| **Vallone v Vulcano** |
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| 2022 NY Slip Op 32099(U) |
| June 30, 2022 |
| Supreme Court, New York County |
| Docket Number: Index No. 805163/2019 |
| 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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KEITH VALLONE,

Plaintiff,

- v -

ETTORE VULCANO, M.D., MOUNT SINAI HEALTH SYSTEM, INC., and MOUNT SINAI WEST,

Defendants.

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INDEX NO. 805163/2019

MOTION DATE 05/06/2022

MOTION SEQ. NO. 001

**DECISION + ORDER ON MOTION**

The following e-filed documents, listed by NYSCEF document number (Motion 001) 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62

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

In this action to recover damages for medical malpractice based on alleged departures from good and accepted medical practice and negligent hiring and supervision, the defendants move pursuant to CPLR 3212 for summary judgment dismissing the complaint. The plaintiff opposes the motion. The motion is granted to the extent that the defendants are awarded summary judgment dismissing the complaint insofar as asserted against the defendant Mount Sinai Health System, Inc., and dismissing the cause of action alleging negligent hiring and supervision as against all of the defendants, and the motion is otherwise denied.

The crux of the plaintiff's claim is that the defendant Ettore Vulcano, M.D., departed from good and accepted practice by improperly performing surgery upon the plaintiff's right heel. Specifically, he alleged that Vulcano failed to identify a neurovascular "safe zone" in the course of employing a "blind," minimally invasive surgical procedure, and thus caused a partial tear of the plaintiff's Achilles tendon at the point where that tendon is inserted into the side of the heel. The plaintiff alleged that the surgical point of incision was not sufficiently close to the front of the heel and was made at an atypical angle, and that this method of surgery departed from good

practice. The plaintiff alleged that, as a consequence of the tear, he was compelled to undergo a retrocalcaneal exostectomy, that is, the removal of the bony prominence at the back of the heel bone, with debridement and reattachment of the Achilles tendon and repair with a speed bridge, which is a type of soft tissue fixation device.

The plaintiff was diagnosed with plaque psoriasis at age 25. Since that time, he has treated the condition with topical agents and biologics. On or about August 9, 2017, he first visited Vulcano, an orthopedist specializing in problems with feet and ankles, during a visit to Mount Sinai Orthopedics. Vulcano asserted that the plaintiff then complained of persistent right foot and ankle pain, specifically, pain at the medial tubercle, or midsection protuberance, of the calcaneus, or heel bone, and over the plantar fascia, the thick band of tissue that covers the bones on the bottom of the foot. The plaintiff, however, denied that he complained of persistent right foot and ankle pain on that date.

The plaintiff explained to Vulcano that he had sustained a twisting injury to his right foot and ankle several weeks prior to that visit, and that he had previously seen a podiatrist, who had prescribed Stelara injections to treat the psoriasis. While Vulcano asserted that the plaintiff informed him that the podiatrist had also prescribed Mobic, a non-steroidal anti-inflammatory drug (NSAID) used to treat rheumatoid arthritis, the plaintiff has contested this allegation. Upon examination, the plaintiff's vital signs were normal, he was 5'10'' tall, weighed 260, and had a body mass index of 37.31. The plaintiff exhibited a normal gait, a high arch on his feet with an inward slanting heel, pulses at 2+, intact sensation, and strength at the level of five out of five in all tested muscle groups.

Vulcano's records revealed that, upon examination, the plaintiff exhibited a normal and painless foot and ankle range-of-motion with no instability, although Vulcano noted tenderness upon palpation at the calcaneofibular ligament (CFL) and anterio-talofibular ligament (ATFL), but not at the tibialis posterior tendon at the syndesmosis, an immovable joint in which bones are joined by connective tissue. According to Vulcano's interpretation of X-rays that were taken

of the right foot and ankle during that visit, the plaintiff's right ankle mortise was intact, leading Vulcano to rule out a fracture or signs of ankle instability, and contributing to his assessment that the plaintiff had sustained a sprain of the tibiofibular ligament of right ankle and plantar fasciitis, that is, inflammation of the plantar fascia. He purportedly prescribed Meloxicam, an NSAID, although the plaintiff disputes this. Vulcano recommended physical therapy and orthotics to treat the plaintiff's high arches. In his notes, Vulcano indicated that, if the plaintiff did not improve in six weeks, he would recommend an MRI for better assessment.

On December 27, 2017, the plaintiff presented to Manhattan Medical Health Care for physical therapy, at which he was advised to return for physical therapy twice per week for four to six weeks, and also was referred for an MRI of the right ankle. The MRI scan was performed on January 10, 2018 at Lenox Hill Radiology. According to the defendants, the scan revealed injuries to the peroneal tendons and diffuse tendinosis, including a diffuse longitudinal split of the peroneus brevis tendon superimposed on tendinosis, severe tenosynovitis and a chronic sprain of the anterior talofibular and calcaneofibular ligaments with diffuse tendinosis, that is, a tear of two tendons on the outside part of the ankle. The plaintiff, however, disputes Vulcano's contention that the documentary evidence revealed a tear on the outside of the ankle.

The plaintiff returned to Vulcano on February 1, 2018 with continued complaints of pain, after which Vulcano performed a physical examination and observed that there was tenderness to palpation at multiple zones of the peroneal tendon. He reviewed the MRI results and diagnosed an injury to the peroneal tendon of the right foot. After discussing non-surgical and surgical treatment options with the plaintiff, as well as the benefits and risks of surgery, including infection, blood clot, fracture, non-union, malunion, tendon/ligament rupture, temporary or permanent nerve damage, and the otherwise unanticipated need for further surgery, Vulcano recommended that the plaintiff undergo percutaneous Dwyer osteotomy, open peroneal tendon repair, and soft tissue graft in order to realign the heel, partially correct the high arches, and

alleviate pressure on the tendon. A percutaneous Dwyer osteotomy requires a break that removes an outside-based wedge of bone from the heel bone in order to realign the foot.

According to Vulcano, the plaintiff consented to the procedure, but the plaintiff disputes that the documentary evidence cited by Vulcano supported that contention. The plaintiff does not, however, dispute the allegation itself. Thereafter, Vulcano informed the plaintiff that he would have to wear a boot for a period of time subsequent to the surgery, and that it could take up to one year for the foot to heal. On March 27, 2018, the plaintiff presented to Mount Sinai West for right ankle surgery, and underwent a right calcaneus modified percutaneous Dwyer osteotomy, repair of the peroneus longus (a long vertical leg muscle), and a transfer of muscle from the peroneus brevis (a shorter leg muscle) to the peroneus longus, with bone marrow aspirate and right soft tissue grafting. According to Vulcano, the first portion of the surgery was intended to correct the plaintiff's condition of hindfoot varus, which is an angulation towards the midline of the longitudinal axis of the tuberosity of the heel bone that may be accomplished by removing bone from the heel. Vulcano alleged that, during the second portion of the surgery, he inspected the tendons in the right ankle and, upon finding that there was a 90% tear in the peroneus brevis and a 20% tear in the peroneus longus, he determined to perform a proximal and distal transfer of peroneus brevis to longus and a peroneus longus tendon repair.

Vulcano employed a 3-mm burr to perform the calcaneus osteotomy, followed by a 7-mm lateral closing resection with a 2-mm wedge burr, which purportedly allowed for the hindfoot varus to be corrected. The osteotomy was followed by a 7-mm lateral closing wedge resection using a 2-mm burr, which also purportedly allowed for the hindfoot varus to be corrected. The osteotomy was then stabilized using a posterior to anterior 7-mm headless compression screw. Following the procedure, Vulcano instructed the plaintiff to refrain from weightbearing for two weeks and to return to his office at that time for follow up. Upon his discharge from the hospital, the plaintiff was prescribed acetaminophen, ascorbic acid, vitamin D3, meloxicam, oxycodone, senna, Stelara, and vitamins B12/B9.

Following the surgery, the plaintiff experienced pain throughout his foot following the surgery that, according to Vulcano, was not concentrated in the Achilles tendon area but which, according to the plaintiff did, in fact, affect that area. He returned to see Vulcano for postoperative follow up on April 12, 2018, after which Vulcano noted that the plaintiff was doing well, as his incisions were healed, his pulses were at 2+, sensation was intact, and there was normal and painless foot and ankle range-of-motion with no instability. According to Vulcano, weightbearing X-rays of the ankle taken that day showed good alignment and proper positioning of the installed hardware. The plaintiff allegedly experienced pain in his foot that he described as “normal,” but, according to Vulcano, purportedly averred that he did not experience or complain of any localized pain in the Achilles area.

Vulcano instructed the plaintiff to wear a cam boot, resume physical therapy, and follow up in four weeks, providing the boot and instructing the plaintiff him to wear it all day and night.

On May 17, 2018, the plaintiff presented to Vulcano for a follow-up appointment. As Vulcano recalled it, the plaintiff did not express any complaints, and Vulcano thus concluded that he was doing well, reporting that the physical examination of the right ankle and foot was unremarkable, with a normal and painless range-of-motion with no instability. The plaintiff, however, asserted that he had indeed made such complaints of pain. In any event, Vulcano instructed the plaintiff to begin wearing a sneaker or supportive shoe, continue physical therapy, and follow up in six weeks. In fact, the plaintiff had resumed therapy at Professional Physical Therapy on April 18, 2018 and continued through at least mid-June 2018, with notes indicating that he was progressing well, had decreased complaints of soreness with manual treatment, and evinced improved range-of-motion and joint mobility. By June 5, 2018, the physical therapy notes indicated that the patient was tolerating therapy and demonstrating appropriate strength gains relative to his right lower extremity, right ankle, and foot. The plaintiff reported that his pain level was 4 out of 10, with 10 being the most painful, and that he did not experience any pain at the surgical site, but that he felt discomfort at the heel and bottom of foot and mild

muscle soreness in the calf. The patient was able to resume some physical recreational activities.

On June 14, 2018, when the plaintiff returned to physical therapy, he reported increased soreness in his foot and ankle after walking on the beach, asserting that his ankle had become uncomfortable. On June 29, 2018, the plaintiff saw Vulcano for a follow-up visit, and expressed complaints of Achilles tendon pain, reporting that his symptoms had started the previous week after walking on the beach. Vulcano then performed a physical examination, noting that there was tenderness upon palpation at the bursa and the small membrane in front of the bursa, with all muscle groups, including the Achilles tendon, evaluated at a strength level of 5/5. Vulcano diagnosed the plaintiff with Achilles tendinitis of the lower extremity and ordered continued physical therapy, application of ice to relieve swelling, and Meloxicam for two to three weeks. That was the plaintiff's last visit with Vulcano.

The plaintiff next saw podiatrist Rick Delmonte, D.P.M. As Vulcano described it, a September 10, 2018 X-ray of the plaintiff's right foot reflected that the osteotomy with screw fixation that he had performed was in "near anatomic alignment," with no evidence either of hardware complication, acute fracture, or dislocation, revealing only thickening of the distal Achilles tendon soft tissues, with soft tissue fullness in the region of the retrocalcaneal bursa. The plaintiff disputes Vulcano's description in this regard, suggesting that there was no anatomic alignment, and that there was indeed a hardware complication. As Vulcano interpreted it, an MRI of the plaintiff's ankle without contrast depicted a thickening of the distal Achilles tendon and a partial thickness defect or tear of the medial most deep insertional fibers of the Achilles tendon, and extensive tendinosis, although the plaintiff asserted that there also was excessive tendinitis. On September 20, 2018, the plaintiff appeared for an appointment with Dr. Delmonte, who noted that, since Vulcano's surgery, the plaintiff complained of progressive pain in the right posterior heel at the insertion of the Achilles tendon, although the

plaintiff apparently failed to inform Dr. Delmonte of recent recreational beach activities that may have placed increased strain on his ankle and heel.

Dr. Delmonte noted that he and the plaintiff discussed treatment options, including continued use of the boot and physical therapy but, according to the defendants, the plaintiff declined to continue that treatment. Dr. Delmonte noted that he also discussed the possibility that the Achilles tendon was somehow cut during the osteotomy. Finally, Dr. Delmonte noted that he and the plaintiff discussed surgery which would involve retrocalcaneal exostectomy with debridement and reattachment of the Achilles tendon and repair with a speed bridge.

On October 4, 2018, Vulcano telephoned the plaintiff to inquire of his condition, in response to which the plaintiff informed Vulcano that he was scheduled for Achilles tendon surgery the following week, and that Dr. Delmonte theorized that the Achilles tear occurred in the course of Vulcano's surgery. Vulcano recommended that the plaintiff see an orthopedic surgeon for a second opinion, and requested the plaintiff provide him with the latest MRI for further assessment, thereafter noting that an Achilles injury was unlikely during surgery because the procedure was done at the calcaneus, which is 1.5 centimeters away from the Achilles tendon. The plaintiff did not further follow up with Vulcano.

On October 10, 2018, at NYU Lagone Hospital, Dr. Delmonte performed right foot debridement of hypertrophic Achilles tendon and calcifications, repair of Achilles tendon and right foot retrocalcaneal exostectomy surgery. The operative report asserted that intra-tendinous calcifications were observed and that the surrounding intra-tendinous fibers were unhealthy and hypertrophied. Although there was no specific finding in the operative report of an iatrogenic injury to the Achilles tendon, that is, an injury caused by Vulcano's procedure, Dr. Delmonte later asserted that there was such an injury. In any event, in the course of Dr. Delmonte's procedure, portions of the plaintiff's Achilles tendon were debrided, and Dr. Delmonte's postoperative diagnosis was of tendinosis.

On October 27, 2019, an MRI of the plaintiff's right ankle was obtained, and the radiologist's report noted that the thickening of the Achilles tendon had increased from the September 10, 2018 study, as well as new areas of tears involving the Achilles tendon that had not been present on the earlier study. The new tears involved the deep surface of the distal Achilles tendon and extended for about 2.3 cm from the tendon insertion. The radiologist opined that these were secondary to either tendinitis or Dr. Delmonte's October 10, 2018 surgery. In 2020, Dr. Delmonte reported that the pain in the plaintiff's Achilles tendon had worsened and that, although there was a possibility that the plaintiff had some underlying rheumatologic condition that could have been interfering with the plaintiff's inability to heal, he later concluded that the possible existence of that condition did not exculpate the defendants.

The plaintiff continued to receive Stelara injections to treat plaque psoriasis up to and including January 10, 2020.

In his bill of particulars, the plaintiff alleged that the defendants treated him from on or about August 9, 2017 and continuing through on or about June 29, 2018. He contended that the institutional defendants were negligent in retaining incompetent, unskilled, untrained, inexperienced, and negligent physicians, nurses, and medical personnel. The plaintiff asserted that the defendants neglected properly to maintain its records, perform a complete and accurate physical examination, or consider the diagnostic options for the plaintiff's evaluation. The plaintiff, in addition, alleged that the defendants failed timely to diagnose and properly treat right peroneal and Achilles tendon injury, as well as bilateral patellofemoral stress syndrome. He averred that the defendants performed contraindicated procedures and negligently performed Dwyer calcaneal osteotomy and peroneal tendon repair. The plaintiff also contended that the defendants failed to perform necessary studies, and negligently prescribed physical therapy and medications.

In support of their motion, the defendants submitted the pleadings, the bills of particulars, the parties' deposition transcripts, relevant medical and hospital records, and the

affirmation of orthopedic surgeon Peter Mangone, M.D., who opined that none of the defendants departed from good and accepted practice, and that none of their acts or failures to act caused or contributed to the plaintiff's injuries. Specifically, he concluded that the injuries that the plaintiff sustained were not caused by Vulcano's surgery, but by the plaintiff's own weight-bearing, physical, and recreational activities subsequent to the surgery that placed undue stress on his Achilles tendon, coupled with his pre-existing, systemic psoriatic condition. The defendants also submitted the affidavit of Beth R. Essig, the Executive Vice President and General Counsel of the defendant Mount Sinai Health System, Inc. (MSHS), who asserted that MSHS was a corporate entity that is not a hospital or medical facility, is not involved in providing medical care or in making medical decisions, and does not employ any medical or health-care personnel who provide medical care or make medical decisions.

According to Dr. Mangone, Vulcano recorded the details of "thorough and meticulous" examinations that enabled him to make well-informed and reliable medical assessments. Dr. Mangone averred that Vulcano took an appropriate orthopedic history of the plaintiff that included the origin of his injury, prior treatment, social history, allergies, and medications, performed thorough manual physical examinations of the plaintiff's right foot and ankle throughout the course of his treatment, and documented in detail the plaintiff's vital signs, physical presentation, gait, pulses, strength, sensation, pain level, and presumed diagnosis. He opined that Vulcano appropriately ordered an X-ray of the right foot and ankle prior to the plaintiff's first appointment on August 9, 2017, as well as during the April 12, 2018 appointment. Dr. Mangone asserted that Vulcano's decision to proceed with physical therapy, anti-inflammatories, and orthotics following the initial appointment was entirely proper under the circumstances, and that no additional testing was indicated at that juncture.

Dr. Mangone opined that the Dwyer surgery was indicated and entirely appropriate given the plaintiff's high arch deformity, which had led to stress on the lateral side of his foot and ankle. He stated that manifestations of that condition were visible on preoperative testing that

depicted damage to the tendons on the outside of the plaintiff's foot. According to Dr. Mangone, the presence of peroneal tendon subluxation/dislocation, chronic ankle instability, or hindfoot varus deformity, in association with retrofibular pain and swelling, were indicia of a possible tear of the peroneal tendon that could require surgical intervention. As he explained it, the plaintiff informed Vulcano that he had unsuccessfully tried a more conservative approach through cryotherapy, and that when Vulcano's initial conservative treatment plan did not alleviate the plaintiff's condition, it was appropriate and within the standard of care to recommend and perform surgery to address the tear of the peroneal tendon.

Dr. Mangone concluded that Vulcano's surgical approach was entirely appropriate and, given the location of the procedure and instruments that he employed, "it would have been extremely unlikely for him to have injured the Achilles tendon." As he described it, the procedure involved two phases: (1) an osteotomy to remove a wedge section of heel bone to correct high arch deformity and (2) repair of torn tendons. He explained that the first portion of the surgery was intended to correct the hindfoot varus and was accomplished by a calcaneus osteotomy, and opined that this was proper because a surgeon should treat the primary or contributing causes of the tear at the same time as the tendon repair. Dr. Mangone noted that Vulcano utilized specialized percutaneous burrs, each of which were low-speed, high-torque devices and "known to be extremely safe on soft tissue." He thus concluded that "it would have been highly unlikely for the burr to inadvertently cut tissue; it would have required a significant and unusually drastic and unrequired amount of deliberate force." Dr. Mangone asserted that

> "[t]he plaintiff's claim that Dr. Vulcano caused his Achilles injury during surgery is without merit. The postoperative MRI from September 10, 2018 shows a significant amount of inflammation in or around numerous tendons, which is consistent with a systemic inflammatory process (i.e. psoriatic disease), not iatrogenic injury. Following a calcaneal osteotomy, there is typically a period of mechanical adjustment to a new foot position that can result in increased stress on the Achilles tendon. This study, therefore, depicts tendons that were likely stressed and inflamed from the plaintiff's underlying systemic disease as well as his new foot position. When you combine these circumstances during the plaintiff's surgical recovery with his multiple contraindicated postoperative weight-bearing activities that included walking/dancing on the beach and bouncing off a

> diving board, it is apparent that those issues are directly related to his Achilles tendon injury, not at the hand of Dr. Vulcano. Here, the combination of the plaintiff's systemic disease and the stress he placed on the right foot/Achilles tendon during his vacation activities changed the forces on the tendon causing his Achilles injury."

In support of that conclusion, Dr. Magone asserted that there were never any immediate post-surgical indications that the plaintiff experienced complications from the surgery that Vulcano performed, and that the plaintiff never expressed any complaints of Achilles tendon pain either to Vulcano or his physical therapists until after his beach activities. Dr. Mangone noted that, rather the plaintiff did not complain about his Achilles tendon until two months after Vulcano's surgery, and that prior to his beach vacations, the plaintiff had only complained of pain throughout the entirety of his foot, which Dr. Mangone characterized as a normal post-surgical occurrence. He further averred that documentation both from Vulcano and the physical therapist corroborated this timeline of events. Dr. Mangone also noted that Vulcano had never given the plaintiff permission to walk or dance barefoot on dry sand, or to jump off a diving board, while he was recovering from an extensive surgical reconstruction of his foot and ankle.

According to Dr. Mangone,

> "[i]nvolvement of the distal Achilles tendon is frequent in psoriatic arthritis. Systemic damage to the plaintiff's tendons, including the Achilles, is entirely consistent with damage from psoriasis as opposed to being an iatrogenic injury. The plaintiff was diagnosed with psoriasis when he was 25 years old and has been treating with biologic injections that he still requires to this day. As demonstrated by the plaintiff's peroneal tendon injuries and rotator cuff injury, his history contains multiple examples of tendon pathology with relatively minor injuries. That the plaintiff tore a rotator cuff simply by holding onto a handrail while slipping down steps is also a testament to the unhealthiness of his tendons. Given his underlying systemic inflammatory disease which is known to cause problems at the distal Achilles insertion, it becomes even more clear that the plaintiff's surgery was not the reason his Achilles tendon developed problems."

Dr. Mangone also concluded there was no indication that any other hospital staff or personnel ever departed from the standard of care in providing treatment to the plaintiff and that, hence, the hospital could neither be held vicariously liable for their negligence or for negligent hiring or supervision.

In opposition to the defendants' motion, the plaintiff relied upon the same pleadings, bills of particulars, medical records, and deposition transcripts as did the defendants, and also submitted the affirmation of Dr. Delmonte, who had performed the follow-up surgery described above. Contrary to Dr. Mangone's description of the plaintiff's medical history, Dr. Delmonte asserted that the plaintiff did, in fact, frequently complaint of pain to his Achilles tendon in the months following Vulcano's surgery. Dr. Delmonte averred that he first saw the plaintiff on September 20, 2018, examined him, and reviewed diagnostic scans, all of which supported his conclusion that the plaintiff had sustained a torn Achilles tendon in his right heel. According to Dr. Delmonte, the plaintiff expressed his frustration that Vulcano did not seem to heed his complaints of pain, a factor leading to the plaintiff's determination to cease treatment with Vulcano.

Dr. Delmonte asserted that, on or about October 10, 2018, he performed right foot debridement of a hypertrophic Achilles tendon and calcifications in the plaintiff's right leg and foot, a repair of a partially torn Achilles tendon, and right foot retrocalcaneal exostecomy surgery. As Dr. Delmonte explained it, Vulcano performed

> "a right calcaneus modified Dwyer osteotomy, peroneus longus repair, peroneus brevis to longus transfer with bone marrow aspirate, and right soft tissue grafting upon Mr. Vallone. An osteotomy is the removal of bone. Here, Dr. Vulcano removed bone from Mr. Vallone's right heel (the calcaneus). He then performed a repair to Mr. Vallone's peroneus longus muscle. The peroneus longus and brevis are the two peroneal muscles which begin high on the outer aspect of the lower leg and become tendons as they approach the ankle. They primarily serve to help stabilize the ankle and foot. Dr. Vulcano . . . then performed a peroneus brevis to longus transfer. The peroneus brevis attaches at the base of the midfoot, whereas the peroneus longus tendon runs in a similar direction but then wraps underneath the foot and attaches under the inside part of the foot."

He noted that the Achilles tendon is a strong fibrous cord that connects the muscles in the back of the calf to the calcaneus, and is posterior within the leg and foot, adjacent to the peroneal tendons, and attaches directly to the calcaneus. Dr. Delmonte reported that Vulcano performed his surgery using a minimally invasive approach, as opposed to an open approach, constituting

a percutaneous surgery involving the making of an incision without direct visualization of the underlying target structures. He opined that,

> "[i]n this type of 'blind' procedure, it is important to identify a neurovascular 'safe zone' for this approach to reduce iatrogenic injury. It is a departure from the standard of care to fail to identify the neurovascular 'safe zone' during this approach. Negligent failure to do so adequately can cause nerve and/or tendon injury."

Dr. Delmonte recalled that, intraoperatively, he observed "a partially torn right Achilles. This iatrogenic injury, present at the time of this repair procedure, was caused by Dr. Vulcano, due to his negligent performance of the osteotomy." Specifically, he asserted that he observed a partial tear to the Achilles tendon at the point of insertion to the lateral aspect of the calcaneus. Dr. Delmonte opined that

> "[t]he injury was consistent with an insufficiently anterior, incisional approach, at an atypical angle, at the same location where the osteotomy was performed by Dr. Vulcano. It was, and is, my opinion, within a reasonable degree of medical certainty, that this Achilles tendon tear was not the result of a rupture or any other non-iatrogenic cause. Rather, it was resultant from Dr. Vulcano's negligent failure to properly perform the osteotomy of the calcaneus bone and peroneus tendon transfer by iatrogenically causing the tear to the Achilles during those procedures. As a result of the negligent departures on the part of Dr. Vulcano from the relevant standard of care, he caused this injury to Mr. Vallone."

He further opined that the nature of this iatrogenic injury to the Achilles tendon, in conjunction with such a significant delay in diagnosis after Vulcano's surgery, resulted in a permanent injury to the plaintiff's Achilles tendon and surrounding tendons. Dr. Delmonte further concluded that it was "unsurprising" that the ambulatory difficulties that the plaintiff experienced during his recovery from his own surgery caused further injuries, such as when he lost his footing and fell down a flight of subway stairs, and tore his rotator cuff when he attempted to grab onto a handrail or bannister.

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 (s*ee 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 (se*e 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).

The defendants made a prima facie showing of entitlement to judgment as a matter of law dismissing the complaint insofar as asserted against MSHS by demonstrating that it did not provide medical care or treatment and employed no one for the purpose of providing medical care or treatment. They thus established that MSHS cannot be held liable for medical malpractice (*see Garcia v Global Prop. Servs., Inc*., 2018 NY Slip Op 30957[U], *7-8, 23, 2018 NY Misc LEXIS 1870, *9-10, 34 [Sup Ct, Bronx County, Apr. 3, 2018]). In opposition to that showing, the plaintiff did not address the issue and, hence, failed to raise a triable issue of fact with respect thereto. Hence, the defendants are entitled to summary judgment dismissing the complaint insofar as asserted against MSHS.

The defendants further made a prima facie showing of entitlement to judgment as a matter of law dismissing the medical malpractice cause of action with their expert affirmation and the medical records, by demonstrating that Vulcano and Mount Sinai West did not depart from good and accepted practice in diagnosing the plaintiff's injuries and conditions, or in

recommending or performing a percutaneous Dwyer osteotomy. They adduced evidence that the procedure was properly performed, that Vulcano did not compromise the plaintiff's Achilles tendon during the course of surgery, and that any tear of the Achilles tendon was sustained after the surgery when the plaintiff engaged in weight-bearing, physical, recreational activities at the beach. The plaintiff, however, raised triable issues of fact with his expert's affirmation as to whether a percutaneous Dwyer osteotomy without visualization was indicated, whether Vulcano's surgical technique deviated from good and accepted practice, and whether the undisputed Achilles tendon tear was an iatrogenic injury, that is, caused by Vulcano in the course of his surgical treatment of the plaintiff. Consequently, the court must deny those branches of the defendants' motion seeking summary judgment dismissing the medical malpractice cause of action insofar as asserted against Vulcano and Mount Sinai West, based on alleged departures from good and accepted care.

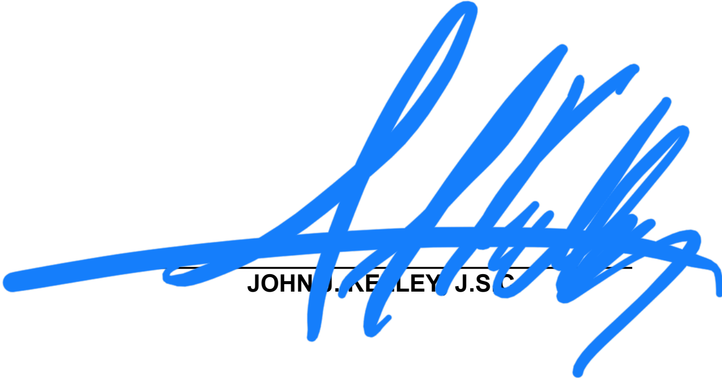
The institutional defendants demonstrated that they neither "knew, [n]or should have known," of the treating physician's "propensity for the sort of conduct which caused the injury" (*Sheila C. v Povich*, 11 AD3d 120, 129-130 [1st Dept 2004]; *see Kuhfeldt v. New York Presbyt./Weill Cornell Med. Ctr*., _____AD3d_____, 2022 NY Slip Op 03076, *1 [May 10, 2022]). They further established, prima facie, that personnel other than Vulcano did not engage in negligent conduct. The defendants thus demonstrated their prima facie entitlement to judgment as a matter of law dismissing the cause of action alleging negligent hiring and supervision. In opposition to that showing, the plaintiff failed to raise a triable issue of fact. Hence the defendants must be awarded summary judgment dismissing that cause of action.

Accordingly, it is

ORDERED that the defendants' motion is granted to the extent that summary judgment is awarded to the defendant Mount Sinai Health Systems, Inc., dismissing the complaint insofar as asserted against it, and to all of the defendants dismissing the negligent hiring and supervision cause of action, and the motion is otherwise denied; and it is further,

ORDERED that the complaint is dismissed insofar as asserted against the defendant Mount Sinai Health Systems, Inc., and the negligent hiring and supervision cause of action is dismissed insofar as asserted against all of the defendants.

This constitutes the Decision and Order of the court.



**6/30/2022**
**DATE**

**JOHN J. KELLEY, J.S.C.**

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