SHORT FORM ORDER

SUPREME COURT OF THE STATE OF NEW YORK

PRESENT: HON. DENISE L. SHER
Acting Supreme Court Justice

ANDRICE GITTLER and JEREMY GITTLER,

Plaintiffs,

-against-

STEVEN H. PINSKY, M.D., ROCKVILLE ANESTHESIA GROUP, LLP, PERRY ROBERT STEVENS, M.D., SOUNDVIEW MEDICAL GROUP PLLC, MERCY MEDICAL CENTER, CATHOLIC HEALTH SYSTEM OF LONG ISLAND, INC. and NORTH SHORE UNIVERSITY HOSPITAL,

Defendants.

TRIAL/IAS PART 30
NASSAU COUNTY

Index No.: 603576/19
Motion Seq. No.: 01
Motion Date: 11/20/2020

The following papers have been read on this motion:

	Papers Numbered
Notice of Motion (Seq. No. 01), Affirmation and Exhibits	1
Affirmation in Opposition to Motion (Seq. No. 01) and Exhibits	2
Affirmation in Reply to Motion (Seq. No. 01) and Exhibit	3

Upon the foregoing papers, it is ordered that the motion is decided as follows:

Defendants Steven H. Pinsky, M.D. ("Dr. Pinsky") and Rockville Anesthesia Group, LLP ("Rockville Anesthesia") move (Seq. No. 01), pursuant to CPLR § 3212, for an order granting summary judgment dismissing plaintiffs' Verified Complaint, with prejudice, as against them; and move for an order striking the names of the moving defendants from the caption. Plaintiffs oppose the motion (Seq. No. 01).

In support of the motion (Seq. No. 01), counsel for defendants Dr. Pinsky and Rockville Anesthesia asserts, in pertinent part, that, "[t]his is an alleged malpractice action arising from the

treatment and care provided to the plaintiff, Andrice Gittler ('patient', 'plaintiff', or 'Mrs. Gittler') for the period from January 3, 2016 through January 27, 2016. Plaintiff alleges that the defendants, including Dr. Pinsky, a pain management specialist, failed to timely diagnose a staphylococcus aureus ('staph') infection located in her right hip capsule. With regard to Dr. Pinsky, there was only an alleged delay of five days between the time he first treated the patient to when she was admitted to Mercy Medical Center ('Mercy'), where the infection was ultimately diagnosed. Thus, any delay in diagnosis was medically insignificant and did not cause any of the alleged injuries, as opined by Dr. Pinsky's expert. It must be noted at the outset that plaintiff does not allege that Dr. Pinsky, or any of the co-defendants for that matter, actually caused the infection, as plaintiff herself admits she has no idea how she contracted the infection. She thus simply claims the defendants failed to timely diagnose the infection. In this regard, it is important to understand that the very nature of the infection is incredibly rare to have occurred in this nature, deep in the hip capsule, as staph typically presents on the exterior skin of a patient. Furthermore, the hip joint is a large, tight joint, which will ostensibly contain the infection. This prevents the infection from spreading systemically and manifesting clinical symptoms of infection, such as fever, diarrhea and nausea, thereby making it all the more difficult to diagnose. Perhaps most tellingly, the infectious disease specialist did not believe the patient had an infection on the first day of her admission to Mercy, despite elevated erythrocyte sedimentation rate ('ESR', an inflammatory marker which can indicate infection) results. The orthopedic surgery service, who ultimately irrigated and debrided the infected hip capsule, also did not believe the patient had an infection on the first day of the admission. Thus, it is factually and medically evident that there is no causal basis between any claimed injury and Dr. Pinsky's alleged failure to diagnose the infection merely five days earlier. Also of significance, when

Mrs. Gittler first presented to Dr. Pinsky, a pain management specialist, on January 8, 2016, she was referred to him by co-defendant Dr. Perry Robert Stevens ('Dr. Stevens') with a working diagnosis of sciatica versus lumbar radiculopathy and had undergone an MRI, which revealed bulging discs at the L3-4 and L4-5 levels of the patient's lumbar spine with impingement on the thecal sac. Thus, the patient's complaints of radiating pain from her lower back to her right knee were consistent with Dr. Stevens' differential diagnosis and the MRI results. Accordingly, Dr. Pinsky's administration of epidural steroids to the L3-4 and L4-5 levels on January 11, 2016 was properly indicated and within the standard of care for a pain management specialist, as explained by Dr. Pinsky's expert. Two days later, on January 13, 2016, the patient advised Dr. Pinsky that her pain remained severe following the injections, and he thus properly referred her to the emergency department at Mercy for further treatment, where she was ultimately diagnosed with (*sic*) staph infection to her right hip capsule two days later on January 15, 2016. Furthermore, Dr. Pinsky is entitled to and in fact it is sound medical practice to rely on the other specialists directing the care of the patient. This includes the physicians who treated the patient prior to Dr. Pinsky, including Dr. Stevens, a neurologist, who had diagnosed a radicular lumbar condition, and the physicians at co-defendant facility North Shore University Hospital ('North Shore'), who diagnosed the patient with a hip sprain/strain, as well as the subsequent providers at Mercy, including the hospital's infectious disease service and orthopedic surgery team. For these reasons, and as further stated below, there is flatly no medical or factual evidence that Dr. Pinsky departed from accepted medical care or that any of his care caused the patient's alleged injuries. Moreover, there is no evidence that any alleged deviation on his behalf caused any of the alleged injuries, including a delay in diagnosis of the infection which was not done until two days into the Mercy admission, or otherwise altered her course, including the irrigation and debridement

procedure. Also, other than plaintiff's (*sic*) bald allegations in the complaint regarding an alleged lack of informed consent, there is no basis for any causal relationship for any such inadequate consent for the epidural steroid injections, as plaintiff does not allege this procedure caused the infection. Therefore, Dr. Pinsky and Rockville Anesthesia respectfully request that this Court grant this motion in its entirety and dismiss all claims against them, with prejudice, and strike their names from the caption."

In further support of the motion (Seq. No. 01), counsel for defendants Dr. Pinsky and Rockville Anesthesia submits the transcripts from the Examinations Before Trial testimony of plaintiffs, defendant Dr. Pinsky, defendant Perry Robert Stevens, M.D. ("Dr. Perry"), and the two (2) witnesses who testified on behalf of defendant North Shore University Hospital, Dr. Robert Wighton and Dr. Megan Slowey. *See* Defendants Dr. Pinsky and Rockville Anesthesia's Affirmation in Support Exhibits F-K.

Counsel for defendants Dr. Pinsky and Rockville Anesthesia also submits the expert affirmation of Christopher G. Gharibo, M.D. ("Dr. Gharibo"). *See* Defendants Dr. Pinsky and Rockville Anesthesia's Affirmation in Support Exhibit Q. Dr. Gharibo asserts, in pertinent part, that, "[p]laintiff, Andrice Gittler ('Gittler, 'patient' or 'plaintiff'), has alleged that Dr. Pinsky, and co-defendants North Shore University Hospital ('North Shore') and Dr. Perry Robert Stevens ('Dr. Stevens') failed to timely diagnose a staphylococcal aureus ('staph') infection in her right hip capsule, which was diagnosed on January 15, 2016 when plaintiff was admitted to Mercy Medical Center ('Mercy'). It must be noted at the outset that it is incredibly rare for any patient to develop a staph infection deep in the hip capsule, as this type of infection most commonly manifested (*sic*) externally on the skin. Further, given the nature of the hip joint, which is a large, tightly encapsulated joint, an infection there would typically be localized to the

hip and thus not present clinically with other systemic symptoms, making it all the more difficult to diagnose or suspect. Perhaps most significantly, the infectious disease specialist at Mercy Medical Center himself, Dr. Maqsood Alam, did not initially believe the patient's pain was due to a hip infection even when the patient's erythrocyte sedimentation rate ('ESR, an inflammatory marker) lab test was high, but rather also believed the pain was associated with her lower back condition. Thus, it would not be within the standard of care for a pain management specialist, such as Dr. Pinsky, to have considered such an infection when he treated Mrs. Gittler several days earlier when she was presented at his office on January 8, 2016 with pain radiating from her lower back and a positive MRI showing disc bulge with impingement at the L3-4 and L4-5 levels of the lumbar spine, when he made the diagnoses of degenerative lumbar conditions or when he treated these (*sic*) conditions on January 11, 2016 when he performed epidural steroid injection to those levels of her lumbar spine. Accordingly, as further set forth below, I find with a reasonable degree of medical certainty that Dr. Pinsky did not depart from accepted medical practice, nor did the limited pain management care he provided cause and/or contribute to the patient's alleged injuries, including the aforementioned staph infection of her right hip or necessitate the irrigation and debridement procedure she ultimately underwent." *See id.*

Dr. Gharibo further contends, in pertinent part, that, "Dr. Pinsky, an anesthesiologist with a pain management subspecialty, rendered adequate and proper treatment to the patient, Andrice Gittler. As indicated above, this patient was ultimately diagnosed with a staphylococcal aureus infection of her right hip capsule, which is deep in the hip joint. This is significant in that contracting (*sic*) staph infection in the hip joint is incredibly rare, as this type of infection typically presents on the skin. Furthermore, based on the fact that the hip joint is a large, tightly encapsulated joint, which will prevent an infection from manifesting itself systemically

elsewhere in the body, making the diagnosis of such an infection incredibly difficult. In this case, when the patient presented to Dr. Pinsky's office on January 8, 2016, she did not have any clinical signs of infection, including persistent infection, fevers, weight loss, diaphoresis, night sweats, chest pain, irregular heartbeat or palpitations, and breathing or swelling problems.... Plaintiff was otherwise a 40 year old female in good overall health, with no other demographics or pre-dispositions to infection. Rather, plaintiff presented to Dr. Pinsky's office on January 8, 2016, complaining of (*sic*) radiating from her low back, down her right hip to her right knee, and had a positive MRI showing a bulging disc at L4-5 impinging on the thecal sac, and a bulging disc at L3-4. The image findings are consistent with radiating pain and radiculopathy as reported by the patient. In this regard, the patient's report of anterior thigh pain based on the colored area of her lower back and upper right leg that she provided on Dr. Pinsky's intake form on January 8, 2016 was also consistent with nerve inflammation from the L4-5 herniation seen on the imaging. Additionally, the plaintiff's physical exam of her hip was negative for any abnormality. Based on the patient's (*sic*) presenting symptoms to Dr. Pinsky of radiating pain from her back down her hip and a positive MRI at L4-5, the suspicion would be that the issue was likely to be emanating from the lumbar spine. Accordingly, all of the patient's presenting symptoms suggested that more likely than not, the pain was emanating from the lumbar spine. Therefore, I find that Dr. Pinsky's administration of epidural steroid injections to the L3-4 and L4-5 levels of the patient's lumbar spine were properly indicated. Furthermore, the patient called Dr. Pinsky's office the next day, on January 12, 2016, and reported she had a 'big improvement' in pain relief from the injection, supporting the fact that Dr. Pinsky made the correct diagnoses for the condition that was reported to her (*sic*) and she responded well to the injection without any infectious complications. If the epidural had caused the infection, the pain would not have

improved and would have gotten worse. It is also significant that the patient was referred to Dr. Pinsky by Dr. Stevens with a working diagnosis of sciatica versus lumbar radiculopathy, as well as an MRI interpreted by Dr. Malhotra as showing bulging discs with impingement at L3-4 and L4-5. Dr. Pinsky, a pain management specialist, is entitled to and may rely on the expertise of other specialists, including Dr. Stevens, a neurologist, and Dr. Malhotra, the interpreting radiologist. As indicated below, the patient's symptoms of radiating pain were consistent with the prior treatment, including the lumbar spine MRI. Further, any right hip etiology of the patient's pain, would have been consistent with a hip sprain/strain, as diagnosed by North Shore, not any infection. Moreover, I find with a reasonable degree of medical certainty that there was no indication to order imaging of the patient's right hip or abdomen, including an x-ray, CT scan, ultrasound or MRI, as the patient's physical exam of the hip was normal and there were no neurological deficits of the lower extremities on exam and there were no abdominal symptoms or signs to indicate its imaging. For these same reasons, I find within a reasonable degree of medical certainty that there was no reason for Dr. Pinsky to refer the patient to another specialist, including an orthopedist or infectious disease specialist, or the emergency department prior to January 13, 2016. I also find with a reasonable degree of medical certainty that Dr. Pinsky properly referred the patient to the emergency department on January 13, 2016 after she reported continued significant pain following the epidural injections. This is the standard of care for a patient, such as Mrs. Gittler, whose pain is intractable following an epidural steroid injection. Because plaintiff lacked any clinical sign of infection and that it was most likely that the patient's pain appeared to be emanating from her lumbar spine as set forth above, I find within a reasonable degree of medical certainty that Dr. Pinsky did not depart from accepted medical care by not ordering serial blood cultures for the patient prior to her admissions

to Mercy Medical Center. Once the patient was admitted to Mercy Medical Center, Dr. Pinsky, a pain management specialist, is entitled to and in fact it is good practice to rely on the other specialists at the hospital. This includes the medical team, orthopedic surgery service, and infectious disease service. Accordingly, Dr. Pinsky is entitled to and should in fact rely on the care of those specialists in directing the patient's care, including ordering imaging of the patient's spine, right hip and/or abdomen, and ordering blood cultures and other lab tests, including c-reactive protein and ESR tests. To the extent that plaintiff's allegations regarding the treatment of the patient's case as a 'surgical emergency' are directed at Dr. Pinsky, they are equally without merit. Determining whether or not a surgery should proceed on an urgent or emergent basis is not within the scope of Dr. Pinsky's care, as a pain management specialist, but rather was the duty of the orthopedic surgical team treating Mrs. Gittler. Dr. Pinsky appropriately referred the patient to Mercy Medical Center, where her care was directed by the specialists there, including the orthopedic service, who determined the nature and extent of any surgeries, including the subject irrigation and debridement procedure. For the above stated reasons, I find within a reasonable degree of medical certainty that Dr. Pinsky did not depart from proper and accepted medical practice in any of his treatment of the patient, Andrice Gittler. Furthermore, there is no evidence that the care provided by Dr. Pinsky caused any of the patient's alleged injuries. It must be noted that the plaintiff is not alleging that she contracted the staph infection due to the care of Dr. Pinsky. Thus, there is no allegation that Dr. Pinsky caused the patient's septic hip injury.... Rather, plaintiff only alleges that Dr. Pinsky delayed in diagnosing the infection. Dr. Pinsky first saw the patient on January 8, 2016, which was a total of five days prior to transferring care to Mercy Medical Center on January 13, 2016. As indicated above, once the patient was referred to the emergency department at Mercy, Dr. Pinsky is entitled to rely on the

specialists there to manage the patient's care, including any potential infectious process. Thus, this brief period of 5 days cannot be considered within a reasonable degree of medical certainty to have caused and/or contributed to a worsening of the infection. This is perhaps the most evident based on the fact that, upon admission, Dr. Alam, the infectious disease specialist, himself did not initially believe there was an infection even after the patient had an elevated ESR.... The orthopedist also did not believe there was an infection at the time of admission. In fact, none of the specialists or staff at Mercy were able to diagnose the infection until January 15, 2016, when the patient still lacked many clinical signs of infection, including fevers and an elevated white blood cell count. Further, the blood cultures only showed a sparse amount of staphylococcal aureus organisms in the hip capsule, indicating that there was not significant worsening over this brief period.... Plaintiff (*sic*) has also alleged that Dr. Pinsky failed to provide proper informed consent to the patient. It must be noted that there is no medical basis for any argument that the lack of proper consent caused any of the alleged injuries here. The only procedure Dr. Pinsky performed was the epidural steroid injection to the patient's lumbar spine on January 11, 2016. As indicated above, plaintiff does not allege that Dr. Pinsky caused the infection during this procedure, nor is there no (*sic*) basis to state that this procedure caused any infection to the patient's hip given that it was isolated to the lumbar spine. Accordingly, whether or not Dr. Pinsky properly advised the patient of the risks, benefits, and alternatives of the procedure, and whether or not she would have proceeded with the procedure, are in no way causally related to the allegations of a delay in diagnosis of the infection." *See* Defendants Dr. Pinsky and Rockville Anesthesia's Affirmation in Support Exhibits O-Q.

In opposition to defendants Dr. Pinsky and Rockville Anesthesia's motion (Seq. No. 01), counsel for plaintiffs asserts, in pertinent part, that, "[a]t the outset, Plaintiffs do not oppose that

branch of Defendants' motion seeking to dismiss the informed consent claims. It is submitted that the Defendants' motion for summary judgment should be otherwise denied under the circumstances of this case since: (1) The Defendants have failed to establish their *prima facie* entitlement to summary judgment, as the expert affirmation and other physician averments submitted in support are conclusory, fail to address the totality of the evidence, and fail to address Plaintiffs' pertinent allegations; (2) even assuming Defendants met their initial motion burden, Plaintiffs have raised issues of fact by proffering expert physician affirmations which, upon addressing all of the relevant evidence and facts, identify multiple departures as to ... STEVEN H. PINSKY, M.D., and ROCKVILE ANESTHESIA GROUP, LLP that were a (*sic*) proximate cause (*sic*) of the injuries suffered by Plaintiffs; and (3) At a minimum, the conflicting expert opinions present material issues of fact that should be resolved by a jury at trial. In short, as avowed by Plaintiffs' experts, had the Defendants not deviated from standards of care, Mrs. Gittler's condition could have been properly managed, her infection would not have been remotely as severe, no surgery would have been required, and her resulting pain and suffering would have been avoided."

In support of the opposition, counsel for plaintiffs submits the expert affirmation of Ira Mehlman, M.D. ("Dr. Mehlman"). *See* Plaintiffs' Affirmation in Opposition Exhibit A. Dr. Mehlman asserts, in pertinent part, that, "[i]t is my opinion, within a reasonable degree of medical certainty, that the defendant[s], ... Dr. Pinsky, departed from acceptable standards of medical care in the treatment of the plaintiff ANDRICE GITTLER in failing to recognize the clear signs and symptoms of an infection and to, in compliance with mandatory standards of care, timely, entertain this very serious possibility in their 'differential diagnoses' and properly and appropriately evaluate and treat for same. Furthermore, it is my opinion within a reasonable

degree of medical certainty, that the deviations of the defendants, proximately caused the injuries suffered by ANDRICE GITTLER including the need for surgery and extended hospital stay, need for intravenous medication, pain, and anguish, and future probable likely sequelae. In sum, based upon the review of the records, it is my opinion that defendants deviated from standards of care in missing an opportunity to diagnose plaintiff as suffering from, inter alia Staphylococcus aureus infection, Staphylococcal arthritis of the right hip, right septic hip, and treat ANDRICE GITTLER, at an early stage when appropriate treatment would in all probability (*sic*) been curative with full recovery and no risk of future complications from delayed untimely diagnosis and treatment. It is my opinion, within a reasonable degree of certainty, that when Mrs. Gittler presented to defendants, she presented with clinical signs and symptoms which required further investigation and the mandatory inclusion in the differential diagnosis of deep seated infection which required further testing, and immediate consideration and treatment." *See id.*

Dr. Mehlman further asserts, in pertinent part, that, "[i]n my medical opinion from fifty years of evaluating such patients, and familiarity with the medical literature regarding these issues, within a reasonable degree of medical certainty, it is not at all rare or unusual for patients with such serious infections to present afebrile or to present with a normal or even low white blood cell count. Patients presenting with SIRS (systemic inflammatory response syndrome) from a bacterial infection even with sepsis often have a pulses (*sic*) greater than 90 bmp, and can have high, normal or low WBCs and be afebrile or even have low temperatures, well described in the literature and from my experience with such cases.... It is also my medical opinion, within a reasonable degree of medical certainty, that since Mrs. Gittler's pains were present for more than three days, and in fact, worsening, and not relieved by the typical treatment of rest and ibuprofen or anti-inflammatories, the differential diagnosis of infection should have been

considered – including deep seated infection in that right hip – the standard of care for such patients.... Lastly, I find within a reasonable degree of medical certainty, Dr. Pinsky deviated from the standard of care in that he: (1) he (*sic*) ignored the patient's clinical history and condition and failed to appreciate its clinical significance; (2) performed an unnecessary and potentially dangerous epidural injection to plaintiff's lumbar spine without first ruling out the alternative true causes of her symptoms as noted; (3) failed to perform an MRI of the hip, the primary source of plaintiff's pain; (4) failed to appreciate the patient's history, exam and non-diagnostic MRI of the spine and failed to timely refer the plaintiff to specialists, including the emergency room, an infectious disease doctor, and/or an orthopedist; (4) (*sic*) failed to order appropriate ancillary blood tests such as C-reactive protein, sedimentation rate, CBC, cultures and appropriate imaging such as an MRI of the continuing still symptomatic right hip; and (5) (*sic*) failed to treat the plaintiff as the medical emergency she was. Typically, with infections in deep seated joints (such as spine, hip, shoulder) it can be difficult to determine 'warmth, swelling, or redness', as there may be 3-4 inches of body 'tissues' in the way, which is why proper imaging is critical. Unexplained, persistent, or worsening deep joint pain, unrelenting and even worsening, even at rest, without a known cause or understood mechanism would be indicative of possible deep seated joint infection. It must be investigated and a differential diagnosis of infection or space occupying lesion such as a tumor must be considered. Direct appropriate imaging such as an MRI of the affected area must be done – in this case it is clear the right hip was repeatedly remarked as the site of pain – it is a clear deviation from standards of care to have not had a right hip infection at the top of the differential diagnoses, by likelihood and by acuity because such infections demand early timely diagnosis and treatment to insure best and safest outcomes. The defendants should have ordered an MRI of Mrs. Gittler's hip, the area

that was symptomatic and the c-reactive protein and sed rate should have been tested along with the above other concerns. Not at all unusual, and well known clinically and in the medical literature, patients may present with serious infections even life-threatening, without a fever, possibly even hypothermic, with a normal white blood cell count or even a low WBC, and such lab tests may be relatively normal and non-contributory or non-diagnostic, but regardless they are the standard of care when serious infectious conditions including deep seated joint infections are rightfully included in the differential diagnosis as ***should have been*** when patient Gittler presented on January 3, 2016, and each day afterwards. With persisting unexplained unrelenting pain in the right hip, the same pain present prior to January 3rd when patient Gittler presented to North Shore ED and subsequently to Drs. Stevens and Pinsky, with the same otherwise non-contributory history and symptoms, without fever or elevated WBC count, when these doctors, although repeatedly noting the ***chief complaint of right hip pain***, none of them ordered imaging of the right hip area with imaging of either a CAT scan or MRI (best), never ordered the CBS and sedimentation rate and/or C reactive protein, which in my opinion would have led to the timely diagnosis of her right hip infection early and timely when she presented. The defendants (*sic*) experts would have one believe this was an unusual case but it was not, the patients (*sic*) complaint of right hip pain is consistently present throughout ***all*** the encounters, even the radiologist Dr. Vidya Malhortra noted the right hip symptoms in his reading/report for the spine MRI, and even Dr. Stevens (January 4th) in his assessment remarked to 'consider right hip etiology,' all as I noted above, BUT none of these 'care-givers' did… and hip infections are the most acute diagnosis, the most destructive diagnosis which should be in (*sic*) at the top of the 'differential diagnosis' for such a patient as patient Gittler, because 'time=tissue' and failure to diagnosis (*sic*) timely places the patient at increased risk of even sepsis and death and certainly

as noted of progressive cartilage and bone destruction if diagnosis is not made and treatment with antibiotics initiated timely. These deep seated infections occur, are clearly not rare, and when appropriately searched for by ***'thinking of them'*** as when the right hip joint effusion was noted on January 13th when ***incidentally*** the effusion was noted on an abdominal CAT scan… (again the wrong x ray (*sic*) but close enough to the right hip that it detected the right hip effusion) which would have been clear on a CAT scan or even better an MRI of the hip January 3, 4, or onward if it had been performed, as it should have been – namely, the standard of care in this patient. Then it became inescapable that the diagnosis of probable right hip infection would explain what was right in front of these doctors, but they ignored … at patient Gittler's expense and well-being.… This case was not rare, not difficult to diagnose, it just needs to be appropriately logically entertained in a patient with persistent, unresolving right hip pain on every visit, pain even at rest.… ***Of important note, when the C-reactive protein and sedimentation rate were finally ordered on 1/13/2016, they were respectively 14.70 and 85 – very elevated, and both consistent with deep seated infection. It is my strong opinion they would have been likewise elevated January 3rd and the other days, had they been appropriately done, in such a case – the standard of care.***… For the above stated reasons, I find within a reasonable degree of medical certainty that the defendant[s],… Dr. Pinsky, departed from proper and accepted medical practice in their care and treatment of Mrs. Gittler, and their deviations denied her the best outcome, (*sic*) prolonged pain, and almost certainly will lead to long term sequelae because of prolonged and worsening bone and cartilage destruction from delays of timely diagnosis and definitive treatment – namely, standard of care." *See id.*

Also in support of the opposition, counsel for plaintiffs submits the expert affirmation of John Schaefer, M.D. ("Dr. Schaefer"). *See* Plaintiffs' Affirmation in Opposition Exhibit B.

Dr. Schaefer asserts, in pertinent part, that, "[i]t is my opinion within a reasonable degree of medical certainty, that the deviations of the defendants proximately caused the injuries suffered by ANDRICE GITTLER including the need for surgery and extended hospital stay, need for intravenous medication, pain, and anguish, and future probable likely sequelae. As detailed below, it is my opinion within a reasonable degree of medical certainty that the Defendants in this action, departed from accepted standards of care causing Mrs. Gittler's injuries. In sum, based upon the review of the records, when Mrs. Gittler presented to the defendants, she presented with clinical signs and symptoms which required further investigation and the mandatory inclusion in the differential diagnosis of deep seated infection which required further testing, and immediate consideration and treatment. The defendants deviated from standards of care in missing an opportunity to diagnose plaintiff as suffering from, inter alia Staphylococcus aureus, Staphylococcal arthritis of the right hip, right septic hip, and treat ANDRICE GITTLER, at an early stage when appropriate treatment would in all probability been curative with full recovery and no risk of future complications from delayed untimely diagnosis and treatment." *See id.*

In reply to the opposition, counsel for defendants Dr. Pinsky and Rockville Anesthesia contends, in pertinent part, that, "[a] plain reading of plaintiffs' opposition to the within motion clearly indicates plaintiffs' (*sic*) have failed to rebut movants' *prima facie* entitlement to summary judgment, as their opposition is entirely based on speculation, conclusory statements, and purely hindsight, which wholly ignore the undisputed medical records and the opinions of movant's (*sic*) expert anesthesiologist/pain medicine specialist, Dr. Christopher Gharibo. More specifically, plaintiffs rely on (*sic*) physician's affirmation of Dr. Ira Mehlman, an emergency medicine doctor, and Dr. John Schaefer, an infectious disease specialist, neither of whom are

qualified to opine as to the standard of care of an anesthesiologist and pain medicine specialist, such as movant, Dr. Pinsky, practicing in New York in 2016. Moreover, Dr. Mehlman's affirmation states that he retired from the Army Medical Corps in 1992 and does not otherwise indicate he was practicing medicine in New York in 2016, or anywhere for that matter. Dr. Schaefer's affirmation states that he is a Virginia licensed physician, and does not indicate he has ever practiced medicine in New York. Nor has either expert established that they are otherwise familiar with the standard of care of a pain management specialist. Therefore, this court must reject both affirmations in their entirety and grant the instant application without further consideration as plaintiffs have not rebutted Dr. Pinsky's *prima facie* showing of his entitlement to summary judgment. Nevertheless, as established by Dr. Pinsky's expert anesthesiologist and pain medicine specialist, Dr. Gharibo, in his reply affirmation annexed hereto …, none of the departures alleged by plaintiffs' experts have any merit, as they are wholly speculative, conclusory, and not based on facts in the medical records. Furthermore, plaintiffs' own infectious disease expert, Dr. Schaefer does not contest that it is incredibly rare to contract (*sic*) staph infection deep in the hip capsule, as this infection typically presents on the skin. He also agrees that it is 'not rare or unusual' for a patient such as plaintiff with such a deep seated infection to not exhibit any clinical symptoms of infection, or ever have an elevated while blood cell count, making all the more difficult to diagnose. Thus, under plaintiffs' own expert's analysis, the infection was virtually undetectable at the time she presented to Dr. Pinsky on January 8, 2016, just five days prior to the patient's admission to Mercy Medical Center where she was ultimately diagnosed. Perhaps most telling is what actually occurred here, which plaintiff's (*sic*) experts do not dispute. Namely, once Dr. Pinsky's (*sic*) timely and properly referred the patient to Mercy Medical Center after epidural steroid injections provided minimal

relief, neither the infectious disease specialist nor orthopedic surgeon at Mercy believed the patient had an infection upon admission, even despite elevated erythrocyte sedimentation rate ('ESR', and inflammatory marker) results which were also believed to be associated with the patient's lumbar spine condition. Thus, it is factually and medically evident that there is no causal basis between any claimed injury and Dr. Pinsky's alleged failure to diagnose the infection merely five days earlier. Also of significance, plaintiffs' experts do not contest or address Dr. Gharibo's expert opinion and established medical practice, and legal holdings, that Dr. Pinsky is entitled to and in fact it is good practice to rely on the other specialists involved in the patient's care, including co-defendants Dr. Stevens who referred the patient to Dr. Pinsky with a working diagnosis of sciatica versus lumbar radiculopathy. Further, the patient had undergone an MRI, which revealed multi-level disc disease, which correlated exactly with the radiating pain Mrs. Gittler was experiencing from her lower back to her right knee based on her own admission. Accordingly, Dr. Pinsky's administration of epidural steroids to the L3-4 and L4-5 levels on January 11, 2016 was properly indicated and within the standard of care for a pain management specialist, as explained by Dr. Pinsky's expert again on reply. In fact, plaintiffs' experts' lack of expertise as to the diagnostic process of epidural injections belies the inadequacy of their opposition. In this regard, these injections are an important diagnostic tool in ruling or (*sic*) out the source of a patient's pain, which in this case the medical evidence overwhelmingly suggest was the patient's lumbar spine. With a patient such as Mrs. Gittler, who experienced only temporary relief, it was evident that there was another source of pain, which turned out to be her hip. Dr. Pinsky's role was thus significant in working through the potential diagnoses, and resulted in his referral to the emergency department where the ultimate diagnosis was made, albeit several days later. Further, Plaintiffs' causation expert, Dr. Schaefer's affirmation is

premised on the exact same inaccuracies and speculation as their liability expert, Dr. Mehlman rendering his affirmation without any probative value. The failure to causally link any alleged departure to a claimed injury is equally fatal to their opposition." *See* Defendants Dr. Pinsky and Rockville Anesthesia's Affirmation in Reply Exhibit R.

It is well settled that the proponent of a motion for summary judgment must make a *prima facie* showing of entitlement to judgment as a matter of law by providing sufficient evidence to demonstrate the absence of material issues of fact. *See Sillman v. Twentieth Century-Fox Film Corp.*, 3 N.Y.2d 395, 165 N.Y.S.2d 498 (1957); *Alvarez v. Prospect Hospital*, 68 N.Y.2d 320, 508 N.Y.S.2d 923 (1986); *Zuckerman v. City of New York*, 49 N.Y.2d 557, 427 N.Y.S.2d 595 (1980); *Bhatti v. Roche*, 140 A.D.2d 660, 528 N.Y.S.2d 1020 (2d Dept. 1988). To obtain summary judgment, the moving party must establish its claim or defense by tendering sufficient evidentiary proof, in admissible form, sufficient to warrant the court, as a matter of law, to direct judgment in the movant's favor. *See Friends of Animals, Inc. v. Associated Fur Mfrs., Inc.*, 46 N.Y.2d 1065, 416 N.Y.S.2d 790 (1979). Such evidence may include deposition transcripts, as well as other proof annexed to an attorney's affirmation. *See* CPLR § 3212 (b); *Olan v. Farrell Lines Inc.*, 64 N.Y.2d 1092, 489 N.Y.S.2d 884 (1985).

If a sufficient *prima facie* showing is demonstrated, the burden then shifts to the non-moving party to come forward with competent evidence to demonstrate the existence of a material issue of fact, the existence of which necessarily precludes the granting of summary judgment and necessitates a trial. *See Zuckerman v. City of New York, supra.* When considering a motion for summary judgment, the function of the court is not to resolve issues but rather to determine if any such material issues of fact exist. *See Sillman v. Twentieth Century-Fox Film*

Corp., *supra*. Mere conclusions or unsubstantiated allegations are insufficient to raise a triable issue. *See Gilbert Frank Corp. v. Federal Ins. Co.*, 70 N.Y.2d 966, 525 N.Y.S.2d 793 (1988).

Further, to grant summary judgment, it must clearly appear that no material triable issue of fact is presented. The burden on the court in deciding this type of motion is not to resolve issues of fact or determine matters of credibility, but merely to determine whether such issues exist. *See Barr v. Albany County*, 50 N.Y.2d 247, 428 N.Y.S.2d 665 (1980); *Daliendo v. Johnson*, 147 A.D.2d 312, 543 N.Y.S.2d 987 (2d Dept. 1989). It is the existence of an issue, not its relative strength that is the critical and controlling consideration. *See Barrett v. Jacobs*, 255 N.Y. 520 (1931); *Cross v. Cross*, 112 A.D.2d 62, 491 N.Y.S.2d 353 (1st Dept. 1985). The evidence should be construed in a light most favorable to the party moved against. *See Weiss v. Garfield*, 21 A.D.2d 156, 249 N.Y.S.2d 458 (3d Dept. 1964).

"'In order to establish the liability of a physician for medical malpractice, a plaintiff must prove that the physician deviated or departed from accepted community standards of practice, and that such departure was a proximate cause of the plaintiff's injuries.'" *Leigh v. Kyle*, 143 A.D.3d 779, 39 N.Y.S.3d 45 (2d Dept. 2016) *quoting Stukas v. Streiter*, 83 A.D.3d 18, 918 N.Y.S.2d 176 (2d Dept. 2011).

"A defendant seeking summary judgment in a medical malpractice action bears the initial burden of establishing, *prima facie*, either that there was no departure from the applicable standard of care, or that any alleged departure did not proximately cause the plaintiff's injuries." *Michel v. Long Is. Jewish Med. Ctr.*, 125 A.D.3d 945, 5 N.Y.S.3d 162 (2d Dept. 2015) *lv denied* 26 N.Y.3d 905, 17 N.Y.S.3d 86 (2015). *See also Barrocales v. New York Methodist Hosp.*, 122 A.D.3d 648, 996 N.Y.S.2d 155 (2d Dept. 2014); *Berthen v. Bania*, 121 A.D.3d 732, 994 N.Y.S.2d 359 (2d Dept. 2014); *Trauring v. Gendal*, 121 A.D.3d 1097, 995 N.Y.S.2d 182

(2d Dept. 2014); *Stukas v Streiter*, *supra* at 23; *Gillespie v. New York Hosp. Queens*, 96 A.D.3d 901, 947 N.Y.S.2d 148 (2d Dept. 2012). Expert evidence is required when evaluating the "performance of functions that are an integral part of the process of rendering medical treatment ... to a patient." *D'Elia v. Menorah Home and Hosp. for the Aged & Infirm*, 51 A.D.3d 848, 859 N.Y.S.2d 224 (2d Dept. 2008). *See also Koster v. Davenport*, 142 A.D.3d 966, 37 N.Y.S.3d 323 (2d Dept. 2016) *lv to appeal denied* 28 N.Y.3d 911, 47 N.Y.S.3d 227 (2016). Additionally, the conclusions reached by the defendant and his or her expert(s) must be supported by evidence in the record. *See Poter v. Adams*, 104 A.D.3d 925, 961 N.Y.S.2d 556 (2d Dept. 2013).

"Once a defendant physician has made such a showing, the burden shifts to the plaintiff to demonstrate the existence of a triable issue of fact, but only as to the elements on which the defendant met the prima facie burden." *Gillespie v. New York Hosp. Queens*, 96 A.D.3d 901, 947 N.Y.S.2d 148 (2d Dept. 2012).

"Establishing proximate cause in medical malpractice cases requires a plaintiff to present sufficient medical evidence from which a reasonable person might conclude that it was more probable than not that the defendant's departure was a substantial factor in causing the plaintiff's injury." *Semel v. Guzman*, 84 A.D.3d 1054, 924 N.Y.S.2d 414 (2d Dept. 2011) *citing Johnson v. Jamaica Hosp. Med. Ctr.*, 21 A.D.3d 881, 800 N.Y.S.2d 609 (2d Dept. 2005); *Goldberg v. Horowitz*, 21 A.D.3d 802, 73 A.D.3d 691, 901 N.Y.S.2d 95 (2d Dept. 2010). *See also Skelly–Hand v. Lizardi*, 111 A.D.3d 1187, 975 N.Y.S.2d 514 (2d Dept. 2013). A plaintiff is not required to eliminate all other possible causes. *See Skelly–Hand v. Lizardi*, *supra* at 1189. "'The plaintiff's evidence may be deemed legally sufficient even if [her] expert cannot quantify the extent to which the defendant's act or omission decreased the plaintiff's chance of a better outcome or increased [the] injury, as long as evidence is presented from which the jury may infer

that the defendant's conduct diminished the plaintiff's chance of a better outcome or increased [the] injury.'" *Alicea v. Ligouri*, 54 A.D.3d 784, 864 N.Y.S.2d 462 (2d Dept. 2008) *quoting Flaherty v. Fromberg*, 46 A.D.3d 743, 849 N.Y.S.2d 278 (2d Dept. 2007) *citing Barbuto v. Winthrop Univ. Hosp.*, 305 A.D.2d 623, 760 N.Y.S.2d 199 (2d Dept. 2003); *Wong v. Tang*, 2 A.D.3d 840, 769 N.Y.S.2d 381 (2d Dept. 2003); *Jump v. Facelle*, 275 A.D.2d 345, 712 N.Y.S.2d 162 (2d Dept. 2000) *lv denied* 95 N.Y.2d 931, 721 N.Y.S.2d 607 (2000) *lv denied* 98 N.Y.2d 612, 749 N.Y.S.2d 3 (2002).

"'While it is true that a medical expert need not be a specialist in a particular field in order to testify regarding accepted practices in that field ... the witness nonetheless should be possessed of the requisite skill, training, education, knowledge or experience from which it can be assumed that the opinion rendered is reliable.'" *Behar v. Coren*, 21 A.D.3d 1045, 803 N.Y.S.2d 629 (2d Dept. 2005) *lv denied* 6 N.Y.3d 705, 812 N.Y.S.2d 34 (2006) *quoting Postlethwaite v. United Health Servs. Hosps.*, 5 A.D.3d 892, 773 N.Y.S.2d 480 (2d Dept. 2004). "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." *Behar v. Coren*, *supra* at 1047. "'[G]eneral allegations that are conclusory and unsupported by competent evidence tending to establish the essential elements of medical malpractice are insufficient to defeat a defendant's motion for summary judgment.'" *Bendel v. Rajpal*, 101 A.D.3d 662, 955 N.Y.S.2d 187 (2d Dept. 2012) *quoting Bezerman v. Bailine*, 95 A.D.3d 1153, 945 N.Y.S.2d 166 (2d Dept. 2012). *See also Savage v. Quinn*, 91 A.D.3d 748, 937 N.Y.S.2d 265 (2d Dept. 2012); *Myers v. Ferrara*, 56 A.D.3d 78, 864 N.Y.S.2d 517 (2d Dept. 2008) *citing Alvarez v. Prospect Hosp.*, *supra* at 325; *Thompson v. Orner*, 36 A.D.3d 791, 828 N.Y.S.2d 509 (2d Dept. 2007); *DiMitri v. Monsouri*, 302 A.D.2d 420, 754 N.Y.S.2d 674 (2d Dept. 2003). A plaintiff's expert's statement which

"fail[s] to respond to relevant issues raised by the defendants' experts" does not suffice to establish the existence of a material issue of fact. *See Ahmed v. Pannone*, 116 A.D.3d 802, 984 N.Y.S.2d 104 (2d Dept. 2014) *lv dismissed* 25 N.Y.3d 964, 8 N.Y.S.3d 261 (2015) *rearg denied* 26 N.Y.3d 944, 17 N.Y.S.3d 61 (2015); *Brinkley v. Nassau Health Care Corp.*, 120 A.D.3d 1287, 993 N.Y.S.2d 73 (2d Dept. 2014). Furthermore, an expert's opinion which is conclusory and fails to set forth his or her rationale, methodology and reasons therefore also fails to establish an issue of fact. *See Rivers v. Birnbaum*, 102 A.D.3d 26, 953 N.Y.S.2d 232 (2d Dept. 2012); *Dunn v. Khan*, 62 A.D.3d 828, 880 N.Y.S.2d 653 (2d Dept. 2009).

Based upon the above, the Court finds the Expert Affirmations of Dr. Mehlman and Dr. Schaefer, offered in support of plaintiffs' opposition, are deficient in many respects, as outlined in defendants Dr. Pinsky and Rockville Anesthesia's expert physician's Affirmation in Reply. *See* Defendants Dr. Pinsky and Rockville Anesthesia's Affirmation in Reply Exhibit R.

Accordingly, defendants Dr. Pinsky and Rockville Anesthesia's motion (Seq. No. 01), pursuant to CPLR § 3212, for an order granting summary judgment dismissing plaintiffs' Verified Complaint, with prejudice, as against them; and for an order striking the names of the moving defendants from the caption, is hereby **GRANTED**.

This constitutes the Decision and Order of this Court.

ENTER:

DENISE L. SHER, A.J.S.C.

ENTERED
May 05 2021
NASSAU COUNTY
COUNTY CLERK'S OFFICE

Dated: Mineola, New York
April 30, 2021