthopedic surgeon, on June 12, 2018. In his report, Dr. Berezin did not express any criticism of Dr. Pischeria’s treatment and care, or report any physical examination findings that would support allegations of malpractice. In fact, she asserts, Dr. Berezin explicitly stated that Alfieri “has received appropriate treatment.” Halford argues that Dr. Berezin’s report demonstrates that counsel’s assertions regarding the importance of a medical examination are disingenuous.

Further, she notes, Rousseau argues that the risk of hardware failure was not documented in Dr. Pischeria’s notes as having been discussed pre-operatively with Alfieri. However, Halford argues, this is entirely irrelevant, as there is no claim in the action that Dr. Pischeria failed to obtain Alfieri’s informed consent.

Rousseau also argues that Dr. Egol failed to explain why a bone graft was indicated during the second surgery, but not during the first. “Confusingly,” Halford asserts, “and without any evidentiary support, her attorney argues that Dr. Egol’s opinions concerning the indications for using graft/substrate material are somehow inconsistent with the fact that ‘there was no appreciable displacement of the fracture or plate.’” However, Halford argues, it is entirely unclear how a lack of displacement would have any relevance to the indications for using graft/substrate material during either of Alfieri’s surgeries. In terms of the distinction between the first and second surgeries, she asserts, this is abundantly clear; when Dr. Piserchia operated on May 9, 2016, Alfieri was known to have had a prior non-union due to delayed bone healing. As Dr. Piserchia explained at his deposition, given Alfieri’s prior history of delayed union, he decided to use bone substrate during the second surgery in an effort to enhance and speed up healing at the fracture site.

Further, she notes, Dr. Egol and Dr. Piserchia concur that the standard of care did not require the use of bone graft or bone substrate during the initial surgery; which was uncontroverted.

Rousseau also argues that Dr. Egol’s opinions regarding Dr. Piserchia’s closure of the incisions are insufficient because they are based upon Dr. Piserchia’s “self-serving” operative reports, and because Dr. Egol did not physically examine plaintiff.

However, she asserts, these assertions are completely baseless and speculative. Dr. Piserchia’s operative reports were dictated on the same dates as the respective surgeries. Thus, she argues, there is no basis to claim that the operative reports do not accurately reflect the steps that were taken by Dr. Piserchia in the O.R. during each of the surgeries.

Otherwise, she asserts, Conklin failed to come forward with any admissible evidence that would establish that Alfieri's infection arose due to improper closure of her surgical wounds.

Halford argues that the last four pages of Conklin's opposition papers pertain to Dr. Piserchia's management of Alfieri's wound infection, an aspect of the treatment and care that has never been in issue. That is, in the bills of particulars, there is no claim that the wound infection was improperly managed, that appropriate antibiotics were not prescribed, that surgical treatment was not rendered in a timely fashion, or that there was any delay in ordering an infectious diseases consultation. Thus, she argues, Conklin is raising new theories of liability, without any supporting expert opinion, for the first time in her opposition papers, which is not permitted.

Further, she asserts, in addition to the fact that no allegations relating to the wound infection were ever raised during disclosure, Conklin has failed to submit any expert opinion to support her claims or to rebut the affirmation of Dr. Egol, who opined that Dr. Piserchia's treatment of the infection was appropriate. Rather, Halford argues, her attorney merely offers speculative statements regarding the possible significance of minor aspects of her care.

For example, Rousseau questions why Dr. Piserchia removed Alfieri's sutures and staples on May 26, 2016, "despite the presence of drainage." However, Halford asserts, it should be noted that, just five days later, Alfieri was examined by a non-party orthopedist, Dr. Dassa, who described her incisions as "well-healed" and clean without any swelling, erythema, or signs of infection.

Rousseau also questions why Dr. Piserchia prescribed oral antibiotics on June 2, 2016, despite the fact that the wound appeared to be healing. However, Halford asserts, contrary to Rousseau contention, this was addressed by Dr. Egol, to wit: "Dr. Egol very clearly explained

that the antibiotics were prescribed to prevent an infection, not to treat an existing infection.”

Rousseau also speculates that the absorbable, buried sutures that Dr. Piserchia removed during office visits on June 2, 2016, and June 23, 2016, may have contributed to the infection. However, she notes, Rousseau dismisses Dr. Piserchia’s clinic notes dated June 10, 2016, and June 17, 2016, which indicate no evidence of wound infection, as baseless.

Further, she asserts, Rousseau “speculates that there may have been a negligent three-day delay by Dr. Piserchia in ordering an infectious diseases consult during plaintiff’s hospitalization in October of 2016, notwithstanding the fact that wound cultures were obtained and IV antibiotics were started immediately upon plaintiff’s admission.”

Similarly, she argues, Rousseau “speculates that there may have been a negligent four-day delay in operating during the October 2016 admission,” when Dr. Egol’s affidavit establishes that a wound infection is not a surgical emergency if the patient, as here, is hemodynamically stable with no signs of systemic infection.

In addition, she asserts, Rousseau improperly avers, without supporting expert opinion, that Alfieri’s wound infection was allowed to progress to an “extreme point,” and improperly suggests, without any foundation, that the results of the wound cultures, which grew out MRSA, may have presented a surgical emergency.

Halford argues that none of the above claims was pleaded or developed during disclosure. Rather, she asserts, Dr. Piserchia’s management of the wound infection has never been in issue. Thus, she argues, all of the arguments must be rejected by this Court.

In addition, she asserts, the arguments are nothing more than unsupported conjecture on the part of Rosseau. That is, Conklin failed to submit any expert opinion to support her claims,

and thus failed to rebut Dr. Egol's opinion that Dr. Piserchia's management of the wound infection was appropriate. Indeed, she opines, the frivolous arguments advanced by Alfieri "are nothing more than a transparent attempt to keep Dr. Piserchia in this case for the purpose of extracting a settlement offer."

Discussion/Legal Analysis

On a cause of action alleging medical malpractice, a plaintiff must prove a deviation or departure from good and accepted standards of medical practice, and that such departure was a proximate cause of damages. *Goldberg v. Horowitz*, 73 A.D.3d 691 [2nd Dept. 2010]. In general, expert testimony is necessary to prove a deviation from accepted standards of medical care and to establish proximate cause. *Goldberg v. Horowitz*, 73 A.D.3d 691 [2nd Dept. 2010]. Because causation is often a difficult issue, a plaintiff need do no more than offer sufficient evidence from which a reasonable person might conclude that it was more probable than not that defendant's deviation was a substantial factor in causing the injury. *Goldberg v. Horowitz*, 73 A.D.3d 691 [2nd Dept. 2010]. A plaintiff's evidence of proximate cause may be found legally sufficient even if his or her expert is unable to quantify the extent to which defendant's act or omission decreased plaintiff's chance of a better outcome or increased the injury, as long as evidence is presented from which the jury may infer that defendant's conduct diminished plaintiff's chance of a better outcome or increased the injury. *Semel v. Guzman*, 84 A.D.3d 1054 [2nd Dept. 2011]; *Goldberg v. Horowitz*, 73 A.D.3d 691 [2nd Dept. 2010].

A defendant moving for summary judgment in a medical malpractice case must demonstrate the absence of any material issues of fact with respect to at least one of these elements. *DiLorenzo v. Zaso*, 148 A.D.3d 1111 [2nd Dept 2017]. A defendant must establish,

prima facie, either that there was no departure from good and accepted medical practice or that, if there were, the plaintiff was not injured thereby. *Contreras v. Adeyemi*, 102 A.D.3d 720, 958 N.Y.S.2d 430, (2nd Dept. 2013). The defendant is required to address the factual allegations set forth in the plaintiffs' bill of particulars with reference to the moving defendant's alleged acts of negligence and the injuries suffered with competent medical proof. Bare conclusory assertions by a defendant that he or she did not deviate from good and accepted medical practices, with no factual relationship to the alleged injury, does not establish that the cause of action has no merit so as to entitle defendants to summary judgment. *DiLorenzo v. Zaso*, 148 A.D.3d 1111 [2nd Dept 2017].

In opposing a motion for summary judgment in a medical malpractice case, a plaintiff needs only to rebut the moving defendant's *prima facie* showing. *DiLorenzo v. Zaso*, 148 A.D.3d 1111 [2nd Dept 2017].

Summary judgment is not appropriate in a medical malpractice action where the parties adduce conflicting medical expert opinions. *DiLorenzo v. Zaso*, 148 A.D.3d 1111 [2nd Dept 2017]. However, general and conclusory allegations of medical malpractice, unsupported by competent evidence tending to establish the essential elements of medical malpractice, are insufficient to defeat a defendant physician's summary judgment motion. Rather, the plaintiff's expert must specifically address the defense expert's allegations. *DiLorenzo v. Zaso*, 148 A.D.3d 1111 [2nd Dept 2017].

A medical expert need not be a specialist in a particular field in order to testify regarding accepted practices in that field. *DiLorenzo v. Zaso*, 148 A.D.3d 1111 [2nd Dept 2017]. However, the witness must be possessed of the requisite skill, training, education, knowledge or experience

from which it can be assumed that the opinion rendered is reliable. *DiLorenzo v. Zaso*, 148 A.D.3d 1111 [2nd Dept 2017]. Thus, where a physician opines outside his or her area of specialization, a foundation must be laid tending to support the reliability of the opinion rendered. Where no such foundation is laid, the expert's opinion is of no probative value. *DiLorenzo v. Zaso*, 148 A.D.3d 1111 [2nd Dept 2017].

Here, the evidence submitted by the Piserchia Defendants, in particular the expert affidavit of Dr. Obel, was sufficient to demonstrate, *prima facie*, that the Piserchia Defendants did not deviate from good and accepted medical practice in their care and treatment of Alfieri at any relevant time.

In opposition, no party raised a triable issue of fact.

Indeed, Conklin's decision not to submit an affidavit of an expert is noteworthy, as so many of the issues raised require expert testimony.

Further, the Court finds, Conklin did not demonstrate that the Piserchia Defendants failed to address any of the relevant allegations, or that issues of fact could be discerned without the need for expert testimony.

For example, the Court notes, lack of informed consent is a distinct cause of action requiring proof of facts not contemplated by an action based merely on allegations of negligence. *Friedberg v. Rodeo*, 193 A.D.3d 825 [2nd Dept. 2021]. To establish a cause of action for malpractice based on lack of informed consent, plaintiff must prove (1) that the person providing the professional treatment failed to disclose alternatives thereto and failed to inform the patient of reasonably foreseeable risks associated with the treatment, and the alternatives, that a reasonable medical practitioner would have disclosed in the same circumstances, (2) that a reasonably

prudent patient in the same position would not have undergone the treatment if he or she had been fully informed, and (3) that the lack of informed consent is a proximate cause of the injury.

Friedberg v. Rodeo, 193 A.D.3d 825 [2nd Dept. 2021].

Here, as noted by the Piserchia Defendants, Conklin did not plead a cause of action based on lack of informed consent.

Accordingly, and for the reasons cited herein, it is hereby,

ORDERED, that the motion is granted, and the third-party complaint is dismissed; and it is further,

ORDERED, that the remaining parties are directed to appear for a status conference on Tuesday, July 13, 2021, at 1:30 p.m., at the Orange County Supreme Court, Court room #3, 285 Main Street, Goshen, New York, if the Courts are open to the public at that time. If not, a virtual conference will be scheduled on said date, at a time to be determined by the Court.

The foregoing constitutes the decision and order of the Court.

Dated: May 21, 2021
Goshen, New York

ENTER

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