Buck v Vulcano
2022 NY Slip Op 30529(U)
February 10, 2022
Supreme Court, New York County
Docket Number: Index No. 805104/2020
Judge: John J. Kelley
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SUPREME COURT OF THE STATE OF NEW YORK
NEW YORK COUNTY

PRESENT: HON. JOHN J. KELLEY, *Justice* **PART** **56M**

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MARGARET BUCK

Plaintiff,

- v -

ETTORE VULCANO,

Defendant.

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INDEX NO. 805104/2020

MOTION DATE 11/15/2021

MOTION SEQ. NO. 002

DECISION + ORDER ON MOTION

The following e-filed documents, listed by NYSCEF document number (Motion 002) 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57

were read on this motion to/for JUDGMENT - SUMMARY.

In this action to recover damages for medical malpractice, based on the defendant's alleged departure from good and accepted medical practice and failure to obtain the plaintiff's informed consent to a minimally invasive surgery (MIS) for the correction a bunion in the plaintiff's left foot, the defendant moves pursuant to CPLR 3212 for summary judgment dismissing the complaint. The plaintiff opposes the motion. The motion is granted to the extent that summary judgment is awarded to the defendant dismissing the lack of informed consent cause of action and so much of the cause of action alleging a departure from good and accepted practice as was based on contentions that the surgery was not indicated and that the defendant inappropriately performed the surgery by, among other things, removing an excessive amount of bone, making improper cuts at the surgical site, using improper screws and plates, or improperly fixing the screws and plates. The motion is otherwise denied, as there are triable issues of fact as to whether the post-operative care provided by the defendant to the plaintiff deviated from good and accepted practice, and whether such deviation caused or contributed to the injuries claimed by the plaintiff or to the necessity for revision surgeries.

In her complaint, the plaintiff alleged that the defendant treated her for unspecified conditions between March 1, 2018 and September 1, 2018. In her bill of particulars, the plaintiff specified that the defendant treated her on March 22, 2018, May 15, 2018, May 31, 2018, June 29, 2018, August 13, 2018, and September 14, 2018, both at his office and at Mount Sinai West, including a May 15, 2018 bunion correction surgery that involved osteotomies of the left proximal phalanx and first metatarsal of her left foot, with implants at each osteotomy site. The plaintiff further asserted that she sustained a nonunion of the osteotomy at the first metatarsal and, as a consequence, was required to undergo further surgeries on March 7, 2019 and December 19, 2019 to correct a nonunion of a metatarsal bone.

Specifically, the plaintiff alleged in her bill of particulars that the defendant departed from good and accepted medical practice by failing properly to stabilize or immobilize the osteotomies. She further asserted that the defendant removed an excessive amount of bone, leaving the relevant metatarsal excessively shortened, and removed bone from improper locations. In particular, the plaintiff asserted that defendant's removal of the metatarsal heads was an "egregious" act of malpractice, as she presented with no recognized and accepted indications for this procedure, and that the procedure was thus unnecessary.

The plaintiff also alleged that the defendant departed from good and accepted practice by failing to take a full and proper history, make a correct assessment of the relevant bunion deformity prior to surgery, take appropriate measurements, correlate his assessment with the plaintiff's complaints and history, or take the proper and necessary x-rays. She claims that the soft tissue in and about the metacarpophalangeal joint was not adequately assessed to address a bunion deformity, and that the length of the surgical cut was not effectuated in the proper manner, direction, and length, resulting in the capital fragment not being properly realigned. In addition, she averred that the defendant failed to employ implants of proper size, design, and dimensions, improperly placed the implants so that they encroached into joint spaces, and failed properly to monitor the osteotomy sites post-operatively. The plaintiff further asserted that the

defendant failed to adjust the capital fragment so as to result in a congruent joint with sufficient weight-bearing functioning, and otherwise failed to use proper fixation so as to stop movement and provide the best conditions for bone healing. Additionally, the plaintiff claimed that the defendant improperly severed her tendons, and inappropriately failed to perform a tendon lengthening procedure.

The plaintiff contended that, as a result of the defendant's failure to monitor her foot post-operatively, he further departed from good practice by failing to notice, anticipate, or consider the possibility of a delayed union, mal-union, or nonunion of bones at the surgical site and, thus, failed to take the necessary medical steps to reduce the possibility of adverse effects from such outcomes. The plaintiff further alleged that the defendant falsely told her after the surgery that she was healing properly, and thus provided her with misinformation as to the nature and extent of post-operative physical activity that she could sustain.

With respect to the lack of informed consent claims, the plaintiff asserted in her bill of particulars that

> "defendant failed to give plaintiff an adequate amount of time to consider surgery, its benefits, risks and alternatives; defendant had plaintiff sign a consent form which did not accurately describe all of the procedures to be performed, did not describe them in a manner so that a non-medically training patient would understand, and the consent form did not conform to the standard of care for consent forms for this type of procedure(s)."

In support of his motion, the defendant submitted the pleadings and bills of particulars, the parties' deposition transcripts, relevant medical records and scans, and the expert affirmation of board-certified orthopedic surgeon Anne H. Johnson, M.D.

In her affirmation, Dr. Johnson sets forth, in detail, the history of the defendant's treatment of the plaintiff. Upon her review of the records, Dr. Johnson asserted that, when the plaintiff presented to the defendant, the plaintiff had already developed a bunion on the left foot at least three years earlier that had caused pain for two years. An examination of the plaintiff at the time revealed mild pes planus, in which the entire sole of her left foot touched the floor when

she was in a standing position, with hindfoot valgus, that is, a misalignment of the rear of the foot, that nonetheless corrected when she raised her heel. The plaintiff's left foot and ankle otherwise had normal and painless range of motion without instability, but there was tenderness to the medial eminence of the hallux, or big toe, when palpated. Pulses, sensation, and strength were intact. Dr. Johnson reported that the medical records further reflected that the defendant obtained weight-bearing, three-view x-rays of the plaintiff's left foot that depicted the hallux valgus, commonly known as a bunion, a hallux valgus angle (HVA) of 20 degrees, the existence of the pes planus, with an intermetatarsal angle (IMA) of 13 degrees, and no evidence of fractures. As Dr. Johnson reported it, the defendant "formed an impression of mild left hallux valgus."

Dr. Johnson asserted that

> "Non-operative and operative treatment options were discussed with Ms. Buck including the risks and benefits of each. The plan was for percutaneous hallux valgus correction with Chevron and Akin (MIS bunion correction). The risks and potential complications to the MIS bunion correction procedure were discussed with Ms. Buck and included infection, blood clot, fracture, nonunion, malunion, tendon/ligament rupture, temporary or permanent nerve damage, and unexpected need for further surgery."

She further noted that the plaintiff signed an "informed consent" form prior to surgery.

As Dr. Johnson interpreted the medical records, on May 15, 2018, the defendant operated on the plaintiff's left foot to correct the left-foot hallux valgus, specifically performing left hallux percutaneous Chevron and Akin osteotomies, characterized as a minimally invasive surgery (MIS) bunion correction, with placement of Wright Medical 4 mm and 3 mm screws. She opined that the surgery was indeed indicated, as documented by a longstanding history of painful left hallux valgus that remained unresolved after non-operative treatments.

According to Dr. Johnson's reading of the operative report, the defendant first created a pocket through a stab incision at the medial dorsal aspect of the first metatarsal head flare, performed both limbs of the Chevron cut using a Shannon burr, utilized a Peanut™ instrument to correct the intermetatarsal angle, stabilized the structure with a k-wires and a 4 mm screw

that reportedly obtained "excellent bite." The medial bone overhang was then shaved using a wedge burr. Next, a second stab incision was made at the middle third of the hallux proximal phalanx base, through which a burr was inserted into the bone under fluoroscopic guidance, and an Akin osteotomy was performed and thereafter stabilized with a 3 mm headless screw inserted through the distal medial first metatarsal incision. Dr. Johnson's reading of the operative report indicated that "[f]inal fluoroscopy confirmed good alignment of the osteotomies as well as osteotomy stability under stress maneuver." The procedure took 43 minutes to complete, at which point the plaintiff was transferred to the post-anesthesia care unit.

Dr. Johnson asserted that the records further reflected that the plaintiff was given instructions to allow for weight bearing, as far as she could tolerate it, was provided with a "post-operative sandal" to wear, was discharged after approximately six hours, and was instructed to follow up as an outpatient with the defendant two weeks later. The defendant's records indicate that the plaintiff did indeed return to see him on May 31, 2018, shortly more than two weeks after the surgery, at which time a physical examination revealed normal and painless left foot and ankle range of motion, without instability, along with intact pulses, sensation, and strength, as well as "normal post-operative swelling." Dr. Johnson reported that the "weight-bearing three view x-ray of the foot revealed hardware in place with good alignment and no fracture." Additional follow-up visits with the defendant on June 29, 2018 and September 14, 2018, and x-rays taken on those dates, reportedly showed that the plaintiff's bone was healing well, with good alignment.

The defendant's expert, however, also interpreted the plaintiff's subsequent history, in which she conceded that the plaintiff suffered from post-surgical discomfort in her left foot, sought further opinions from a podiatrist and a physician in January 2019, and had her foot x-rayed again. As Dr. Johnson noted, Dr. Stuart Katchis, the physician who examined the plaintiff in January 2019, recorded that the plaintiff

> “experienced swelling and pain thought to be secondary to nonunion. Physical examination revealed an antalgic gait on the left, enlargement of the first metatarsal phalangeal joint, and tenderness around the first metatarsal. Neurovascular status of the left lower extremity was intact.”

Dr. Katchis reported that “the screw appears to be somewhat prominent proximally and I think that is giving her a problem and distally it appears there is a nonunion, although it is difficult to say for certain. Given the level of her pain, I think most likely this is a nonunion.” He further diagnosed a “nonunion s/p MIS surgery for bunion” and recommended a CT of the left foot to assess the healing. A January 24, 2019 Lenox Hill Radiology x-ray report concluded that the plaintiff exhibited a “nonunion of the first metatarsal osteotomy with dorsal medial swelling at the site of the nonunited osteotomy; proximal margin of first metatarsal fixation is proud with pressure erosion of the adjacent dorsal medial head of the medial cuneiform, and securely united proximal hallux osteotom.” At a follow-up visit on January 25, 2019, Dr. Katchis confirmed the nonunion of the first metatarsal osteotomy, but noted the presence of a well-fixed Akin osteotomy, and recommended that the plaintiff undergo revision surgery for “left foot 1st metatarsal nonunion” and “left foot retained hardware,” which he performed on March 7, 2019.

As Dr. Johnson recounted it,

> “[a]ccording to the operative report, Dr. Katchis performed a reconstruction with autograft iliac crest bone graft which was harvested intraoperatively, removal of hardware and lengthening of the first metatarsal to anatomic length. Following the completion of same, Ms. Buck continued to see Dr. Katchis at his office post-operatively from March of 2019 through September of 2019. During this time period, Dr. Katchis documented Ms. Buck’s foot and alignment was ‘excellent’ in April of 2019; however, by July 15, 2019, Ms. Buck reported problems along the medial side, with Dr. Katchis noting that it was unclear whether complete healing was taking place. Following a review of Ms. Buck’s CT scan, Dr. Katchis reported on September 4, 2019 that one of the proximal screws was a ‘little bit prominent’ and that same may be causing ‘some irrigation of the soft tissues.’”

Dr. Katchis thereafter recommended that the plaintiff consider having at least one middle screw removed and a bone graft into the area of the nonunion or delayed union.

On October 11, 2019, orthopedic surgeon Kenneth Mroczek, M.D., examined the plaintiff, who at that time reported left foot pain and evinced tenderness along the prominent

screw, as well as decreased motion of the hallux metatarsophalangeal joint. After discussing various treatment options with Dr. Mroczek, the plaintiff returned to Dr. Katchis on November 25, 2019, who noted decreased swelling but some remaining irritation in the center where the plate and a prominent screw had been implanted. Dr. Johnson asserted that images obtained on that date suggested that the "area of prior concern" had by then fused, and she noted that, if there had been a complete fusion, the hardware could have been removed in its entirety.

On December 19, 2019, Dr. Katchis, upon diagnosing the plaintiff with "painful hardware status post repair of 1st metatarsal nonunion" and "hypertrophic bone and hallux rigidis of the 1st metatarsophalangeal joint," performed another surgery on the plaintiff's left foot. He described "current difficulties with the plate that was used [in the repair] as well as with some bone spurring along the 1st metatarsal head" as indications for the procedure. Dr. Katchis performed a cheilectomy of the first metatarsophalangeal joint and a removal of hardware from the first metatarsal bone, specifically removing the plate along with five screws. Although he observed bone spurring at the first metatarsophalangeal joint, he removed it to allow for improved range of motion and concluded, upon reviewing imaging, that the "nonunion repair was solid."

Dr. Johnson noted that the plaintiff had several follow-up visits with Dr. Katchis and Dr. Mroczek during 2019, which revealed gradual healing with some residual symptoms. She further reported that Dr. Christopher Burke interpreted an MRI scan taken on October 29, 2020 and concluded that the scan revealed post-surgical changes of the healed first metatarsal osteotomy, moderate osteoarthritis of the first metatarsophalangeal joint, "hallux sesamoid complex up," a third webspace neuroma, suspected small second webspace neuroma, mild third submetatarsal bursitis, first, second, and third intermetatarsal bursitis, and frayed, albeit intact, second through fourth plantar plates.

Dr. Johnson opined, within a reasonable degree of medical certainty, that the defendant's examination and treatment of the plaintiff, including the May 15, 2018 surgery and

post-operative care, did not deviate from good and accepted medical practice, and that none of his actions or failures to act caused or contributed to the plaintiff's claimed injuries. She concluded that the surgery was indeed indicated in light of the fact that the plaintiff had been in pain for several years as a consequence of an unaddressed hallux valgus, and had even consulted with a different orthopedic surgeon as early as 2015 to discuss an appropriate course of treatment.

The defendant's expert also asserted that the surgical techniques that the defendant employed were within the appropriate standard of care, and did not deviate from good and accepted practice. Specifically, she concluded that the defendant's use of one, rather than two, screws for fixation was appropriate, and within the bounds of professional judgment, as it provided a better cosmetic result and allowed for the removal of more bony material. She agreed with the defendant's deposition testimony that such a choice rests properly in the discretion of the surgeon. Dr. Johnson also averred that the use of one screw rather than two did not cause or contribute to a nonunion. She further opined that the size and type of screw employed was appropriate. As Dr. Johnson additionally concluded,

> "Dr. Vulcano made all proper cuts and inserted and placed the implant/screw in such a manner to achieve optimal stability and fixation for Ms. Buck. Thus, there was absolutely no indication that the screw should have been removed by Dr. Vulcano once fixation was accomplished and it would be contrary to good and accepted practice to remove the screw intraoperatively and risk the fixation."

She continued that

> "Dr. Vulcano properly made a stab incision at the medical dorsal of the first metatarsal head flare and inserted the 4 mm headless screw with 'excellent bite' achieved, demonstrating proper fixation. Similarly, Dr. Vulcano appropriately made a stab incision at the middle third of the hallux proximal phalanx base, inserted the burr into the bone under fluoroscopic guidance and performed the Akin osteotomy, all of which was the correct technique for the performance of Ms. Buck's MIS bunion correction procedure. To this point, plaintiff's allegations that Dr. Vulcano failed to utilize fluoroscopy intraoperatively are also without merit, as the operative report specifically states that part of the procedure was performed under fluoroscopic guidance and Dr. Vulcano subsequently utilized fluoroscopic guidance to confirm proper alignment of the osteotomies."

Dr. Johnson further opined that

> “the 3.0 mm headless compression screw was appropriately inserted through the proximal phalanx base and the 4.0 mm headless screw was appropriately inserted through the metatarsal incision, with succeeding imaging confirming good alignment and that the hardware was in place,”

that an appropriate amount of bone was removed during the procedure, including the first metatarsal, that all bone removed was at the proper locations, and that the plaintiff’s medical records do not support her contentions that the cut made in the metatarsal was improper, that the length and shortening of the metatarsal were improper, or that the joint spaces were improperly entered or damaged.

The defendant’s expert further concluded that his post-operative instructions to the plaintiff as to weight-bearing activities were proper and that all post-operative recommendations, care, and treatment that he gave or rendered was well within the appropriate standard of care.

In light of both the consent form executed by the plaintiff, the records of the discussions that she had with the consulting orthopedic surgeon in 2015, and the defendant’s testimony concerning the information that he provided to the plaintiff as to risks of, and alternatives to, the procedure that he ultimately performed, Dr. Johnson concluded that the quality of the consent obtained more than satisfied the applicable standard of care.

Dr. Johnson further opined that nothing that the defendant did or did not do caused or contributed to the plaintiff’s injuries.

In opposition to the defendant’s motion, the plaintiff relied on the same pleadings, bills of particulars, deposition transcripts, and records, and also submitted the affirmation of a podiatrist. Although the plaintiff initially submitted a copy of the affirmation with both the signature and all of the affiant’s credentials redacted, at the court’s request, she submitted an unredacted version for the court’s consideration. Upon reviewing the affirmation, the court notes that the podiatrist has 37 years of experience, is a board-certified podiatric surgeon, and maintains an active practice in the New York City metropolitan area, with surgical privileges at three major area hospitals. The plaintiff’s expert further asserted that she has significant

experience in performing hundreds bunion correction surgeries involving osteotomies with fixation of screws and plates. She averred that she examined the plaintiff on December 18, 2019, the day before the plate was surgically removed by Dr. Katchis, and again on February 15, 2021.

After providing a short history of MIS bunion corrections, current accepted practice in performing those procedures, the advantages and disadvantages of MIS versus open surgery, and a detailed history of the plaintiff's pre-operative, operative and post-operative treatment and care, the plaintiff's expert explained that the standard of care includes proper post-operative monitoring of the patient with x-rays and periodic examinations to make sure bone healing is progressing and that the osteotomy is healing in the position placed during surgery, that is, that the bone has not shifted. As she phrased it, however, her "opinions as to the deviations from the standard of care by Dr. Vulcano *are limited . . . to his post-surgical management of Mrs. Buck"* (emphasis added).

The plaintiff's expert explained that

> "x-ray evidence of something less than full union and a symptomatic patient at 6 months would be a strong suggestion of a non-union. When there is a non-union the metatarsal is often shortened due to destruction of bone secondary to excessive motion at the osteotomy. When surgically fixing a non-union one needs to clean the necrotic bone ends and place a bone graft to restore as much length as possible to the bone so as to maintain proper foot function and avoid a variety of problems including increased weight bearing pressure on the lesser metatarsals, plantar plate injury, and inflammation and pain in these areas. Dr. Katchis' surgery to fix Mrs. Buck's non-union did just this: he added a bone graft to restore some length to the first metatarsal."

She reported that the defendant

> "saw Mrs. Buck for only 3 visits after the surgery and refused to see her for one scheduled visit. Despite her unchanging symptoms of pain and swelling, Dr. Vulcano discharged her from his care on the last of the three visits only 4 months after surgery. When she called his office at 6 months post op to make an appointment to see him the receptionist or nurse refused to give her an appointment. All throughout this time Mrs. Buck had unremitting pain and swelling. A closer look at these visits will show that Dr. Vulcano deviated from basic post-surgical principles, i.e., deviated from the standard of care, each of which was a contributing factor to the non-union of the first metatarsal, the two surgeries performed by Dr. Katchis, the pain and disability associated with having

> to undergo two additional surgeries, and injuries and conditions I confirmed in my examinations of Mrs. Buck."

The expert asserted that, on the two post-operative visits that the plaintiff had with the defendant on May 31, 2018 and June 29, 2018, there was little evidence of bone healing and, even though she conceded that it was then very early in the healing process, the plaintiff should have anticipated a diminution of swelling and pain by that juncture. The expert opined that, in light of the continuing and unabated pain and swelling at that point, the defendant should have, but did not, undertake a course of periodic full examinations of the foot, with x-rays. As she explained it,

> "[t]he standard of care requires regular follow up with the patient until there is sufficient x-ray evidence of bone healing and the patient's symptoms and complaints have sufficiently reduced. This is true for any type of bunion correction surgery . . . Even if bone healing seems to be progressing on x-ray, it is still important, and the standard of care, to follow a patient with periodic examinations who still has continuing pain and swelling because these, along with positive findings on examination such as pain elicited on palpation of the surgical area, usually mean bone healing is not progressing despite what is seen on x-rays. The most common failures in bone healing would be due to excessive motion at the osteotomy site from a variety of things such as hardware failure or improper surgical technique. Excessive motion at the osteotomy site causes the new bone cells to resorb often resulting in a non-union. This is exactly what happened here."

Despite the expert's conclusion that the defendant should have further examined and x-rayed the plaintiff's foot going forward to assess the apparent failure of the hardware that was implanted, that was likely due to excessive motion at the surgical site, the expert noted that, when the plaintiff returned to see the defendant on August 9, 2018, the defendant refused to meet with her because she was allegedly 15 minutes late for her appointment. Rather, as the plaintiff sat in his waiting room, the defendant telephoned her, and prescribed an x-ray and anti-inflammatory drug without examining her. The plaintiff's expert opined that this was a deviation from the standard of care, particularly because the plaintiff should have been experiencing decreased pain and swelling at that time in light of the fact that she underwent MIS, which is supposed to minimize pain and swelling in contrast to open surgery. Although the aborted

August 9, 2018 visit and concomitant prescriptions were not included in the defendant's records, the plaintiff testified to those events, and relevant entries were included in hospital records.

As the plaintiff's expert noted, when the x-rays that had been ordered were finally taken on August 13, 2018, the films revealed that, although there was some bone healing, "gaps" remained at the osteotomy site. She opined that the plaintiff's unremitting pain and swelling were signs that there was a problem with bone healing, and that the treatment that was indicated under those circumstances was to off-load the foot with a cast to encourage bone healing. This was not done. According to the expert, had this step been taken, it is more likely than not that the metatarsal would have healed, there would have been no nonunion, the plaintiff would not have lost length in the metatarsal bone, her pain and swelling would have abated, and she would not have required additional surgeries. Hence, the plaintiff also would not have sustained any permanent, unavoidable problems that necessarily were related to the additional surgeries. The medical records and the plaintiff's deposition testimony reflect that, when she returned for her fourth post-operative visit with the defendant on September 14, 2018, she still had unremitting and "excruciating" pain and increased swelling, and informed the defendant thereof. Although the defendant took x-rays at that visit that revealed some bone healing, including the anteroposterior (front-to-back) x-ray, the expert opined that there were significant gaps, leading her to conclude that the healing was far from complete as of that date. The defendant nonetheless told the plaintiff that everything was fine.

The plaintiff's expert concluded that the defendant's discharge of the plaintiff from his care on September 14, 2018, along with his failure to limit the plaintiff's weight bearing on her left foot, his failure to place her in a cast, and his failure to schedule follow-up examinations, constituted deviations from good practice that caused the continued nonunion of the bone to now become unavoidable and uncorrectable without additional surgery. Based on the plaintiff's deposition testimony that the defendant informed her that she could begin jogging by November 2018, and that the plaintiff attempted to do so, the expert concluded that the defendant's

recommendations deviated from good practice, and that pain and swelling that remained were avoidable. The expert noted that the plaintiff sought to make an appointment with the defendant that month, but was told that healing could take a year and that the defendant declined to schedule an appointment. The expert concluded that, in light of the plaintiff's continuing symptoms, this was a deviation from good practice. As the expert further noted,

> "More likely than not there was still excessive motion at the osteotomy site which was causing a non-union and resulting in unremitting pain and swelling. There are no other likely causes of a non-union under these circumstances. The defense expert offers no reasonable alternative for the non-union. She never explained how it occurred."

Hence, she concluded that the defendant should have examined the plaintiff in November 2018 and that, had he done so, he should have prescribed a cast, and directed the plaintiff to avoid weight-bearing activities to avoid excessive motion. The expert opined that, had the defendant done so, nonunion could have been avoided and the bone might have been able to heal properly.

The plaintiff's expert asserted that, by the time that the plaintiff underwent the first of two revision surgeries in March 2019, she had experienced shortening of the first metatarsal by virtue of the defendant's 2018 surgery, and also had sustained bone destruction from excessive motion at the osteotomy site that had been ongoing for 10 months. According to the expert, these two factors caused overloading of the lesser metatarsals that, by itself, resulted in painful pathologies. She opined that "[t]here is no doubt that the fraying of the plantar plate was the result of the failed bunion correction surgery performed by Dr. Vulcano which resulted in the altered biomechanics of the left foot," and that the defendant's deviations from good care during the post-operative period in permitting the overloading caused or contributed to those altered biomechanics, including osteoarthritis.

It is well settled that the movant on a summary judgment motion "must make a prima facie showing of entitlement to judgment as a matter of law, tendering sufficient evidence to eliminate any material issues of fact from the case" (*Winegrad v New York Univ. Med. Ctr*., 64

NY2d 851, 853 [1985] [citations omitted]). The motion must be supported by evidence in admissible form (*see Zuckerman v City of New York*, 49 NY2d 557, 562 [1980]), as well as the pleadings and other proof such as affidavits, depositions, and written admissions (*see* CPLR 3212). The facts must be viewed in the light most favorable to the non-moving party (*see Vega v Restani Constr. Corp*., 18 NY3d 499, 503 [2012]). In other words, "[i]n determining whether summary judgment is appropriate, the motion court should draw all reasonable inferences in favor of the nonmoving party and should not pass on issues of credibility" (*Garcia v J.C. Duggan, Inc*., 180 AD2d 579, 580 [1st Dept 1992]). Once the movant meets his or her burden, it is incumbent upon the non-moving party to establish the existence of material issues of fact (*see Vega v Restani Constr. Corp*., 18 NY3d at 503). A movant's failure to make a prima facie showing requires denial of the motion, regardless of the sufficiency of the opposing papers (*see id*.; *Medina v Fischer Mills Condo Assn.,* 181 AD3d 448, 449 [1st Dept 2020]).

"The drastic remedy of summary judgment, which deprives a party of his [or her] day in court, should not be granted where there is any doubt as to the existence of triable issues or the issue is even 'arguable'" (*De Paris v Women's Natl. Republican Club, Inc*., 148 AD3d 401, 403-404 [1st Dept 2017]; *see Bronx-Lebanon Hosp. Ctr. v Mount Eden Ctr*., 161 AD2d 480, 480 [1st Dept 1990]). Thus, a moving defendant does not meet his or her burden of affirmatively establishing entitlement to judgment as a matter of law merely by pointing to gaps in the plaintiff's case. He or she must affirmatively demonstrate the merit of his or her defense (*see Koulermos v A.O. Smith Water Prods*., 137 AD3d 575, 576 [1st Dept 2016]; *Katz v United Synagogue of Conservative Judaism,* 135 AD3d 458, 462 [1st Dept 2016]).

"To sustain a cause of action for medical malpractice, a plaintiff must prove two essential elements: (1) a deviation or departure from accepted practice, and (2) evidence that such departure was a proximate cause of plaintiff's injury" (*Frye v Montefiore Med. Ctr*., 70 AD3d 15, 24 [1st Dept 2009]; *see Roques v Noble*, 73 AD3d 204, 206 [1st Dept 2010]; *Elias v Bash*, 54 AD3d 354, 357 [2d Dept 2008]; *DeFilippo v New York Downtown Hosp*., 10 AD3d 521, 522 [1st

Dept 2004]). A defendant physician moving for summary judgment must make a prima facie showing of entitlement to judgment as a matter of law by establishing the absence of a triable issue of fact as to his or her alleged departure from accepted standards of medical practice (*Alvarez v Prospect Hosp.,* 68 NY2d 320, 324 [1986]; *Frye v Montefiore Med. Ctr*., 70 AD3d at 24) or by establishing that the plaintiff was not injured by such treatment (*see McGuigan v Centereach Mgt. Group, Inc*., 94 AD3d 955 [2d Dept 2012]; *Sharp v Weber*, 77 AD3d 812 [2d Dept 2010]; *see generally Stukas v Streiter*, 83 AD3d 18 [2d Dept 2011]).

To satisfy the burden, a defendant must present expert opinion testimony that is supported by the facts in the record, addresses the essential allegations in the complaint or the bill of particulars, and is detailed, specific, and factual in nature (*see Roques v Noble*, 73 AD3d at 206; *Joyner-Pack v Sykes*, 54 AD3d 727, 729 [2d Dept 2008]; *Koi Hou Chan v Yeung*, 66 AD3d 642 [2d Dept 2009]; *Jones v Ricciardelli*, 40 AD3d 935 [2d Dept 2007]). If the expert's opinion is not based on facts in the record, the facts must be personally known to the expert and, in any event, the opinion of a defendant's expert should specify "in what way" the patient's treatment was proper and "elucidate the standard of care" (*Ocasio-Gary v Lawrence Hospital*, 69 AD3d 403, 404 [1st Dept 2010]). Stated another way, the defendant's expert's opinion must "explain 'what defendant did and why'" (*id*., quoting *Wasserman v Carella*, 307 AD2d 225, 226, [1st Dept 2003]). Furthermore, to satisfy his or her burden on a motion for summary judgment, a defendant must address and rebut specific allegations of malpractice set forth in the plaintiff's bill of particulars (*see Wall v Flushing Hosp. Med. Ctr*., 78 AD3d 1043 [2d Dept 2010]; *Grant v Hudson Val. Hosp. Ctr*., 55 AD3d 874 [2d Dept 2008]; *Terranova v Finklea*, 45 AD3d 572 [2d Dept 2007]).

Once satisfied by the defendant, the burden shifts to the plaintiff to demonstrate the existence of a triable issue of fact by submitting an expert's affidavit or affirmation attesting to a departure from accepted medical practice and opining that the defendant's acts or omissions were a competent producing cause of the plaintiff's injuries (*see Roques v Noble*, 73 AD3d at

207; *Landry v Jakubowitz*, 68 AD3d 728 [2d Dept 2009]; *Luu v Paskowski*, 57 AD3d 856 [2d Dept 2008]). Thus, to defeat a defendant's prima facie showing of entitlement to judgment as a matter of law, a plaintiff must produce expert testimony regarding specific acts of malpractice, and not just testimony that contains "[g]eneral allegations of medical malpractice, merely conclusory and unsupported by competent evidence tending to establish the essential elements of medical malpractice" (*Alvarez v Prospect Hosp*., 68 NY2d at 325; *see Frye v Montefiore Med. Ctr*., 70 AD3d at 24). In most instances, the opinion of a qualified expert that the plaintiff's injuries resulted from a deviation from relevant industry or medical standards is sufficient to preclude an award of summary judgment in a defendant's favor (*see Murphy v Conner*, 84 NY2d 969, 972 [1994]; *Frye v Montefiore Med. Ctr*., 70 AD3d at 24). Where the expert's "ultimate assertions are speculative or unsupported by any evidentiary foundation, however, the opinion should be given no probative force and is insufficient to withstand summary judgment" (*Diaz v New York Downtown Hosp*., 99 NY2d 542, 544 [2002]; *see Frye v Montefiore Med. Ctr*., 70 AD3d at 24). Consequently, where the parties' conflicting expert opinions are adequately supported by the record, summary judgment must be denied (*see Frye v Montefiore Med. Ctr.*, 70 AD3d at 24 *Cruz v St. Barnabas Hospital,* 50 AD3d 382 [1st Dept 2008]).

To oppose a summary judgment motion in a medical malpractice action, the affidavit or affirmation submitted by the plaintiff "must be by a qualified expert who 'profess[es] personal knowledge of the standard of care in the field of . . . medicine [at issue], whether acquired through his practice or studies or in some other way'" (*Bartolacci-Meir v Sassoon*, 149 AD3d 567, 571 [1st Dept 2017], quoting *Nguyen v Dorce*, 125 AD3d 571, 572 [1st Dept 2015]). The courts of this State repeatedly have rejected the concept that only a specialist practicing in a particular specialty is competent to testify as to medical issues that may overlap with another specialty (*see Fuller v Preis*, 35 NY2d 425, 431 [1974]; *Bartolacci-Meir v. Sassoon*, 149 AD3d at 572; *Bickom v Bierwagen*, 48 AD3d 1247, 1248 [4th Dept 2008]; *Julien v Physician's Hosp*., 231 AD2d 678, 680 [2d Dept 1996]; *Matter of Enu v Sobol*, 171 AD2d 302, 304 [3d Dept 1991];

Joswick v Lenox Hill Hosp., 161 AD2d 352, 355 [1st Dept 1990]; *cf. Colwin v Katz*, 122 AD3d 523, 524 [1st Dept 2014] [expert failed to assert that he possessed necessary knowledge and training or explain how he came to it, and also failed to set forth the standard of care allegedly violated]).

> "To qualify as an expert, the witness should be possessed of the requisite skill, training, education, knowledge or experience from which it can be assumed that the opinion rendered is reliable. Thus, if a physician possesses the requisite knowledge and expertise to make a determination on the issue presented, he need not be a specialist in the field. The question of whether a physician may testify regarding the standard of accepted medical practice outside the scope of his specialty can be a troublesome one, but appellate courts have rejected claims of error directed at a physician's qualifications to offer an opinion outside the scope of his specialty when the witness's specialty is closely related to the specialty at issue"

(*Matter of Enu v Sobol*, 171 AD2d at 304 [citations omitted]). Thus, in *Fuller v Preis* (35 NY2d at 431), a neurologist was permitted to give an opinion in the closely related specialty of psychiatry on the issue of whether an accident was the proximate cause of a subsequent suicide. In *Humphrey v Jewish Hosp. & Med. Center* (172 AD2d 494 [2d Dept 1991]), a general surgeon was held to be not unqualified to render an opinion in the specialty of obstetrics and gynecology. And in *Matter of Sang Moon Kim v Ambach* (68 AD2d 986, 987 [3d Dept 1979]), the opinion testimony of a qualified neurosurgeon at a professional misconduct hearing was sufficient to permit a finding of gross negligence or gross incompetence of an orthopedic surgeon during spinal surgery.

Here, the plaintiffs' expert podiatrist asserted that she was fully familiar with the standards of care applicable to bunion correction surgery, and had performed hundreds of such procedures herself. Even though she is not an orthopedic surgeon, the plaintiffs' expert thus is competent to render an opinion not only as to the standard of care applicable to the defendant, but which of his acts constituted a departure from those standards, and whether such a departure caused or contributed to the particular injuries claimed here.

The defendant established his prima facie entitlement to judgment as a matter of law dismissing so much of the medical malpractice cause of action as alleged that the MIS bunion correction was not indicated, and that he inappropriately performed the surgery by, among other things, removing an excessive amount of bone, making improper cuts at the surgical site, using improper screws and plates, or improperly fixing the screws and plates. Inasmuch as the plaintiff's expert did not address these issues, the plaintiff failed to raise a triable issue of fact in connection therewith, and summary judgment must be awarded to the defendant dismissing those claims. Conversely, although the defendant established his prima facie entitlement to judgment as a matter of law dismissing so much of the medical malpractice cause of action as was based on deviations from good practice in the course of post-operative care, the plaintiff raised a triable issue of fact in connection therewith. Hence, summary judgment must be denied to the defendant with respect to that claim.

The elements of a cause of action for lack of informed consent are

> "(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"

(*Spano v Bertocci*, 299 AD2d 335, 337-338 [2d Dept 2002]; *see Zapata v Buitriago*, 107 AD3d 977, 979 [2d Dept. 2013]). For a statutory claim of lack of informed consent to be actionable, a defendant must have engaged in a "non-emergency treatment, procedure or surgery" or "a diagnostic procedure which involved invasion or disruption of the integrity of the body" (Public Health Law § 2805-d[2]).

The defendant established his prima facie entitlement to judgment as a matter of law dismissing the lack of informed consent cause of action by adducing proof that he fully informed the plaintiff of the risks and benefits of the MIS, and compared those risks and benefits to those associated with performing other procedures or declining to treat the condition at all. The

plaintiff's unsupported testimony that she didn't understand all of the risks and benefits is insufficient to raise a triable issue of fact in opposition to the defendant's showing in this regard. Since her expert did not address the quality of the information imparted by the defendant to the plaintiff or the quality of the consent obtained, her affirmation also failed to raise a triable issue of fact with respect to the issue of informed consent. Hence, that branch of the defendant's motion seeking summary judgment dismissing the lack of informed consent cause of action must be granted.

In light of the foregoing, it is

ORDERED that the defendant's motion is granted to the extent that he is awarded summary judgment dismissing the lack of informed consent cause of action and so much of the cause of action alleging a departure from good and accepted medical practice as was based on contentions that the surgery was not indicated and that the defendant inappropriately performed the surgery by, among other things, removing an excessive amount of bone, making improper cuts at the surgical site, using improper screws and plates, or improperly fixing the screws and plates, and the motion is otherwise denied.

This constitutes the Decision and Order of the court.

2/10/2022
DATE

[illegible] KE[illegible]LEY, J.S.C.

CHECK ONE:	☐ CASE DISPOSED		☒ NON-FINAL DISPOSITION	
	☐ GRANTED	☐ DENIED	☒ GRANTED IN PART	☐ OTHER
APPLICATION:	☐ SETTLE ORDER		☐ SUBMIT ORDER	
CHECK IF APPROPRIATE:	☐ INCLUDES TRANSFER/REASSIGN		☐ FIDUCIARY APPOINTMENT	☐ REFERENCE