

Kessler v Stuchin

2022 NY Slip Op 34922(U)

June 13, 2022

Supreme Court, Kings County

Docket Number: Index No. 505614/2018

Judge: Pamela L. Fisher

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At an IAS Term, Part 15 of the Supreme Court of the State of New York, held in and for the County of Kings, at the Courthouse thereof at 360 Adams St., Brooklyn, New York on the 13th day of June 2022.

P R E S E N T:

HON. PAMELA L. FISHER,
J.S.C.

-----X
ILENE KESSLER,

Plaintiff,

DECISION/ORDER

- against -

Index No: 505614/2018

STEVEN A. STUCHIN, M.D., VLADIMIR STEINBERG, M.D., and NYU LANGONE MEDICAL CENTER-HOSPITAL FOR JOINT DISEASES

Defendants.

-----X

Recitation, as required by CPLR §2219(a), of the papers considered in the review of this motion:

Papers Numbered

Notice of Motion/Cross Motion/Order to Show Cause and Affidavits (Affirmations) Annexed _____
Opposing Affidavits (Affirmations) _____
Reply Affidavits (Affirmations) _____

1-4, 5-8
9-11, 12-14
15, 16-17

Upon the foregoing papers in this medical malpractice action, defendant, Steven A. Stuchin, M.D., moves in motion sequence 3, pursuant to CPLR § 3212, for summary judgment, dismissing plaintiff’s complaint against him in its entirety. Defendants, Vladimir Steinberg, M.D., and NYU Langone Hospitals s/h/a NYU Langone Medical Center-Hospital for Joint Diseases, move in motion sequence 4, pursuant to CPLR § 3212, for summary judgment, dismissing plaintiff’s complaint against them in its entirety. Defendants also move to amend the caption to reflect their dismissal from the action, to sever the claims against them from the claims against the remaining defendants, and to direct the entry of judgment with prejudice in their favor.

Plaintiff commenced this action by filing a summons and complaint on March 20, 2018 (Defendant’s Affirmation in Support ¶ 5, motion sequence 3; Summons & Complaint, annexed as

Exhibit B to defendant's motion papers, motion sequence 3). Issue was joined by defendant, Dr. Stuchin on April 17, 2018, and by defendants, Dr. Steinberg and NYU Langone Hospitals on May 11, 2018 (Defendant's Affirmation in Support ¶ 5, motion sequence 3; Answers annexed as Exhibit C to defendant's motion papers, motion sequence 3). Plaintiff served separate bills of particulars upon defendants on or about August 2, 2018 (Defendant's Affirmation in Support ¶ 6, motion sequence 3; Bills of Particulars annexed as Exhibit D to defendant's motion papers, motion sequence 3, and as Exhibit E to defendants' motion papers, motion sequence 4).

In her complaint and bills of particulars, plaintiff alleges that defendants departed from good and acceptable medical practice during their treatment of her from July 16, 2015, to October 20, 2016 (Complaint ¶ 15; Verified Bill of Particulars as to Dr. Stuchin ¶¶ 1, 3; Verified Bill of Particulars as to Dr. Steinberg ¶¶ 1, 2; Verified Bill of Particulars as to NYU ¶¶ 1, 2). Specifically, as to Dr. Stuchin, plaintiff claims that he deviated from the standard of care by failing to diagnose and treat carpal tunnel syndrome, "performing unnecessary surgeries on the plaintiff's upper extremities," "failing to order, recommend, or obtain appropriate laboratory, radiologic and/or imaging tests and studies," and neglecting to obtain plaintiff's informed consent (Verified Bill of Particulars as to Dr. Stuchin ¶¶ 1, 15). With respect to Dr. Steinberg, plaintiff contends that he deviated from the standard of care during his treatment of the plaintiff on January 6, 2016, at NYU Langone Medical Center-Hospital for Joint Diseases by "failing to properly establish and monitor an intravenous line in the plaintiff's upper extremity," "failing to properly and timely diagnose, detect, appreciate or react to the signs and symptoms which the plaintiff exhibited," "failing to order, recommend or obtain appropriate laboratory, radiologic and/or imaging tests and studies," and neglecting to obtain plaintiff's informed consent (Verified Bill of Particulars as to Dr. Steinberg ¶¶ 1, 2, 18). In her bill of particulars, plaintiff asserts the same claims against NYU Langone Hospitals (NYU), that she has brought against Dr. Stuchin and Dr. Steinberg, and alleges that NYU is "vicariously liable for the negligent acts and/or

omissions of those physicians, nurses, hospital staff and/or independent contractors who were acting under its supervision, direction, and control” while plaintiff “was admitted to NYU Langone Medical Center-Hospital for Joint Diseases, and when she received follow-up care during office visits” with Dr. Stuchin and Dr. Steinberg (Verified Bill of Particulars as to NYU ¶¶ 1, 4, 18). Plaintiff has also included a claim for negligent hiring and supervision against NYU (*Id.* at ¶ 1). As a result of defendants’ alleged malpractice, plaintiff is claiming that she sustained the following injuries: severe left anterior interosseous mono-neuropathy, severe left upper limb pain and dysesthesias with inability to move fingers of the left hand, impaired left thumb opposition and severe weakness of left thumb deep flexion and index finger flexion, contracture at the left elbow, compression of both median nerves at the left wrist, numbness in the dorsum of the left hand and the dorsum of the thumb and index finger, pain in the entire dorsum of the left forearm with throbbing, frozen left shoulder with impaired range of motion, weakness of the C8/T-1 supplied muscles involving the proximal and distal median muscles and distal ulnar supplied muscles, complete denervation of the left flexor pollicis longus and reduced recruitment in the left pronator quadratus, medial cord plexopathy, pain and numbness in the left upper limb, necessity for future surgery(ies), pain, weakness and dysfunction of the right hand due to compensation for loss of function of left hand, loss of sleep, mental anguish, emotional distress, depression, and anxiety (*Id.* at ¶ 7; Verified Bill of Particulars as to Dr. Steinberg ¶ 7; Verified Bill of Particulars as to Dr. Stuchin ¶ 4).

The following facts are not in dispute. From 2010 to 2013, plaintiff received treatment from Dr. Salil Gupta, an orthopedic surgeon, for “bilateral wrist pain” (Statement of Material Facts ¶¶ 1, 2, motion sequence 3). On October 29, 2013, Ms. Kessler presented to Dr. Gupta’s office, and the records from this visit indicate that Dr. Gupta’s “examination of [plaintiff’s] bilateral upper extremities showed that [she] was neurovascularly intact” (*Id.* at ¶ 2). Dr. Gupta’s assessment was that plaintiff “had tears of the triangular fibrocartilage complex (TFCC) and scapholunate,” and he recommended that plaintiff

“wear a wrist brace, take anti-inflammatory medications, and return to see him in six to eight weeks” (*Id.*). On December 24, 2013, plaintiff “returned to Dr. Gupta’s office” “for follow-up care regarding her bilateral wrist ligament tears, arthrosis, and inflammation” (*Id.* at ¶ 3). The chart documents that Ms. Kessler informed Dr. Gupta that her “pain was getting worse, and that her right wrist was more painful than her left” (*Id.*). Dr. Gupta recorded that “Ms. Kessler’s wrists were neurovascularly intact,” but that her “symptoms had worsened despite receiving a cortisone injection and being immobilized” (*Id.*). He “recommended that Ms. Kessler undergo an MRI of the right wrist, and, pending the results of that study, consider an arthroscopic procedure” (*Id.*). Plaintiff underwent an MRI on December 27, 2013, which “revealed a tear of the central TFCC with bone marrow edema, which was suggestive of ulnocarpal impingement syndrome” (*Id.*). Further, the “MRI also detected a partial tear of the scapholunate ligament” (*Id.*). Plaintiff did not return to Dr. Gupta, and “did not see another orthopedist until she presented to Dr. Stuchin in 2015” (*Id.* at ¶ 4).

On July 16, 2015, plaintiff had her first appointment with Dr. Stuchin, and his records state that she complained of “severe bilateral wrist pain for the past five years” (*Id.* at ¶ 6). The chart documents that Dr. Stuchin “performed a physical examination, which revealed [p]laintiff’s wrist motion was 45/45 bilaterally,” “her pronation/supination grip was 90/90,” “her right-hand grip strength was 12,” and “her left-hand grip strength was 10” (*Id.*). Dr. Stuchin noted that the “Tinel’s and Phalen’s signs were negative,” plaintiff “had no evidence of intrinsic or thenar muscle wasting,” “[s]he had mild pain over the dorsal scapholunate interval, but no pain to deep palpation over the distal radioulnar joint” and her “sensation was intact” (*Id.*). Dr. Stuchin “ordered an x-ray” and MRI (*Id.*). The chart states that the “x-ray showed normal joint space alignments and no articular changes,” and the “MRI revealed bilateral arthritis, and damage to the TFCC and the scapholunate ligament” (*Id.*). On July 27, 2015, Ms. Kessler returned to Dr. Stuchin, and he “noted that [she] had multiple areas of ligament and joint compromise” (*Id.* at ¶ 7). He “documented that Ms. Kessler’s wrists showed too many areas of damage

to be improved with a single surgery,” and “suggested a lidocaine injection of the anterior and posterior interosseous nerves” “[a]s an initial intervention” (*Id.*). During this visit, Dr. Stuchin “injected lidocaine into both arms” “[u]nder aseptic conditions” (*Id.*). The records from this visit indicate that Dr. Stuchin discussed “perform[ing] neurectomy procedures, and asked that Ms. Kessler return to see him in four weeks” (*Id.*). On September 10, 2015, plaintiff presented to Dr. Stuchin with complaints of “pain and limited range of motion” in her left wrist after striking “her wrist on a beach chair” (*Id.* at ¶ 8). The chart documents that “Dr. Stuchin’s physical examination revealed pain with range of motion of the left wrist, but no swelling or local tenderness,” and that she “request[ed] surgery” (*Id.*; Certified Medical Records of Dr. Steven A. Stuchin at 2, annexed as Exhibit J to defendant’s motion papers, motion sequence 3). On October 6, 2015, plaintiff underwent a left arm AIN/PIN (posterior and anterior interosseous neurectomy) at NYU, which was performed by Dr. Stuchin (Statement of Material Facts ¶ 9, motion sequence 3). On November 23, 2015, “Ms. Kessler requested that Dr. Stuchin perform the same procedure on her right wrist,” and the surgery was scheduled for January 6, 2016 (*Id.* at ¶¶ 10, 12).

On January 6, 2016, plaintiff underwent a “right posterior and anterior interosseous neurectomy” at NYU, which was performed by Dr. Stuchin (*Id.* at ¶ 12). Prior to the surgery, Dr. Kristina Siliunas, an anesthesiology resident, placed an IV in plaintiff’s left arm, hand, or wrist, “which was removed” by Nurse Regina Orbeta (Statement of Undisputed Facts ¶ 11, motion sequence 4; Plaintiff’s Response to Statement of Material Facts of Defendants ¶¶ 11, 12, motion sequence 4). After the “initial attempt by Dr. Siliunas,” Dr. Steinberg, the attending anesthesiologist, “placed an IV line in the cephalic vein in the [left] forearm, which is located at the postero-lateral aspect of the arm and forearm” (Statement of Undisputed Facts ¶ 13, motion sequence 4). Following the surgery, Ms. Kessler returned to Dr. Stuchin’s office on January 14, 2016, and she informed him “that she had pain on the left wrist at the IV insertion site” (Statement of Material Facts ¶ 13, motion sequence 3). Dr. Stuchin

examined the plaintiff, and “documented a positive Finkelstein test, which was indicative of De Quervain’s tendonitis (inflammation of the tendons on the thumb side of the wrist)” (*Id.*). The records indicate that Dr. Stuchin “injected Ms. Kessler’s first dorsal compartment,” and “[h]e also examined her right wrist, which was clean and healing well” (*Id.*). On January 19, 2016, “pain management/anesthesiology attending Dr. Vladimir Steinberg” recorded that plaintiff “called the Anesthesia department over the weekend” (Statement of Undisputed Facts ¶ 20, motion sequence 4). Dr. Steinberg “returned the patient’s call and noted that she complained of pain in the non-operative left hand,” and that she “believed the pain was caused by the IV insertion attempt” (*Id.*). He also “documented that [Ms. Kessler] complained of pain in the right hand (operative side) radiating up to the elbow,” and “advised [her] that she required an examination by a neurologist to make a diagnosis” (*Id.* at ¶ 21). Dr. Steinberg “provided her with the contact information for Dr. Kiprovski,” and “recommended that [plaintiff] contact Dr. Stuchin’s office” (*Id.* at ¶ 21).

On January 25, 2016, plaintiff returned to Dr. Stuchin’s office for her second post-operative appointment following her “right arm AIN/PIN” (Statement of Material Facts ¶ 14, motion sequence 3). The records state that “Dr. Stuchin’s physician assistant PA Schulgasser examined Ms. Kessler,” and he “documented that Ms. Kessler’s right wrist was doing well,” but she “complained of severe left wrist pain” (*Id.*). Dr. Stuchin also examined “Ms. Kessler, and he noted she had painless range of motion of the right wrist,” and that she “complained of right shoulder pain, but she had no weakness or loss of sensation in her right arm” (*Id.*). The chart indicates that “Ms. Kessler had a positive Finkelstein’s test with pain to percussion over the 1st dorsal compartment” of her left wrist, and Dr. Stuchin “repeated the injection of the 1st dorsal compartment of the left wrist” (*Id.*). Dr. Stuchin asked plaintiff to “return to his office again in three weeks” (*Id.*). On February 18, 2016, plaintiff presented to Dr. Stuchin’s office, and was seen by PA Schulgasser, who “examined Ms. Kessler and documented that Ms. Kessler’s right wrist was doing well,” but that she “continued to complain of severe left wrist

and forearm pain” (*Id.* at ¶ 15). She was examined by Dr. Stuchin, and his “examination revealed a positive Tinel’s sign over the 1st dorsal compartment and cubital tunnel,” but the “Finkelstein’s test was negative” (*Id.*). Dr. Stuchin recorded that “Ms. Kessler’s symptoms were now consistent with a radial sensory nerve distribution, and that Ms. Kessler intended to undergo an evaluation by a neurologist” (*Id.*). He also “planned to obtain an MRI of Ms. Kessler’s left forearm to assess for compression of the radial sensory nerve” (*Id.*).

On February 23, 2016, plaintiff “presented to non-party neurologist Dr. Kiril Kiproviski,” and she informed him that “during the January 2016 surgery, she had an IV inserted in the left forearm, which was painful” (*Id.* at ¶ 16). Ms. Kessler “explained that the pain was over the lateral aspect of the left forearm, extended to her thumb, and wrapped around the back of her wrist to the ulnar aspect of the dorsum of the left hand and ulnar fingers” (*Id.*). Plaintiff “also reported a new sensation of constant tingling and numbing, and she was having trouble holding objects in her left hand” (*Id.*). She reported that she “had tried Percocet and Tramadol, which had been ineffective” (*Id.*). Dr. Kiproviski’s records indicate that she did not have “similar symptoms in the right arm.” His impression was that “she now had neuropathic pain in her left arm, the etiology of which was uncertain,” and he “suggested a trial of Neurontin and continued Cymbalta” (*Id.*). Dr. Kiproviski “referred the patient for occupational therapy” (*Id.*). On March 24, 2016, Ms. Kessler presented to Dr. Kiproviski “for a follow-up evaluation” (*Id.* at ¶ 17). In his notes, he documented that Ms. Kessler “continued to experience unrelieved pain in the same distribution in the left forearm,” but that the “right arm was still asymptomatic” (*Id.*). He recorded that “there was a negative Tinel’s sign on both wrists,” and he “suggested a trial of Lyrica 50 mg daily with gradual increase” (*Id.*). Dr. Kiproviski also “recommended a pain management consultation” (*Id.*). He wrote that “electrodiagnostic studies should be considered, but, given the amount of pain that [Ms. Kessler] was experiencing, an EMG nerve conduction study of the left forearm was not indicated,” and that the “etiology of her symptoms remained uncertain” (*Id.*). On March 24, 2016, plaintiff also visited

“Dr. Stuchin, who documented that the patient had a positive Tinel’s sign over the left radial sensory nerve,” and she “had a negative Finkelstein test on the left side” (*Id.* at ¶ 18). He recorded that his “plan was to obtain an MRI of the left forearm to assess compression of the radial sensory nerve” (*Id.*).

On April 4, 2016, Ms. Kessler “underwent a left arm MRI neurogram, which showed postsurgical changes related to the prior AIN/PIN, but it was otherwise unremarkable” (*Id.* at ¶ 19). Plaintiff returned to Dr. Stuchin on April 7, 2016, and he recorded that “she had a positive Tinel’s at the elbow over the ulnar nerve and the radial sensory nerve in the distal third of the forearm” (*Id.*). Further, he noted that “[c]ubital hyperflexion increased her ulnar nerve symptoms,” and “[h]er intrinsic muscles were 4 out of 5 in strength on the left, but 5 out of 5 on the right” (*Id.*). Dr. Stuchin “injected the radial nerve with lidocaine,” and he “asked her to return in four weeks” (*Id.*). On May 9, 2016, plaintiff had an appointment with Dr. Stuchin, and he “noted that splinting of the left arm had failed to resolve [plaintiff’s] symptoms regarding the cubital tunnel,” but that “her radial nerve symptoms had resolved” (*Id.* at ¶ 20). The chart indicates that plaintiff “complained of pain in her entire left arm from the wrist to the shoulder,” and that “[s]he had weakness of intrinsic muscles of the left hand, a positive Tinel’s sign, and cubital hyperflexion” (*Id.*). The records document that Dr. Stuchin discussed the “risks of hand surgery” with the patient (*Id.*). On June 8, 2016, “Dr. Stuchin performed a left ulnar neurolysis and transposition of the cubital tunnel of Ms. Kessler’s left upper extremity at NYU” (*Id.* at ¶ 21). He “diagnosed the [plaintiff] with left cubital tunnel syndrome, a positive Tinel’s sign, and weakening of the intrinsic muscles, with pain and numbness in the ulnar nerve distribution” (*Id.*). On June 16, 2016, Ms. Kessler returned to Dr. Stuchin’s office for a postoperative appointment (*Id.* at ¶ 22). He documented that her “incision appeared well-healed,” but “she continued to complain of diffuse numbness and swelling” (*Id.*). He also noted that she “had decreased grip strength in her left hand,” and he wrote her a “prescription for physical therapy and advised [her] to follow up with him in three weeks” (*Id.*).

The records from plaintiff's July 11, 2016, appointment with Dr. Stuchin indicate that she "complained of a recurrence of the numbness and tingling in the dorsal sensory radial nerve distribution," and Dr. Stuchin "observed Tinel's sign over the radial sensory nerve at its exit from the intersection, and sensitivity over the cubital tunnel scar" (*Id.* at ¶ 23). He "administered an injection of Lidocaine into the distal radial and dorsal compartment of Ms. Kessler's left forearm, which caused numbness and a radial sensory nerve distribution as well as pain relief" (*Id.*). She returned to Dr. Stuchin's office on July 21, 2016, and the chart states that she "complain[ed] of paresthesia and pain in her entire left arm starting in her fingers and radiating up her forearm" (*Id.* at ¶ 24). Both PA Yip and Dr. Stuchin noted that they "observed Tinel's signs over the intersection point where the radial sensory nerve exits," and Dr. Stuchin "referred Ms. Kessler to a second neurologist, non-party, Dr. Christina Drafta" (*Id.*). He also wrote plaintiff a prescription for "20 mg daily of Cymbalta with instructions to gradually increase the dosage to 60 mg over the course of the week" (*Id.*). On August 2, 2016, Ms. Kessler had an appointment with Dr. Drafta "who performed a neurologic examination" (*Id.* at ¶ 25). She noted that the "motor exam of the left upper arm was limited by pain, but Ms. Kessler had full strength at the left deltoid and right arm," and the "sensory examination was significant for dysesthesia (abnormal sensation) at the left forearm on the lateral dorsal aspect" (*Id.*). Dr. Drafta "performed a nerve conduction study," and "[s]he documented that the needle EMG exam of the left upper extremity was not tolerated by Ms. Kessler, but the exam of the left deltoid was normal" (*Id.*). Her "impression was a normal nerve conduction study of both arms and no electrophysiologic evidence of radiculopathy, polyneuropathy, nerve entrapment, or myopathy" (*Id.*). On October 20, 2016, plaintiff presented to Dr. Stuchin's office "complaining of pain in her entire left arm" (*Id.* at ¶ 26). Dr. Stuchin examined her, and "observed pain over the medial epicondyle, which increased with resisted wrist flexion" (*Id.*). He also noted a "positive Tinel's sign over the exit point of the radial sensory nerve, and in the distal third of the left forearm," and he "observed mild thenar wasting" (*Id.*). He documented

that “a Phalen’s maneuver was positive” (*Id.*). His records indicate that he informed “Ms. Kessler that she had three separate problems: (1) medial epicondylitis (a condition that affects the inside of the elbow and is known as ‘golfer’s elbow;’ (2) compression neuropathy of the radial sensory nerve at the exit point from under the brachial radialis;” and (3) carpal tunnel syndrome (*Id.*). His records document that Ms. Kessler “advised [him] that she was not interested in” surgery, and that he “recommended phonophoresis (ultrasound combined with a medication gel that is applied to the skin) (Certified Medical Records of Dr. Steven A. Stuchin at 14-15; Statement of Material Facts ¶ 26, motion sequence 3). After this appointment, plaintiff discontinued treatment with Dr. Stuchin, and did not seek further treatment for her left arm pain until March 15, 2018 (Strauch Expert Affirmation ¶ 53, annexed as Exhibit A to defendant’s motion papers, motion sequence 3; Statement of Material Facts ¶ 27, motion sequence 3).

After discontinuing treatment with Dr. Stuchin, plaintiff presented to the following providers: neurologist, Dr. Justin Willer, orthopedic surgeon, Dr. David Edelstein, and orthopedic surgeon, Dr. Vipul Patel (*Id.* at ¶¶ 27-29). Dr. Willer “performed a nerve conduction study on March 15, 2018,” and Dr. Edelstein performed an “evaluation of pain in [plaintiff’s] left upper extremity” on May 3, 2018, and diagnosed her with “trigger finger” (*Id.* at ¶¶ 27-28). On November 14, 2018, plaintiff “presented” to Dr. Patel, “complaining of progressive left elbow pain and numbness and tingling in her left hand” (*Id.* at ¶ 29). He noted that she had “positive Tinel, Phalen, and Durkon’s carpal tunnel tests,” and he “diagnosed [her] with left carpal tunnel, left ring finger trigger, and left elbow pain in the medial epicondylitis” (*Id.*). Dr. Patel “recommended a left endoscopic carpal tunnel release (“ECTR”) and ring finger trigger release,” and he performed these surgeries on plaintiff at New York Presbyterian Brooklyn Methodist Hospital (Methodist Hospital) on January 11, 2019 (*Id.* at ¶¶ 29-30). Following the operations, her left-hand symptoms improved, but the records indicate that she continues to have pain in her left elbow (*Id.* at ¶¶ 31-34).

Dr. Stuchin's Motion for Summary Judgment (Motion Sequence 3):

In support of his motion for summary judgment, defendant submits an expert affirmation from Robert J. Strauch, M.D., a physician board certified in orthopedic surgery, who also “hold[s] a Certificate of Added Qualifications in [h]and [s]urgery” (Strauch Expert Affirmation ¶ 1). Dr. Strauch contends that Dr. Stuchin never deviated from the standard of care during his treatment of the plaintiff, and that he did not proximately cause her injuries (*Id.* at ¶ 2). Dr. Strauch’s opinion is based on review of the pleadings, bills of particulars, deposition transcripts, and medical records, as well as his own education, training and experience (*Id.* at ¶ 3). Dr. Strauch opines that Dr. Stuchin appropriately recommended an “AIN/PIN denervation,” as Ms. Kessler responded well to the “lidocaine injections of the wrists,” and “conservative management had failed, including Dr. Gupta’s treatment of immobilizing [plaintiff’s] wrists and providing cortisone injections” (*Id.* at ¶¶ 38-39). Dr. Strauch maintains that both AIN/PIN surgeries were performed in accordance with the standard of care, and that “Ms. Kessler did not sustain any harm or adverse effects” from the procedures (*Id.* at ¶¶ 41, 44). Following the left arm AIN/PIN, Dr. Stuchin documented that plaintiff “had no pain with full range of motion in her left wrist” “for over one month” after the surgery, and that she “denied having any right arm deficits to numerous physicians” after the right arm AIN/PIN, indicating that the surgeries were not “contraindicated” (*Id.* at ¶¶ 42-43). He concludes that “even when an AIN/PIN fails to permanently relieve a patient’s wrist pain, the surgery itself does not impair nerve function, disrupt arm strength, or complicate future corrective surgeries” (*Id.* at ¶ 44).

Dr. Strauch contends that Dr. Stuchin did not depart from acceptable medical practice by failing to timely diagnose plaintiff with carpal tunnel syndrome (*Id.* at ¶¶ 52, 53). He points out that Dr. Gupta, who plaintiff received treatment from prior to Dr. Stuchin, “repeatedly concluded that Ms. Kessler did not have a neurological deficit, which would have included” carpal tunnel syndrome (*Id.* at ¶ 45). Further, Dr. Stuchin “performed a Tinel’s sign and a Phalen’s maneuver” when he began

treating the plaintiff, and both tests were negative, indicating that Ms. Kessler “did not have” carpal tunnel syndrome “at that time” (*Id.*). He suggests that Dr. Stuchin reasonably diagnosed Ms. Kessler with “De Quervain’s tenosynovitis” at her “first post-operative visit following the right AIN/PIN” based on her complaints of “reported pain at the IV site on the left wrist” and the fact that her pain subsided temporarily after Dr. Stuchin injected the “first dorsal component” (*Id.* at ¶ 46). Further, Dr. Strauch emphasizes that plaintiff was evaluated by Dr. Kiproviski, a neurologist, in February and March 2016, and “he did not diagnose [her] with [carpal tunnel syndrome] of either wrist” (*Id.* at ¶ 47). He also points out that the MRI neurogram report from April 2016 “concluded [that] there was no apparent damage to the median, ulnar, or radial nerves,” thereby evidencing that there was no “[delay in] diagnosing Ms. Kessler” with carpal tunnel syndrome before April 2016 (*Id.* at ¶ 48). Dr. Strauch affirms that a “nerve conduction study is the best diagnostic test for diagnosing [carpal tunnel syndrome],” and “Dr. Drafta performed a nerve conduction study” on plaintiff on August 2, 2016, which showed “no evidence of [carpal tunnel syndrome]” (*Id.* at ¶ 51). Based on these results, he claims that “Dr. Stuchin cannot possibly be held responsible for failing to timely diagnose [carpal tunnel syndrome] prior to August 2, 2016” (*Id.*). Dr. Strauch opines that Dr. Stuchin “appropriately began to suspect” that plaintiff had carpal tunnel syndrome on October 20, 2016, based on her “positive Phalen’s test” and “evidence of mild thenar muscle atrophy” on that date (*Id.* at ¶ 52). As plaintiff discontinued treatment with Dr. Stuchin after October 20, 2016, she “deprived Dr. Stuchin of an opportunity to treat her [carpal tunnel syndrome]” (*Id.* at ¶ 53). Dr. Strauch concludes that even if there was a delay in diagnosing plaintiff with carpal tunnel syndrome, she did not “sustain any harm” from this delay, as the “left carpal tunnel release and left trigger finger release performed by Dr. Patel in January 2019 completely relieved [her carpal tunnel syndrome] symptoms” (*Id.* at ¶ 56).

In opposition to defendant’s motion for summary judgment, plaintiff submits an expert affirmation from Justin A. Willer, M.D., a physician board certified in clinical neurophysiology and

neurology, who opines that Dr. Stuchin departed from acceptable medical practice during his treatment of the plaintiff, and that these departures proximately caused the plaintiff's injuries (Plaintiff's Expert Affirmation ¶¶ 1, 5, annexed as Exhibit 1 to plaintiff's opposition papers, motion sequence 3).

Plaintiff's expert opinion is based on his evaluation of the plaintiff on March 15, 2018, and his review of the medical records and deposition transcripts, as well as his own education, training, and experience (*Id.* at ¶¶ 2-5). Dr. Willer contends that Dr. Stuchin deviated from the standard of care by failing to timely diagnose plaintiff with carpal tunnel syndrome at the beginning of her treatment, given her "complaints of numbness and tingling in the hands, particularly on awakening or awakening her from sleep," which are "classic symptoms of carpal tunnel syndrome" (*Id.* at ¶¶ 39, 40). Further, Dr. Willer explains that the "diagnosis of carpal tunnel syndrome is relatively high on the differential diagnosis list of wrist pain in a patient with diabetes," and plaintiff had diabetes since 2000 (*Id.* at ¶¶ 8, 39). Dr. Willer maintains that Dr. Stuchin "should have immediately recommended [plaintiff] for nerve conduction and needle EMG tests to confirm" that plaintiff had carpal tunnel syndrome, instead of just ordering an MRI, which "cannot definitively rule out a nerve injury" (*Id.* at ¶¶ 39, 46). He points out that the EMG/NCV testing that he performed on March 15, 2018, demonstrated that the plaintiff had carpal tunnel syndrome, and affirms that had this test been performed earlier, it "would have provided objective evidence of the carpal tunnel syndrome" (*Id.* at ¶ 39). Although nerve conduction studies were performed by Dr. Drafta, Dr. Willer claims that this test was not sensitive enough, as "Dr. Drafta did not perform any median nerve comparison studies" (*Id.* at ¶ 48). Dr. Willer states that Dr. Stuchin should not have "rule[d] out carpal tunnel syndrome" based on the fact that plaintiff had a "negative Tinel's sign [at] the beginning" of his treatment of her, as "there is a high false negative rate for the Tinel's test" (*Id.* at ¶ 39). He concludes that "Dr. Stuchin's failure to timely diagnose the carpal tunnel syndrome resulted in a missed and significantly delayed opportunity to treat the carpal tunnel syndrome early on by non-invasive techniques, such as stretching or strengthening exercises, nerve

gliding exercises, immobilization or medication” (*Id.* at ¶ 40). Dr. Willer opines that the “carpal tunnel release surgery” “performed by Dr. Patel would not have been necessary if Dr. Stuchin had properly diagnosed carpal tunnel syndrome in the first place, and immediately instituted the aforementioned non-invasive treatment techniques” (*Id.*). Further, he also contends that plaintiff “now requires a carpal tunnel release surgery on her right side,” which “would not have been necessary if she had been properly treated for the carpal tunnel syndrome on the right side from the very beginning” (*Id.*).

Dr. Willer alleges that “Dr. Stuchin departed from accepted standards of medical practice by performing two unnecessary anterior/posterior interosseous neurectomy surgeries, neither of which provided any benefit” to plaintiff (*Id.* at ¶ 41). He explains that “[a]n anterior and/or posterior interosseous neurectomy is” “performed to treat an anterior/posterior interosseous neuropathy” (*Id.* at ¶ 42). He states that “[a]nterior interosseous neuropathy primarily presents with pain in the forearm and elbow and weakness of the Flexor Pollicis Longus, radial half of the Flexor Digitorum Profundus and Pronator Quadratus with weakness of flexion of the distal thumb and index and middle finger, and with difficulty making an ‘OK’ sign with the index finger and thumb” (*Id.*). He affirms that plaintiff did not have “an anterior/posterior interosseous neuropathy” prior to her “two neurectomy surgeries,” as she “did not present with any of these symptoms” (*Id.*). Dr. Willer argues that the “TFCC damage in [plaintiff’s] wrists contributed more to the median nerve compression than it did to causing wrist pain independent of the pain resulting from the median nerve compression” (*Id.* at ¶ 41). Therefore, the surgeries, which “were meant to denervate the damaged areas of the TFCC and [scapholunate] of her wrists, provided no benefit whatsoever to [plaintiff’s] true condition in each wrist which was median nerve compression,” and did not resolve her complaints “of pain and disability in the wrists and hands” (*Id.*). This conclusion is based on the fact that plaintiff “continued to complain of pain in both of her wrists” after the surgeries (*Id.*). Dr. Willer concludes that plaintiff sustained permanent injuries from

the delay in diagnosis of her carpal tunnel syndrome, including “permanent loss of 50% of normal range of motion of thumb opposition” (*Id.* at ¶ 51).

In reply, defendant reiterates that he did not deviate from the standard of care during his treatment of the plaintiff, and that he did not proximately cause her injuries (Reply Affirmation ¶ 5, motion sequence 3). Defendant alleges that the statements in defendant’s statement of material facts “must be deemed admitted,” as plaintiff failed to comply with Uniform Court Rule 202.8-g(d) in her response to defendant’s statement of material facts (*Id.* at ¶¶ 7-9). Further, defendant contends that certain allegations in plaintiff’s bill of particulars must be dismissed, as plaintiff failed to address these allegations (*Id.* at ¶ 10). Defendant argues that plaintiff’s expert affirmation is insufficient to defeat defendant’s motion for summary judgment, as it is speculative, conclusory, based on “evidence outside the record, and hindsight reasoning” (*Id.* at ¶ 14).

Dr. Steinberg’s and NYU’s Motion for Summary Judgment (Motion Sequence 4):

In support of their motion for summary judgment, defendants submit expert affirmations from James B. Eisenkraft, M.D., a physician board certified in anesthesiology, and Jaehon M. Kim, M.D., a physician board certified in orthopedic surgery, “with a subspecialty certification in [s]urgery of the [h]and” (Eisenkraft Expert Affirmation ¶ 1; Kim Expert Affirmation ¶ 1, annexed as Exhibits A and B to defendants’ motion papers, motion sequence 4). Dr. Eisenkraft maintains that defendants did not deviate from the standard of care during their treatment of the plaintiff, and Dr. Kim concludes “that the care rendered by Dr. Steinberg and/or the [NYU] staff did not in any way cause or contribute [to the] injuries alleged” (Eisenkraft Expert Affirmation ¶ 8; Kim Expert Affirmation ¶ 9). Dr. Eisenkraft’s and Dr. Kim’s opinions are based on review of the bills of particulars, medical records, and deposition transcripts, as well as their own education, training, and experience (Eisenkraft Expert Affirmation ¶¶ 3, 6; Kim Expert Affirmation ¶¶ 3, 6). Dr. Eisenkraft contends that defendants properly obtained plaintiff’s “informed consent for anesthesia on January 6, 2016,” as [s]he was advised of the

risks of anesthesia,” including “loss of feeling to a body part” (Eisenkraft Expert Affirmation ¶ 33). Dr. Eisenkraft states that Dr. Steinberg supervised Dr. Siliunas when she “attempt[ed] to place the IV,” and that “it was not inappropriate to allow Dr. Siliunas to place [the] IV line,” as “NYU is a teaching hospital” (*Id.* at ¶ 34). Further, he opines that Dr. Siliunas adhered to the standard of care when she attempted to place the IV line based on Dr. Steinberg’s deposition testimony that “Dr. Siliunas’ initial IV insertion attempt was made at the metacarpal vein in the dorsal part (back) of the hand,” and Dr. Siliunas’ deposition testimony regarding her custom and practice of placing an IV “in the dorsum (or top) of a patient’s hand or wrist” (*Id.* at ¶¶ 35, 43, 45). Further, Dr. Eisenkraft alleges that Dr. Siliunas acted appropriately by removing the IV when the plaintiff complained of pain, as “the standard of care dictates removal of the painful IV and reinsertion in a different location” (*Id.* at ¶ 37). Dr. Eisenkraft affirms that he “find[s] no credence to [the] plaintiff’s contentions that defendants failed to monitor the IV line and failed to appreciate or react to signs and symptoms of neurological and vascular deficits,” as the “NYU record confirms that Ms. Kessler was being consistently monitored in the PACU” (*Id.* at ¶ 38). He points out that “Ms. Kessler’s pain was monitored at 15-minute intervals between 10:15 am and 11:15 am, and at all times her pain score was zero,” and that a note from Nurse Orbeta at 11:02 a.m. indicates that “the plaintiff denied numbness and tingling at the site of the IV” (*Id.* at ¶¶ 38-39). Dr. Eisenkraft claims that “Dr. Steinberg acted swiftly and appropriately when he first learned of Ms. Kessler’s complaints during a telephone call with her during the weekend of January 19, 2016,” by “recommend[ing] that [she] be seen by a neurologist in light of her complaints of pain to the non-operative extremity” (*Id.* at ¶ 41). He states that the allegations against NYU “regarding the diagnosis and treatment of carpal tunnel” “must be dismissed,” as “plaintiff was a private patient of co-defendant Dr. Stuchin,” who “was not an employee of the [h]ospital” (*Id.* at ¶ 46). Dr. Eisenkraft concludes that defendants did not depart from acceptable medical practice during their treatment of the plaintiff, and therefore, they “could not have caused the plaintiff’s claimed injuries” (*Id.* at ¶ 47).

Dr. Kim maintains that plaintiff's alleged injuries could not have been "caused by the placement of the IV lines," as "the anterior interosseous nerve (AIN) is not anatomically located where the IV lines were placed by Drs. Siliunas and Steinberg" (Kim Expert Affirmation ¶ 58). Dr. Kim opines that Dr. Siliunas' placement of the IV line "on the dorsum of the left hand" "could not [have] caused[d] injury to the AIN," as "[t]he AIN is located deep within the forearm," it "does not contribute to any of the sensory nerves in the hand, and it does not innervate any muscles in the hand, only the forearm" (*Id.* at ¶¶ 59, 63). He also claims that Dr. Steinberg's placement of the IV line in the "cephalic vein of the left forearm," could not have injured the AIN, as the "AIN and the cephalic vein are not located in proximity to each other" (*Id.* at ¶ 64). Further, plaintiff's alleged injuries, including "impaired left thumb opposition, severe weakness of left thumb deep flexion, and index finger flexion are not consistent with an injury to the AIN" (*Id.* at ¶ 65). He indicates that "symptoms of injury to the AIN include weakness in the flexor digitorum profundus muscle to the index finger, the flexor pollicis longus muscle to the thumb, and the pronator quadratus of the distal forearm" (*Id.* at ¶ 60). Dr. Kim alleges that plaintiff's claim that the "IV placement by Dr. Steinberg caused compression of both median nerves at the left wrist" lacks merit (*Id.* at ¶ 66). He explains that "compression of" "median nerves," is "a synonym for carpal tunnel syndrome," which "cannot [be] cause[d]" by placement of an "IV line in the patient's forearm," as this is "nowhere near where the median nerve runs through the wrist" (*Id.*). Dr. Kim suggests that the nerve conduction study performed by Dr. Drafta further supports that the IV placement did not injure plaintiff's left AIN, as the study "found no evidence of left radial sensory neuropathy" (*Id.* at ¶ 67). He concludes that defendants are entitled to summary judgment, as there is no "causative relationship between Dr. Steinberg and the [h]ospital's treatment and the plaintiff's injuries" (*Id.* at ¶ 71).

In opposition, plaintiff submits an expert affirmation from Justin A. Willer, M.D., a physician board certified in clinical neurophysiology and neurology, contending that defendants departed from

acceptable medical practice during their treatment of plaintiff, and that they proximately caused her injuries (Plaintiff's Expert Affirmation ¶¶ 1, 5, annexed as Exhibit 1 to plaintiff's opposition papers, motion sequence 4).¹ Plaintiff's expert opinion is based on his evaluation of the plaintiff on March 15, 2018, and his review of the medical records and deposition transcripts, as well as his own education, training, and experience (*Id.* at ¶¶ 2-5). He opines that Dr. Siliunas deviated from the standard of care during her placement of the IV line based on his evaluation of the plaintiff where she "identified" "the location of Dr. Siliunas' IV placement attempt," "in her left proximal forearm approximately 3 to 4 inches up from the wrist," and her recollection that "she lost sensation in her index finger and thumb" when she was stuck with the IV needle (*Id.* at ¶¶ 43, 45). Dr. Willer states that his "physical examination of [plaintiff] on March 15, 2018," revealed that she was "unable to [make] an 'OK' sign with her left hand," and his "needle EMG study" demonstrated "electrophysiologic evidence of a left anterior interosseous mono-neuropathy by the presence of active denervation in the left Pronator Quadratus and Flexor Pollicis Longus muscles and the recruitment of giant motor units in the left Pronator Quadratus and the reduced recruitment in the left Pronator Quadratus" (*Id.* at ¶ 43). He affirms that plaintiff had "no symptoms of an anterior interosseous neuropathy prior to either of her first two surgeries performed by Dr. Stuchin, until after she was stuck with an IV needle on the proximal side of her left forearm" by Dr. Siliunas (*Id.* at ¶ 44). He contends that the IV line was placed "at a location" (3-4 inches above the wrist), "where the anterior interosseous nerve would have been punctured by the IV needle if the trajectory of the needle was steep" (*Id.* at ¶¶ 44, 48). Dr. Willer concludes that Dr. Steinberg also departed from acceptable medical practice by failing to properly supervise Dr. Siliunas during her placement of the IV line (*Id.* at ¶ 45). Further, he claims that Dr. Steinberg also deviated from the standard of care by failing to "[call] a time-out once [plaintiff] identified severe pain due to a failed attempt at IV cannulation in order to determine whether or not a

¹ Dr. Willer also submitted an expert affirmation in opposition to Dr. Stuchin's motion for summary judgment.

traumatic nerve injury occurred, and to evaluate the acute nerve injury rather than to proceed with sedation of the patient” (*Id.* at ¶ 46). Dr. Willer maintains that plaintiff’s nerve injury was “exacerbated” by proceeding with the surgery after the “failed attempt at IV cannulation,” as the “patient’s left arm” “was positioned for surgery,” “contribut[ing] to further compression of the anterior interosseous nerve” (*Id.*). He alleges that “the departures of Dr. Siliunas and Dr. Steinberg, were the proximate causes of [plaintiff’s] severe injury to her left anterior interosseous nerve, and of the permanent pain and impairment of [her] left arm and hand” (*Id.* at ¶ 47).

Dr. Willer disagrees with Dr. Kim’s opinion that “impaired left thumb opposition, severe weakness of left thumb deep flexion and index finger flexion are not consistent with injury to the AIN” (*Id.* at ¶ 49). He agrees with Dr. Kim’s contention that “you cannot have pain in [your] hand due to an anterior interosseous neuropathy,” but points out that plaintiff’s left-hand pain was “her original complaint, associated with her carpal tunnel syndrome” (*Id.*). Following the insertion of the IV on her left side, she began to complain of “pain in the forearm with numbness (not pain) to the thumb and index finger,” which are symptoms “consistent with an anterior interosseous neuropathy” (*Id.*). Further, Dr. Willer also disagrees with Dr. Kim’s conclusion “that the findings by Dr. Drafta of the August 2016 EMG/NCV test were normal with respect to her anterior interosseous nerve, as Dr. Drafta did not perform needle EMG studies of the left arm,” since Ms. Kessler “could not tolerate it” (*Id.*). Therefore, he opines that the “study was incomplete, and cannot form the basis to rule out any injury to the anterior interosseous nerve” (*Id.*).

In reply, defendants reiterate that they did not deviate from the standard of care during their treatment of the plaintiff, and that they did not proximately cause her injuries (Reply Affirmation ¶ 8, motion sequence 4). Defendants argue that Dr. Willer is not qualified to render an opinion in this case (*Id.* at ¶ 9). Defendants maintain that Dr. Willer’s affirmation is insufficient to raise a triable issue of fact, as it includes new information that was not included in his report from 2018, ignores certain facts,

and is conclusory (*Id.* at ¶¶ 19-22). Defendants contend that NYU is not vicariously liable for the alleged malpractice of either Dr. Steinberg or Dr. Siliunas, as Dr. Steinberg was a private attending physician, and Dr. Siliunas “was acting under the direction and control” of Dr. Steinberg (*Id.* at ¶ 29). Defendants claim that Dr. Willer’s contention that “Dr. Steinberg departed from the standard of care by failing to call a time out and assess the plaintiff’s AIN injury,” should be disregarded, as this allegation was not included in the complaint or the bills of particulars (*Id.* at ¶¶ 33-35). Defendants assert that the informed consent claim and the claim that NYU is vicariously liable for Dr. Stuchin’s treatment, should be dismissed, as plaintiff failed to oppose dismissal of these claims (*Id.* at ¶ 4).

Law

To prevail on a cause of action for medical malpractice, the plaintiff must prove that defendant “deviated or departed from accepted community standards of practice, and that such departure was a proximate cause of the plaintiff’s injuries” (*Stukas v. Streiter*, 83 AD3d 18, 23 [2d. Dept. 2011]). On a motion for summary judgment, defendant must “make a prima facie showing that there was no departure from good and accepted medical practice or that the plaintiff was not injured thereby” (*Iulo v. Staten Is. Univ. Hosp.*, 106 AD3d 696, 697 [2d. Dept. 2013]). To “sustain this burden, the defendant must address and rebut any specific allegations of malpractice set forth in the plaintiff’s bill of particulars” (*Anonymous v. Gleason*, 175 AD3d 614, 617 [2d. Dept. 2019]; *Bendel v. Rajpal*, 101 AD3d 662, 663 [2d. Dept. 2012]). Once the defendant meets its burden, the burden then shifts to the plaintiff to “raise a triable issue of fact with respect to the element of the cause of action or theory of nonliability that is the subject of the moving party’s prima facie showing” (*Stukas*, 83 AD3d at 24). If the defendant “makes only a prima facie showing that he or she did not deviate or depart from accepted medical practice, the plaintiff, in order to defeat summary judgment, need only raise a triable issue of fact as to the alleged deviation or departure, and need not address the issue of proximate cause” (*Hayden v. Gordon*, 91 AD3d 819, 821 [2d. Dept. 2012]). Conclusory allegations that are

“unsupported by competent evidence tending to establish the essential elements of medical malpractice are insufficient to defeat defendant physician’s summary judgment motion” (*Deutsch v. Chaglassian*, 71 AD3d 718, 719 [2d. Dept. 2010]). Further, a plaintiff cannot defeat a motion for summary judgment by “rais[ing] a new or materially different theory of” “liability” “for the first time in opposition to a motion for summary judgment” that was not “pleaded in the complaint or bills of particulars” (*Gleason*, 175 AD3d at 617; *Cox v. Herzog*, 192 AD3d 757, 759 [2d. Dept. 2021]; *Abalola v. Flower Hosp.*, 44 AD3d 522, 522 [1st Dept. 2007]). Where the parties have submitted conflicting expert reports, summary judgment should not be granted; “[s]uch credibility issues can only be resolved by a jury” (*Deutsch*, 71 AD3d at 719).

Ordinarily, a hospital may not be held vicariously liable for the “negligent treatment provided by an independent physician, as when the physician is retained by the patient” (*Cynamon v. Mount Sinai Hospital*, 163 AD3d 923, 924 [2d. Dept. 2018]; *Corletta v. Fischer*, 101 AD3d 929, 930 [2d. Dept. 2012]). Further, “[w]here hospital staff, such as resident physicians and nurses, have participated in the treatment of the patient, the hospital may not be held vicariously liable for resulting injuries where the hospital employees merely carried out the private attending physician’s orders” (*Cynamon*, 163 AD3d at 924; *Doria v. Benisch*, 130 AD3d 777, 777 [2d. Dept. 2015]). There are three exceptions to this rule, and a hospital is not “shield[ed]” “from liability” “when (1) the staff follows orders despite knowing that the doctor’s orders are so clearly contraindicated by normal practice that ordinary prudence requires inquiry into the correctness of the orders; (2) the hospital’s employees have committed independent acts of negligence; or (3) the words or conduct of the hospital give rise to the appearance and belief that the physician possesses the authority to act on behalf of the hospital” (*Cynamon*, 163 AD3d at 924-25; *Doria*, 130 AD3d at 777-78).

Analysis: Motion Sequence 3

Here, defendant, Dr. Stuchin, met his prima facie burden. Defendant's expert, Dr. Strauch, affirmed that Dr. Stuchin did not deviate from the standard of care during his treatment of the plaintiff, and that he did not proximately cause her injuries. He opined that Dr. Stuchin did not fail to timely diagnose carpal tunnel syndrome, based on the plaintiff's negative Tinel's and Phalen's tests (Strauch Expert Affirmation ¶ 45). Further, Dr. Stuchin referred plaintiff to a neurologist who performed a nerve conduction study, which did not show evidence of carpal tunnel syndrome (*Id.* at ¶ 51). Dr. Strauch asserted that Dr. Stuchin appropriately performed AIN/PIN surgeries based on plaintiff's complaints, the fact that her pain was reduced when she received lidocaine injections, and the fact that she continued to experience pain relief for a significant length of time after the surgeries (*Id.* at ¶¶ 39, 42, 43). His opinion constitutes competent evidence, in that it is based on the pleadings, bills of particulars, medical records, and deposition transcripts, as well as his own education, training, and experience.

In opposition, plaintiff produced an affidavit of merit from Dr. Willer, attesting to departures from accepted standards of medical practice, and that these departures were a competent producing cause of the plaintiff's injuries. Plaintiff's expert opinion fails to raise a triable issue of fact, as it relies on facts that are not in the record, and is based on hindsight reasoning, "a reasoning back from the fact of injury to find negligence" (*Montilla v. St. Luke's-Roosevelt Hosp.*, 147 AD3d 404, 407 [1st Dept. 2017]; *Brown v. Bauman*, 42 AD3d 390, 392 [1st Dept. 2007]; *Wagner v. Parker*, 172 AD3d 954, 955 [2d. Dept. 2019]; *Tsitrin v. New York Community Hosp.*, 154 AD3d 994, 996 [2d. Dept. 2017]; *G.I. v. Harawitz*, 146 AD3d 476, 476 [1st Dept. 2017]; *Ortiz v. Wyckoff Heights Medical Center*, 149 AD3d 1093, 1095 [2d. Dept. 2017]). Dr. Willer suggests that Dr. Stuchin should have diagnosed Ms. Kessler with carpal tunnel syndrome when he began treating her, based on her diabetic condition, alleged complaints of "numbness and tingling in both hands awakening her from sleep since the early 2000s," and wrist pain (Plaintiff's Expert Affirmation ¶¶ 26, 38, 39, motion sequence 3). However, plaintiff's

complaints of numbness and tingling were not documented in Dr. Willer's report, which was exchanged with defendants in 2018 (Reply Affirmation ¶ 34, motion sequence 3). Further, the medical records and plaintiff's deposition testimony indicate that plaintiff did not begin to complain of numbness and tingling until after the right AIN/PIN surgery on January 6, 2016 (Certified Medical Records of Dr. Steven A. Stuchin at 8, 9; Plaintiff's EBT tr. 120, lines 4-8, annexed as Exhibit A to defendant's motion papers, motion sequence 3). Therefore, Dr. Willer's contention that Dr. Stuchin failed to timely diagnose carpal tunnel syndrome, does not raise a triable issue of fact, as it is not supported by evidence in the record (See *Wagner*, 172 AD3d at 955 (holding that "expert affidavit" that "relied upon facts that were not supported by the record," was "insufficient to defeat summary judgment"); *Tsitrin*, 154 AD3d at 996 (stating that "[i]n order not to be considered speculative or conclusory, expert opinions in opposition should address specific assertions made by the movant's experts, setting forth an explanation of the reasoning and relying on specifically cited evidence in the record")). Dr. Willer also concludes that Dr. Stuchin deviated from the standard of care by failing to "order an EMG/NCV study of both upper extremities, which would have provided objective diagnostic evidence of carpal tunnel syndrome, as it did on the EMG/NCV testing on March 15, 2018" (Plaintiff's Expert Affirmation ¶ 39, motion sequence 3). This conclusion is not entitled to consideration, as it is based on hindsight reasoning, since Dr. Willer is speculating that had a complete EMG/NCV study been performed earlier, it would have produced the same results as the one performed on March 15, 2018, over a year after plaintiff discontinued treatment with Dr. Stuchin (*Ortiz*, 149 AD3d at 1095 (holding that plaintiff's expert opinion was insufficient to defeat summary judgment where patient was diagnosed with endocarditis several days after being discharged from defendant hospital, as the expert's contention that "additional medical testing should have been undertaken was conclusory, speculative, and based on largely hindsight reasoning")). As Dr. Willer's conclusions are "without basis in the record," and rely upon hindsight reasoning, his opinion is "insufficient to defeat" Dr.

Stuchin's motion for summary judgment (*Lahari v. Auteri*, 97 AD3d 799, 799 [2d. Dept. 2012]; *Wagner*, 172 AD3d at 955; *Ortiz*, 149 AD3d at 1095). Accordingly, defendant's motion for summary judgment is granted.

Analysis: Motion Sequence 4

Here, defendants, Dr. Steinberg and NYU, met their prima facie burden. Defendants' anesthesiology expert, Dr. Eisenkraft, affirmed that Dr. Siliunas, Dr. Steinberg, and the staff at NYU did not deviate from the standard of care during their treatment of the plaintiff, and that they did not proximately cause her injuries. He opined that Dr. Steinberg properly obtained plaintiff's informed consent for the anesthesia, and that he adequately supervised Dr. Siliunas when she attempted to insert an IV in plaintiff (Eisenkraft Expert Affirmation ¶¶ 33, 34). Dr. Eisenkraft considered all of the parties' deposition testimony regarding where the IV was initially inserted, and where it was ultimately placed, and concluded that there were no departures from acceptable medical practice (*Id.* at ¶¶ 35-37, 43). He also maintained that the NYU staff appropriately monitored plaintiff after her surgery (*Id.* at ¶¶ 38-41). His opinion constitutes competent evidence, in that it is based on the bills of particulars, deposition transcripts, and medical records, and his own training and experience. Dr. Kim, defendants' expert on proximate causation, did not establish that the location where plaintiff testified Dr. Siliunas inserted the IV needle, is nowhere near the anterior interosseous nerve. However, defendants still sustained their burden on this motion, through the affirmation of Dr. Eisenkraft that there was no deviation or departure from the standard of care (*lulo*, 106AD3d at 697). Accordingly, in order to defeat defendants' motion for summary judgment, plaintiff is only required to raise a triable issue of fact as to whether defendants deviated from the standard of care during their treatment of the plaintiff (*Hayden*, 91 AD3d at 821).

Before examining the merits of plaintiff's opposition, The Court notes that plaintiff's failure to comply with Uniform Rule 202.8-g(d) in opposing defendants' motion for summary judgment, is not

fatal to her case. Uniform Rule 202.8-g(d) requires the plaintiff to cite to “evidence submitted in” “opposition to the motion” when the plaintiff disputes a material fact included in the defendants’ statement of material facts (22 NYCRR 202.8-g(d)). As most of the facts that plaintiff disputed concern the initial IV placement and her symptoms following the placement, and plaintiff has included ample evidence in her opposition papers in support of her contentions, the Court declines to penalize her for not explicitly following the Uniform Rules.

In opposition, plaintiff produced an affidavit of merit from Dr. Willer, attesting to departures from accepted standards of medical practice, and that these departures were a competent producing cause of the plaintiff’s injuries. Dr. Willer “possesse[s]” “the requisite skill, training, education, knowledge or experience” “to render a [reliable] opinion” on the standard of care for starting an IV line, and “diagnosis and treatment with respect to the symptoms presented by the [plaintiff]” (*See Behar v. Coren*, 21 AD3d 1045, 1047 [2d. Dept. 2005]; *Ocasio-Gary v. Lawrence Hosp.*, 69 AD3d 403, 405 [1st Dept. 2010]). Plaintiff’s expert opinion, based on his evaluation of the plaintiff on March 15, 2018, and his review of the medical records and deposition transcripts, raises triable issues of fact as to whether defendants deviated from the standard of care when Dr. Siliunas stuck plaintiff with an IV needle on January 6, 2016 (*See Weeks v. St. Peter’s Hospital*, 128 AD3d 1159, 1161 [3d. Dept. 2015] (affirming denial of defendant’s motion for summary judgment where nurse’s affidavit and plaintiffs’ deposition testimony revealed a “factual dispute as to the manner in which [plaintiff’s] injury was allegedly sustained” when IV was placed)). Due to the conflicting expert reports, defendants’ motion for summary judgment must be denied (*Deutsch*, 71 AD3d at 719).

Defendants contend that Dr. Willer’s affirmation should not be considered, since it includes new information from his examination on March 15, 2018, that was not documented in his report (Reply Affirmation ¶ 20, motion sequence 4). However, some of these symptoms/complaints are not relevant to plaintiff’s alleged injury to her left anterior interosseous nerve, and other

symptoms/complaints are documented in other records or deposition testimony, indicating that defendants will not be prejudiced by the Court's consideration of this information. For example, plaintiff's alleged complaints of "numbness and tingling in both hands awakening her from her sleep since the early 2000s," are not discussed in Dr. Willer's analysis as to the deviations from the standard of care with respect to Dr. Steinberg and NYU, and appear to be related to his discussion about Dr. Stuchin's alleged departures from acceptable medical practice in failing to diagnose carpal tunnel syndrome (Plaintiff's Expert Affirmation ¶ 29, motion sequence 4; Plaintiff's Expert Affirmation ¶ 39, motion sequence 3). Further, the statement in Dr. Willer's affirmation that the IV was initially inserted 3-4 inches above plaintiff's wrist is also stated in plaintiff's and Dr. Stuchin's deposition testimony, and Dr. Kiproviski's records document that plaintiff complained about an IV line that was placed in her left forearm (Plaintiff's Expert Affirmation ¶ 29, motion sequence 4; Plaintiff's EBT tr. 101, lines 15-125; at 102, lines 3-10, annexed as Exhibit H to defendants' motion papers, motion sequence 4; Dr. Stuchin's EBT tr. 79, lines 8-25, annexed as Exhibit J to defendants' motion papers, motion sequence 4; Dr. Kiproviski's records at 7, annexed as Exhibit M to defendants' motion papers, motion sequence 4). Lastly, plaintiff's complaints about difficulty moving the fingers in her left hand after waking up from the surgery, are consistent with her deposition testimony wherein she indicated that she "lost all sensation in" her "index finger and thumb" on her left hand when she was stuck with the IV needle, and continued to experience this numbness when she woke up after the operation (Plaintiff's Expert Affirmation ¶ 29, motion sequence 4; Plaintiff's EBT tr. 105, line 25; at 106, lines 2-4; at 107, lines 6-9).

Defendants also maintain that Dr. Willer should not be entitled to correct an alleged typographical error in his 2018 report, in his expert affirmation (Reply Affirmation ¶¶ 27-29, motion sequence 4). Dr. Willer's 2018 report stated that "[t]here is evidence of a right anterior interosseous mono-neuropathy as shown by the presence of active denervation in the left Pronator Quadratus (C7-8)

and Flexor Pollicis Longus (C7-8), and the recruitment of giant motor units in the left Pronator Quadratus (C7-8) and the reduced recruitment in the left Pronator Quadratus (C7-8)” (Records of Dr. Willer at 2, annexed as Exhibit P to defendants’ motion papers, motion sequence 4). Dr. Willer contends that he made a typographical error, and the report should have stated that there was “evidence of a left anterior interosseous mono-neuropathy” (Plaintiff’s Expert Affirmation ¶ 31, motion sequence 4). As the rest of the sentence following the alleged typographical error relates to the left side, not the right side, the Court declines to penalize plaintiff by disregarding Dr. Willer’s opinion with respect to this injury, as he clearly made a typographical error.

Defendants also claim that NYU should be dismissed from the case, on the grounds that they are not vicariously liable for Dr. Steinberg, who was a private attending physician, or for Dr. Siliunas, who was “acting under the direction and control” of Dr. Steinberg (Reply Affirmation ¶ 29, motion sequence 4). They also contend that NYU is not liable for any alleged deviations from the standard of care by their staff, since they were “at all times under the direction of the private attending surgeon” (*Id.* at ¶ 32). Although NYU would not be vicariously liable if their employees were “merely carr[ying] out the private attending physician’s orders,” a triable issue of fact remains as to whether Dr. Siliunas committed an independent act of malpractice when she stuck plaintiff with the IV needle, given the discrepancies in the parties’ deposition testimony regarding where the needle was placed, and Dr. Willer’s opinion that she did not use the proper technique (*Cynamon*, 163 AD3d at 924-25; *Doria*, 130 AD3d at 777-78; Memorandum of Law in Opposition at 14-15, motion sequence 4; Plaintiff’s Expert Affirmation ¶ 45, motion sequence 4). Further, there are also triable issues of fact as to whether Dr. Steinberg properly supervised Dr. Siliunas (*Id.*). Accordingly, defendants’ motion for summary judgment is denied with respect to the first cause of action for medical malpractice, except for all claims against NYU relating to the diagnosis and treatment of carpal tunnel syndrome. NYU is not vicariously liable for Dr. Stuchin’s conduct, as he was a private attending physician retained by the

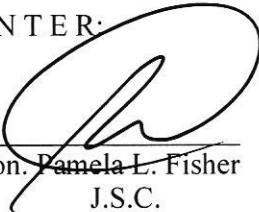
plaintiff, and this action is being dismissed against Dr. Stuchin (See Dr. Eienkraft's Expert Affirmation ¶ 46; *Cynamon*, 163 AD3d at 924; *Corletta*, 101 AD3d at 930). As Dr. Eisenkraft opined that Dr. Steinberg properly obtained plaintiff's informed consent for the anesthesia, and plaintiff did not oppose dismissal of this claim, plaintiff's second cause of action for lack of informed consent is dismissed. The claim for negligent hiring and supervision against NYU, enumerated in paragraph 1 of the bill of particulars, and paragraph 16 of the complaint, must also be dismissed as unopposed (Complaint ¶ 16, Verified Bill of Particulars as to NYU ¶ 1). Accordingly, defendants' motion for summary judgment is granted in part and denied in part.

Conclusion

Dr. Stuchin's motion for summary judgment is granted in its entirety. Dr. Steinberg's and NYU's motion for summary judgment is granted in part and denied in part. Defendants' motion is denied with respect to the medical malpractice cause of action, except for the claims that NYU failed to diagnose and treat plaintiff's carpal tunnel syndrome, and that the hospital is vicariously liable for Dr. Stuchin's conduct. Defendants' motion is granted on the second cause of action for lack of informed consent, and on the negligent hiring/supervision claim against NYU. All other relief is denied.

This constitutes the decision and order of the Court.

ENTER:


Hon. Pamela L. Fisher
J.S.C.

HON. PAMELA L. FISHER