SUPREME COURT OF THE STATE OF NEW YORK
NEW YORK COUNTY

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

Justice

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RONALD MIELE,

Plaintiff,

- v -

WILLIAM MACUALAY, M.D., DEBRA SPICEHANDLER, M.D., LAWRENCE HOSPITAL, and NEW YORK PRESBYTERIAN HOSPITAL,

Defendants.

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INDEX NO. 805260/2017

MOTION DATE 11/16/2022

MOTION SEQ. NO. 005

DECISION + ORDER ON MOTION

The following e-filed documents, listed by NYSCEF document number (Motion 005) 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167

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

I. INTRODUCTION

In this action to recover damages for medical malpractice based on alleged departures from good and accepted practice and lack of informed consent, the defendants William Macualay, M.D., Lawrence Hospital, and New York Presbyterian Hospital (collectively the NYPH defendants) together move pursuant to CPLR 3212 for summary judgment dismissing the complaint insofar as asserted against them. The defendant Debra Spicehandler, M.D., separately moves, in papers incorrectly denominated as a cross motion, for summary judgment dismissing the complaint insofar as asserted against her. The plaintiff opposes both motions.

In the first instance, Spicehandler's motion was not a proper cross motion because it did not seek relief against a moving party; instead, her motion was, in effect, a separate motion (*see* CPLR 2215; *Asiedu v Lieberman*, 142 AD3d 858, 858 [1st Dept 2016]; *Kershaw v Hospital for Special Surgery*, 114 AD3d 75, 88 [1st Dept 2013]; *Guzetti v City of New York*, 32 AD3d 234 [1st Dept 2006]; *Gaines v Shell-Mar Foods, Inc.*, 21 AD3d 986 [2d Dept 2005]; *Sheehan v*

Marshall, 9 AD3d 403, 404 [2d Dept 2004]; *Lucheux v William Macklowe Co., LLC*, 2017 NY Slip Op 31044[U], 2017 NY Misc LEXIS 187 [Sup Ct, N.Y. County, May 11, 2017]). CPLR 2214(b) requires such a separate motion to be made on at least eight days' notice. The mislabeling of a motion as a cross motion, however, may treated as a "technical" defect to be disregarded, particularly where the nonmoving party does not object and the consideration of the application results in no prejudice to the nonmoving party (*see Sheehan v Marshall*, 9 AD3d at 404), and where, as here, the moving party made her application far more than eight days prior to the return date, thus giving the plaintiff ample opportunity to be heard on the merits (*see Daramboukas v Samlidis,* 84 AD3d 719, 721 [2d Dept 2011]; *Matter of Jordan v City of New York*, 38 AD3d 336, 338 [1st Dept 2007]; *Della-Mura v White Plains Hosp. Med. Ctr.*, 2022 NY Slip Op 31085[U], *3, 2022 NY Misc LEXIS 1697, *3-4 [Sup Ct, N.Y. County, Mar. 31, 2022] [Kelley, J.]). Hence, Spicehandler's "cross motion" may be considered as a properly noticed separate motion (*see Matter of Jordan v City of New York*, 38 AD3d at 338).

The motions are granted only to the extent that summary judgment is awarded to all of the defendants dismissing the lack of informed consent cause of action. The motions are otherwise denied.

II. BACKGROUND

The crux of the plaintiff's claim is that William Macaulay, M.D., incorrectly sued herein as William Macualay, M.D., performed a medial unicompartmental arthroplasty, also known as MUKA surgery, on his left knee on May 25, 2016 at NYPH, and that Macaulay's malpractice in the course of post-operative care caused the plaintiff to become infected with methicillin-resistant staphylococcus aureus (MRSA) in his left tibia that, in turn, resulted in osteomyelitis. The plaintiff further alleged that the additional post-operative care rendered by infectious disease specialist Spicehandler at Lawrence Hospital was deficient, that the infection was not arrested and cured as a consequence, and that her failure properly to treat the infection at that juncture caused or contributed to the plaintiff's osteomyelitis and resultant bone necrosis.

The plaintiff began treating with orthopedic surgeon Macaulay on December 19, 2014, complaining of a five-year history of pain in the medial region of his left knee that had been worsening over time. Conservative management, including activity modification, weight loss, the administration of non-steroidal anti-inflammatory drugs, and cortisone injections, had not successfully resolved the plaintiff's pain. X-rays taken in 2014 revealed advanced degenerative changes in the medial compartment of the plaintiff's left knee. Macaulay believed that the plaintiff was an excellent candidate for left medial unicompartmental knee arthroplasty. According to Macaulay, he informed the plaintiff that significant complications arose from that procedure in 1%-2% of patients, including death, heart attack, venous thromboembolism, dislocation/instability, peri-prosthetic fracture, component loosening, component malposition, leg length discrepancy, nerve/artery damage, reactive bone formation/stiffness, and infection. While the plaintiff does not concede that Macaulay imparted that information to him, he does concede that a note in Macaulay's records indicated that he and Macaulay had a discussion about the potential risks of that surgery.

Macaulay arranged for the plaintiff to return in May 2015 for the procedure, but surgery was delayed for more than a year because the plaintiff sustained a bilateral quadriceps tendon injury that required surgical repair. At the May 2015 appointment, the plaintiff thus was administered several injections to his right knee to address ongoing pain, and Macaulay again recommended that the plaintiff undergo the arthroscopic procedure on his left knee.

Macaulay obtained a signed, written consent form from the plaintiff, in which the plaintiff indicated that Macaulay explained the risks and benefits of the arthroscopic procedure to him. Macaulay performed a left medial unicompartmental knee arthroplasty on May 25, 2016 at NYPH, employing a Mako® robotic-arm and Mako® implant system components to assist in undertaking the procedure, which involved the implantation of array pins in the tibia and femur, as determined by the Mako-plasty system. During the procedure, Macaulay used antibiotic-infused cement for the placement of the components. As he described it, he removed the array

pins during the procedure and cleaned the pin sites with pulsatile lavage, then placed staples at the pin sites, and covered them with dressings. Macaulay administered the antibiotic Ancef to the plaintiff perioperatively, and continued him on it for a period of 24 hours

According to Macaulay, immediately after the surgery, the plaintiff was afebrile with a stable white blood cell count. The plaintiff was discharged from NYPH on May 27, 2016. Macaulay asserted that there was no indication of infection during the plaintiff's hospitalization, that the procedure was successful, and that the postoperative plan was for the plaintiff to follow up with Macaulay in four weeks, but that he advised the plaintiff to contact him sooner if he was experiencing certain symptoms, including redness, increased drainage, swelling, or worsening pain.

Macaulay ordered Visiting Nurse Services (VNS) to attend to the plaintiff at his home for a period of eight weeks, at a frequency of one to two days per week, beginning on May 28, 2016, the day after the plaintiff's discharge from NYPH. The plan was for the dressing to be removed on the seventh day after the surgery and for the staples to be removed on the fourteenth day after the surgery. Macaulay directed the plaintiff to contact him if the plaintiff experienced a fever, redness, drainage from the incision, worsening pain, or numbness, tingling or weakness.

On June 3, 2016, a VNS nurse removed the original surgical dressing that had been placed by Macaulay on May 26, 2016, revealing edema in the plaintiff's left leg. The nurse sent Macaulay a photograph of the incision line and, according to Macaulay, there were no signs or symptoms of infection, while the plaintiff's left lower shin evinced a small amount of clear drainage with no redness. The VNS nurse thus applied hydrogel and a new dressing, and advised the plaintiff to monitor himself for signs and symptoms of infection. On June 4, 2016, the plaintiff called VNS because his left shin wound was draining outside of the dressing, reporting that the area of the wound was red and painful, with yellow drainage, upon which a VNS nurse advised him to change the dressing. A VNS nurse visited the plaintiff later that day,

confirmed the findings, and reported them to Macaulay, indicating that the wound appeared to be infected. The VNS nurse requested that Macaulay order an antibiotic to treat the infection. Macaulay agreed, and instructed the nurse to remove the staple at the site of the wound. On June 5, 2016, a nurse practitioner in Macaulay's office, Emily Doctor, who had undergone training in orthopedics during her residency, called a pharmacy to order the antibiotic empiric Augmentin (amoxicillin clavulanate) to administer to the plaintiff.

A VNS nurse returned to the plaintiff's home on June 6, 2016. The nurse noted that the plaintiff's leg wound was red and swollen, with yellow drainage, and the nurse thereafter cleaned the wound and applied a dressing. The nurse spoke that day with a representative from Macaulay's office, while the plaintiff sent a photograph of the wound to Macaulay, who advised the plaintiff to come to his office on June 7, 2016.

The plaintiff presented to Macaulay's office on June 7, 2016 with a quarter-inch open wound at a pin insertion site on his distal left tibia, with purulent, that is, pus-infused, drainage. Although the area was a reddish color, Macaulay concluded that there was no erythema or induration. According to Macaulay, the plaintiff denied severe pain or constitutional symptoms. Health-care personnel at Macaulay's office removed the staples, cleaned the tibial wound with Betadine, and dressed the wound with Xeroform, gauze, and an Ace bandage. The plan was for the plaintiff to follow up the next week to monitor the tibial wound. A VNS nurse next saw the plaintiff on June 8, 2016. On that same date, Macaulay's office issued new wound-care orders that included cleansing the wound with normal saline solution and applying a Xeroform dressing. As Macaulay characterized it, the redness had decreased, and the wound measured 1 centimeter (cm) by 1 cm by 0.3 cm, with moderate, yellow, serosanguinous drainage. On June 10, 2016, a VNS nurse noted that the leg wound was improving, and appeared less red and swollen, with only minimal drainage of that nature. As the plaintiff noted, on June 10, 2016, the visiting nurse recorded that there was no scabbing and less than 25% granulation, that the nurse nonetheless made notations of positive edema and erythema, and that he had intermittent

level-2 pain in the area. According to a VNS nurse, by June 13, 2016, the wound had further healed, with diminished redness, swelling, and drainage, but the plaintiff added that the nurse also noted edema in the area of the tibial wound, as recorded his complaints of continuous level-2 pain in the area. According to Macaulay, the plaintiff expressed that he wished to be cleared to return to work.

On June 14, 2016, the plaintiff returned to Macaulay's office, at which time the tibial wound was still open, albeit with decreased redness and warmth. Macaulay characterized an X-ray film taken that day as showing a "well-positioned, well-cemented knee prosthesis." The plan formulated at that juncture was for Macaulay to see the plaintiff in three to four weeks for wound care. Macaulay directed the plaintiff to continue changing the dressing twice per day with Xeroform, gauze, and an Ace bandage, and noted that the course of the administration of the antibiotic Augmentin was to be completed on June 15, 2016.

On June 17, 2016, the plaintiff presented to his primary care provider, Richard Strongwater, M.D. As Macaulay characterized Dr. Strongwater's notes, on examination, the plaintiff's punctate wound showed no drainage, although there was erythema around the wound, while the plaintiff claimed that he complained that the wound was still "draining yellow drainage" and that Dr. Strongwater's notes indicated that there was "significant erythema about hole (half dollar sized)." Dr. Strongwater prescribed the antibiotic ointments Mupirocin and Bactrim (sulfamethoxazole) to the plaintiff to treat the wound. The plaintiff returned to Macaulay's office on June 24, 2016 for a wound check, after which Macaulay concluded that the primary wound at the central knee location was healing well, that redness had resolved, and that the affected area was no longer tender to the touch, although it is unclear whether Macaulay made any characterization of the tibial wound at that juncture. The plan was to continue the course of Bactrim that Dr. Strongwater had started. The plaintiff next saw Macaulay on July 1, 2016, reporting that there was no redness, erythema, or induration around a 5-mm open skin area at

the site of the inferior tibial pin tract site, although he reported that serous fluid occasionally dripped from the wound.

Macaulay further noted that the tibial pin site was slow healing, and, based on his examination, concluded that it was not infected. The plan was to continue dressing the wound twice per day with Mupirocin ointment and tefla dressing, and the plaintiff was instructed to return to see Macaulay in two months. That same day, the plaintiff also saw Dr. Strongwater again, complaining of stomach discomfort. Dr. Strongwater noted that the plaintiff's tibia wound was small, with a small amount of sanguineous drainage and decrease in the erythema surrounding the wound.

The plaintiff returned to Macaulay's office on July 8, 2016, complaining of significant pain at the tibial pin insertion site. Nurse Practitioner Emily Doctor generated a culture from fluids that emanated from the wound. The culture grew MRSA.

On July 9, 2016, Dr. Strongwater referred the plaintiff to Lawrence Hospital in Bronxville, New York, the plaintiff thereafter presented to hospital staff, and thereupon was admitted Lawrence Hospital assigned Spicehandler to his case, and he consulted with her while he was there. According to the NYPH defendants, Spicehandler was an employee of neither NYPH nor Lawrence Hospital, but instead was employed by Mount Vernon Hospital, performed private consultations at Lawrence Hospital, and billed separately for the services that she rendered at Lawrence Hospital. Spicehandler prescribed a course of the intravenous antibiotic Vancomycin during the admission, but changed the antibiotic to oral Doxycycline immediately prior to the plaintiff's discharge. According to the NYPH defendants, she cleared the plaintiff for discharge "from an infectious disease perspective," as she "did not believe that he had osteomyelitis at that time." The NYPH defendants contended that Macaulay deferred to Spicehandler with respect to the type of antibiotics prescribed and the method of their administration.

After the plaintiff's discharge from Lawrence Hospital, he presented to the emergency room at Phelps Hospital in Sleepy Hollow, New York, on July 17, 2016, complaining of left leg

pain, only to be referred back to his physicians. He thereafter was treated by nonparty infectious disease specialists, who continued his oral antibiotic therapy with Doxycycline. On July 19, 2016, the plaintiff once again presented to Macauley's office while still on the Doxycyclline antibiotic regimen that Spicehandler had prescribed, albeit he was, by then, under the care of an infectious disease specialist other than Spicehandler. On July 25, 2016, the plaintiff saw infectious disease specialist Thomas Rush, M.D., who noted a small superficial erosion in the pretibial area, with erythema and tenderness, and referred the plaintiff for an X-ray of his left leg to rule out osteomyelitis. According to Macaulay, Dr. Rush "doubted" that the plaintiff had osteomyelitis. Also on July 25, 2016, the plaintiff saw orthopedist Louis McIntyre, M.D., for a second opinion. Dr. McIntyre did not diagnose osteomyelitis.

On August 3, 2016, the plaintiff underwent a magnetic resonance imaging (MRI) scan of his left leg, as ordered by his primary care physician, Dr. Strongwater, and the findings were consistent with possible infection. Specifically, the MRI report indicated the presence of left tibial tubular defects with "abundant adjacent osseous and soft tissue edema . . . the extent of associated edema raises suspicion of infection." On the next day, the plaintiff began to treat with a new infectious disease specialist, John Raffalli, M.D., who diagnosed him with osteomyelitis, and started him on a course of intravenous Daptomycin that was administered one time per week at Northern Westchester Hospital in Mount Kisco, New York, via a PICC line.

On August 22, 2016, Macaulay performed an incision and drainage and debridement of the plaintiff's left tibia to treat MRSA osteomyelitis.

The plaintiff remained on a regimen of intravenous antibiotic administration from early August 2016 until late October 2016, with Dr. Raffali switching him from Daptomycin, which had induced fevers, to a combination of Cipro and Vancomycin. As of October 4, 2016, the plaintiff already had undergone 14 sessions of hyperbaric oxygen therapy, and was being followed by Paul White, M.D., at the Northern Westchester Hospital Wound Care Center. On October 26, 2016, Dr. Raffalli documented that the plaintiff had been going for wound care treatments and

was completing a course of Vancomycin on that date, and noted that the tibial wound was granulating well and closing. On November 19, 2016, Dr. Raffalli documented that the plaintiff's antibiotic regimen had been discontinued approximately three weeks earlier, and that he was doing well, although he recommended that the plaintiff follow up with Dr. White for wound care.

III. THE PLAINTIFF'S ALLEGATIONS

In his complaint, the plaintiff alleged that Spicehandler was on the staff of, or had privileges at, Lawrence Hospital. He further alleged that Macaulay treated him from May 25, 2016 until August 12, 2016, and that he was a patient at Lawrence Hospital under Spicehandler's care from July 9, 2016 until July 13, 2016. The plaintiff averred that the defendants were negligent in the treatment that they rendered to him, and alleged that they failed to treat him in accordance with good and accepted practice, failed to diagnose the true nature and severity of his condition, failed to perform requisite diagnostic tests, failed properly to interpret the results of the tests that were administered, and failed to obtain necessary consultations from appropriate specialists. He stated that these acts and omissions proximately caused his condition to deteriorate. In addition, the plaintiff claimed that the defendants failed to obtain his fully informed consent to the procedures that they performed upon him.

In the plaintiff's bill of particulars addressed to Macaulay, the plaintiff asserted that Macaulay departed from good and accepted practice by failing properly to perform a robotic knee replacement that employed metal bars in the top and below the knee, in permitting unqualified agents to treat, monitor, supervise, and perform surgical procedures upon him, and in negligently supervising, performing, and assisting in the monitoring and supervision of surgery and postoperative care. The plaintiff further asserted that Macaulay caused or allowed an infectious process to fester at the site of placement of the array pin in the tibial area and failed to heed the significance of an open nonhealing wound on the tibia, despite the facts that the plaintiff reported stabbing pain and edema in his left lower extremity, with complaints of foul odor, and noted the presence of that wound at visits on June 1, 2016 and June 8, 2016. In this

regard, the plaintiff averred that Macaulay failed to heed nurses' reports of moderate purulent yellowish drainage and accompanying erythema.

The plaintiff additionally alleged that Macaulay was negligent in in failing to rule out or identify the presence of a bacterial infection on June 7, 2016 and in prescribing Augmentin over the phone. As to the former, the plaintiff asserted that Macaulay failed to recognize that the pin tract site was draining for too long a period of time after the operation and, thus, neglected to culture the reported drainage or take an X-ray of the tibia, either of which might have revealed the presence of MRSA. As to the latter, the plaintiff alleged it was a departure from good practice to have failed to consider the possibility of an MRSA infection and prescribe an appropriate antibiotic, instead prescribing Augmentin, a drug that was known to have no effect on MRSA. The plaintiff further contended that, by relying on Augmentin without determining the nature of the infection, Macaulay allowed the infection to spread to the bone and no longer be amenable to antibiotic therapy. He asserted that Macaulay failed to consider the significance of the plaintiff's diabetes and susceptibility to infection. The plaintiff further faulted Macaulay in ceasing the administration of the antibiotic Bactrim without fully ruling out a deeper infectious process, thus delaying identification of MRSA and Corynebacterium, and resulting in chronic osteomyelitis and permanent destruction of the tibia.

In addition, the plaintiff alleged that Macaulay failed to advise him of the risks, hazards, an dangers attendant to his surgery and post-operative pain and non-abatement of drainage, and failed to obtain a proper informed consent both to the surgery itself and the administration of Augmentin.

In the plaintiff's bill of particulars addressed to Lawrence Hospital, he reiterated many of the departures that he had particularized in his bill of particulars addressed to Macaulay. In addition, he alleged that Lawrence Hospital departed from good and accepted care in failing to render a complete diagnosis, noting only the presence of surface cellulitis, rather than MRSA, and in failing to note the history of the invasive puncture wound at the site of the inflamed tibial

shaft. He contended that Lawrence Hospital failed to note that the Bactrim that previously had been prescribed did not eradicate the infectious process, and that it failed take steps to determine why Bactrim was ineffective. The plaintiff also asserted that Lawrence Hospital failed to perform an MRI or computed tomography (CT) scan of the tibial area, thus failing timely to identify changes consistent with osteomyelitis. He faulted Lawrence Hospital for neglecting to prescribe intravenous antibiotics for at least six to eight weeks, which he asserted was the standard therapy for treating his infectious process and osteomyelitis.

The plaintiff further asserted that Lawrence Hospital failed properly to manage and identify a "draining and now invasive sinus tract at the mid left calf." He faulted it for relying on "plain" films. The plaintiff further asserted that Lawrence Hospital was negligent in failing to heed the history of a prolonged, non-abating, and known MRSA infection at the plaintiff's lower shin, including complaints of steadily increasing pain. He asserted that the hospital should not have administered only a short course of the oral antibiotic Doxycycline towards the end of his admission, and that it should have consulted with an orthopedist prior to his discharge from the hospital in early July 2016. The plaintiff contended that, in light of the hospital's improper diagnosis, it prematurely discharged him, thus allowing adverse changes in his hematological status, including the spread of the MRSA infection to his bone, and rendering the infection resistant to antibiotics.

In response to NYPH's demand for a bill of particulars as to it, the plaintiff essentially reiterated his contentions as to Macaulay in connection with the arthroscopic surgery and immediate post-operative care and his contentions as to Lawrence Hospital in connection with the testing, diagnosis, and treatment of his tibial wound.

The plaintiff's bill of particulars as to Spicehandler essentially reiterated his responses to both Macaulay's and Lawrence Hospital's demands for bills of particulars, alleging that, during the plaintiff's admission to Lawrence Hospital, she failed properly to diagnose MRSA because

she failed to perform the appropriate testing and consider the plaintiff's history, and thereafter administered drugs that were ineffective in treating MRSA.

The plaintiff asserted that, as a proximate result of the alleged acts of malpractice that the he described, he sustained an aggravation and exacerbation of Corynebacterium and MRSA infections that originated at the tibial pin tract site and caused a deep invasion of the tibial bone, thus causing bony destruction and a pathological fracture at the mid-shaft of the left tibia, or, more particularly, cortical fragmentation and disruption of the lateral mid-tibial diaphysis section of the bone, occurring at the level of the inferior-most instrumentation track. He stated that, as a consequence of the MRSA infection and concomitant sub-acute osteomyelitis, he also was caused to suffer from tubular defects with abundant adjacent osseous and soft tissue edema, and required immediate insertion of a PICC line for antibiotic infusion with Vancomycin.

The plaintiff averred that he thus required surgical intervention, with incision and drainage and blunt debridement of the tibial pin tract, followed by long-term, painful use of wound vacuum and 30 sessions of hyperbaric therapy. The plaintiff further contended that, as a consequence of the infection, which did not resolve until September or October 2016, he suffered from episodic fevers up to 101° F., with atelectasis, that is, partial collapse of a lung. According to the plaintiff, he required a program of prolonged and painful physical therapy. He averred that the sub-acute osteomyelitis led to chronic osteomyelitis, with disruption, persistent evidence of tunneling, and a permanent induration and deformity at the site of the multiple surgical interventions, as well as gait changes and aggravation of shoulder and back pain, necessitating not only intensive physical therapy, but also the administration of epidural anesthesia for pain management.

IV. THE SUMMARY JUDGMENT MOTIONS

In support of their motion, the NYPD defendants submitted the pleadings, the bills of particulars addressed to them, transcripts of the parties' depositions, relevant medical and hospital records, an attorney's affirmation, a statement of material facts, and the expert

affirmation of board-certified orthopedic surgeon Fred Cushner, M.D. In the first instance, they claimed that Spicehandler was an employee of neither NYPH nor Lawrence Hospital, but instead was employed by Mount Vernon Hospital, performed private consultations at Lawrence Hospital, and billed separately for the services she rendered at Lawrence Hospital. They thus contended that, even if Spicehandler were held to be negligent, NYPH and Lawrence Hospital could not be held vicariously liable for any such negligence. While the NYPH effectively conceded that Macaulay was an employee of NYPH, they asserted that, inasmuch as the complaint should be dismissed as against Macaulay, and the plaintiff did not allege that any other NYPH employee committed independent acts of negligence, they should also be awarded summary judgment dismissing the complaint against NYPH.

Dr. Cushner opined that none of the NYPH defendants departed from good and accepted medical care in the diagnosis and treatment of the plaintiff, that they obtained his fully informed consent to the procedures and post-operative treatment that they rendered, and that nothing that they did nor did not do caused or contributed to any of the plaintiff's alleged injuries.

Dr. Cushner asserted that the arthroscopic surgery performed by Macaulay was indicated, based on the plaintiff's complaints of left knee pain, radiographic findings of arthritis in the medial aspect of the knee, and the plaintiff's failure to respond to conservative treatment measures. He averred that the alignment of the array pins used for the procedure was determined by the surgical robot and that the techniques employed during the procedure were performed properly, as confirmed in post-operative imaging showing that the knee replacement components were in good anatomical position. Dr. Cushner also noted that there were no complications related to the technical performance of the knee replacement or the joint subsequent to the surgery, and pointed out that, in fact, the allegations of malpractice made by the plaintiff were related to the healing process after the procedure.

In addition, Dr. Cushner opined that Macaulay satisfied the applicable standard of care by properly obtaining the plaintiff's fully informed consent to the May 2016 knee surgery, both

several days prior to the surgery and on the day of the procedure, as Macaulay specifically documented that he discussed all of the risks with plaintiff, including the risk of infection prior to surgery during an outpatient visit. Dr. Cushner explained that

> "[a]lthough the risk of infection can never be eliminated entirely, there are certain steps that can be taken to decrease the risk of infection. Those measures were taken in this case. Specifically, the procedure was performed under sterile conditions and Ancef (cefazolin) was administered perioperatively. This medication is a broad-spectrum cephalosporin antibiotic that is commonly used perioperatively as surgical prophylaxis because it is effective in treating the most common organisms that cause surgical infections, Staphylococcus and Streptococcus. To prevent local infection in the joint, Dr. Macaulay used Palacos G Bone Cement, an antibiotic loaded bone cement. Also, after the pins were removed during surgery in a sterile environment, Dr. Macaulay cleansed the insertion sites with pulsatile lavage. Dr. Macaulay took all of the appropriate perioperative actions to prevent a post-operative infection."

Dr. Cushner further asserted that Macaulay's post-operative monitoring of the plaintiff's surgical wounds was diligent and consistent with the standard of care, as Macauley's discharge instructions were to follow up at his office in four weeks, unless the plaintiff was experiencing certain symptoms, including redness, increased drainage, swelling, or worsening pain. He stated that Macaulay went above and beyond that standard of care, inasmuch as he provided the plaintiff with another level of monitoring and care by arranging for VNS to furnish wound care to the plaintiff at his home. As he explained it, when the VNS nurse expressed a concern for infection on June 4, 2016, Macaulay ordered a course of Augmentin (amoxicillin clavulanate), a broad spectrum antibacterial that is effective in treating skin infections, and advised the nurse to remove a staple in the wound. Dr. Cushner asserted that staple removal was a reasonable measure to take in the context of a possible superficial wound infection, because foreign bodies, like staples, can irritate the skin and tissue and cause infection.

Dr. Cushner opined, however, that it was not necessary for Macaulay to examine the patient in person prior to ordering the antibiotic, as information about the infection had been conveyed to him by a medical professional, a nurse, who was trained in describing the qualities of a wound. He continued that, when the plaintiff's symptoms did not abate for several days,

Macaulay promptly set up an office appointment for June 7, 2016 to examine the wound in person. Hence, Dr. Cushner concluded that the sequence of events during the initial post-operative period was appropriate and consistent with the standard of care for wound monitoring inasmuch as there were no signs or symptoms that warranted presentation to Macaulay's office any sooner, and the plaintiff was being closely monitored by trained nursing staff.

Dr. Cushner asserted that Macaulay's examination and plan of care at the June 7, 2016 visit comported with the standard of care since, at the time of that visit, Dr. Macaulay already had prescribed treatment for a superficial infection. He averred that, based on the description of the wound at this visit, that is, a quarter of an inch, with redness and purulent drainage at the pin insertion site on the tibia, was consistent with a superficial post-operative wound infection. Dr. Cushner concluded that proper action was taken at this visit, as the wound was cleaned with Betadine and dressed with a xeroform dressing that was used to keep the wound clean and promote healing. He stated that the plan at that time, which was to see plaintiff back in Macaulay's office in a week, demonstrated that Macaulay and Doctor acknowledged the plaintiff's wound and were closely following it. Dr. Cushner opined that

> "[a]t this point, the wound was a superficial infection; plaintiff did not have signs of a deep wound infection. Wound culture was not indicated at this point. Swabbing a pin tract site to obtain fluid for a culture under these circumstances is not the standard of care. Putting a swab in this area can cause an infection by introducing bacteria and superficial swabbing can cause skin flora to contaminate the culture and skew the results. Continued cleansing of the wound, protection of the wound site, and oral antibiotics were the correct treatment for this superficial infection. Recommending follow up in a week to assess the wound was appropriate."

Dr. Cushner further opined that, since the wound had improved due to continued cleaning and antibiotic treatment by June 14, 2016, the treatment plan was effective at that juncture, and that it was appropriate for Macaulay to recommend the plaintiff to return to see him three to four weeks later. He noted that, although the plaintiff continued to have symptoms after his course of treatment with Augmentin had been completed, the plaintiff's primary care provider prescribed Bactrim, which was effective in alleviating those symptoms, as evidenced by

Macaulay's in-office evaluation wound check of June 24, 2016. According to Dr. Cushner, at that time, the wound appeared to be healing slowly and the symptoms, redness, and tenderness had resolved, all of which were signs of a resolving superficial infection. He concluded that no treatment other than continuing on the course of Bactrim and twice-daily wound dressings was necessary. Dr. Cushner asserted that

> "[t]he plan was to see him again in a week for another wound check. This plan shows that even though the wound was showing signs of healing, plaintiff continued to be closely monitored by Dr. Macaulay's office. There was no need at that time to recommend additional treatment. A wound culture also was not indicated at this visit as it appeared that the antibiotic that plaintiff was already on was effective in alleviating his symptoms. Furthermore, since he was already taking an empiric antibiotic for the superficial wound, a culture was not likely to grow bacteria."

Dr. Cushner went on to assert that, at the plaintiff's July 1, 2016 office visit with Macaulay, the plaintiff's knee showed signs of continued slow healing, with no redness or pain, and only occasional serous fluid draining. Based on these findings, Dr. Cushner averred that additional antibiotics were not necessary at that time despite the continued drainage of serous fluid, as drainage from the pin site after a robotic knee replacement procedure is normal, and the length of time over which drainage occurs varies from patient to patient, sometimes taking a few weeks for the wound to epithelialize when it is healing. Since the plaintiff was suffering from what Dr. Cushner characterized as a "superficial infection post-operatively," Dr. Cushner expected that the drainage would continue longer than a typical patient who did not have a superficial infection.

According to Dr. Cushner, Macaulay properly revised the plan of care on July 8, 2016, after the plaintiff presented with a return of symptoms in his leg, which Dr. Cushner characterized as a "change in plaintiff's clinical presentation." He asserted that Macaulay's nurse practitioner appropriately cultured fluids from the wound to determine if the wound was infected and, if so, what treatment should be used to treat the infection. As Dr. Cushner explained it, after the culture revealed the presence of MRSA, a bacterial infection that is

"difficult to treat," Macaulay and the physicians at Lawrence Hospital correctly relied on the input of Spicehandler, an infectious disease consultant, during the plaintiff's admission to Lawrence Hospital to provide a plan of care for management of the MRSA infection. He thus contended that Macaulay appropriately relied on Spicehandler to determine which antibiotic should and would be used to treat the infection, as well the mode of administration. Dr. Cushner concluded that, while, "earlier in the course when plaintiff presented with a superficial wound, it was within Dr. Macaulay's purview to recommend an antibiotic," but "when this infection proved to be difficult to treat[,] the recommendations of a specialist was necessary and Dr. Macaulay could rely on those recommendations."

Dr. Cushner opined that incision and drainage performed by Macaulay was timely and appropriately performed in August 2016. He asserted that

> "[t]he first line of treatment for wound infections and osteomyelitis is antibiotics. The goal is for the infection to heal by secondary intention, healing from the bottom of the wound up while on antibiotics. This is often the only course of treatment that is necessary for a post-operative infection. More aggressive measures are only necessary when an infection does not heal by secondary intention and continues to present with clinical symptoms. Here, efforts were made to treat the infection with antibiotics, but clinical symptoms returned and continued. It was reasonable and consistent with the standard of care for Dr. Macaulay to perform the incision and drainage and debridement in August 2016 after the conservative measures did not completely eradicate the infection. Plaintiff's contention that earlier radiological imaging would have changed the course is meritless. Infection is difficult to diagnosis on imaging, even advanced imaging like CT scan or MRI. Physicians must still rely on the clinical presentation of the patient to make treatment decisions for infections."

He continued that, even if osteomyelitis had been diagnosed sooner, it would not have changed the outcome in this case. Dr. Cushner asserted that a course of antibiotics still would have been the first line of treatment and, if that failed, Macaulay would have performed the same procedure that he performed in August 2016 in any event.

Dr. Cushner further concluded that Macaulay's nurse practitioner, Emily Doctor, performed her tasks consistent with the standard of care. He noted that nurse practitioners commonly work with orthopedic surgeons, especially in the outpatient setting, when they are

available for follow-up visits, including wound checks. He averred that Doctor was fully capable of conducting the post-operative office visits, having completed her education and training to become a nurse practitioner and having experience in the hospital and outpatient office setting. He opined that there was "no valid claim that it was a departure from the standard of care for her to handle post operative visits," and that, in any event, Macaulay was involved in the plaintiff's care at each visit and made all of the treatment decisions.

Dr. Cushner rejected the plaintiff's contention that his history of diabetes was not taken into account during the post-operative period. As he explained it, although diabetic patients, particularly those whose blood sugar is not controlled, are at increased risk for healing complications, the plaintiff's last hemoglobin A1C test prior to surgery was 7.0% (i.e., 7.0% of his red blood cells evinced sugar-coated hemoglobin), the upper limit of normal for a diabetic patient. Dr. Cushner thus concluded that the plaintiff's blood sugar was "relatively controlled." He opined that, in any event, Macaulay demonstrated that he considered the patient's risk of infection by arranging for close monitoring with VNS and then having plaintiff come to his office during the post-operative period when there were signs of infection. Dr. Cushner asserted that there was no additional testing or treatment that should have been done merely because the plaintiff was diabetic.

In support of her separate motion, Spicehandler relied on the same submissions that had been provided to the court by the NYPH defendants, including Dr. Cushner's expert affirmation. She highlighted Dr. Cushner's opinion that it was reasonable and consistent with the standard of care to pursue conservative measures to treat the infection prior to incision and drainage, as earlier radiological imaging would not have changed the course of this infection. Spicehandler argued that Dr. Cushner essentially concluded that she provided appropriate and timely diagnosis and treatment.

In opposition to the separate motions of the NYPH defendants and Spicehandler, the plaintiff relied on much of the same documentation, and also submitted an expert affidavit of a

board-certified orthopedic surgeon to oppose the NYPD defendants' motion, and an expert affirmation of a board-certified internist and infectious disease specialist to oppose Spicehandler's motion. The plaintiff also submitted several peer-reviewed articles and the records of his treatment by Dr. Raffalli from August 2016 through December 2016.

The plaintiff's expert orthopedic surgeon concluded that, beginning on June 4, 2016, Macaulay departed from the prevailing orthopedic standard of care applicable to post-operative treatment of the plaintiff, and that Macaulay's "continuing" departures caused the plaintiff to develop osteomyelitis in his left tibia.

The surgeon described Macaulay's deposition testimony as to how the robotic arthroscopic procedure was performed, noting that the significance of the method that Macaulay employed was that the array pins necessarily created what are referred to as "pin tracts" or "pin tracks" in the tibia, which are narrow openings that serve as a "portal" for the MRSA organism to enter the bone and settle therein, leading to the osteomyelitis. The surgeon asserted that it was and is recognized in the orthopedic literature that pin tract infections, and specifically MRSA infections, are a common problem with external fixation and any other metal implant that breaks the skin barrier. In this regard, the plaintiff's expert orthopedic surgeon asserted that staph bacteria have been the leading infection vector in orthopedic surgery practice for the past 10 to 15 years. As the expert explained it, the 2014 edition of the AAOS Comprehensive Orthopedic Review reported that, at that time, staph was "the organism responsible for most musculoskeletal infections," and that MRSA, in particular, was responsible for more than 50% of all staph infections in most communities, while an April 7, 2017 peer-reviewed article reported that, by the end of 2015, there had been little change in the average medical facility's standardized infection ratio, as compared to a 2010-2011 baseline. The plaintiff's expert further referred to another peer-reviewed article that surveyed infection rates 1997 until 2016 that concluded that MRSA had become endemic. As the expert characterized it, the article reported that, of the total number of staph aureus isolates submitted worldwide to the investigators during

the study period, 40.3% were MRSA., while in the United States that number was 47.0%, and that the overall MRSA rate first increased from 1997 to 2008, decreasing to 42.3% from 2009 to 2012, and 39% from 2013 to 2016. The expert nonetheless concluded that, even with the decrease and the geographical differences noted in the literature, MRSA is still a major concern.

The plaintiff's expert orthopedic surgeon wrote that,

> "[w]hile staph organisms can be either of the methicillin sensitive variety (referred to as 'MSSA') or the resistant variety ('MRSA'), there is no way to predict, for any given patient, which variety will strike. MRSA is not only a nosocomial (hospital acquired) organism; any patient's skin can be colonized with MRSA. Therefore, when the patient's skin is pierced (such as it was by the array pins placed during the MUKA surgery), the incisional site is always to be monitored carefully for signs of infection, and if these are observed, *MRSA should always be considered as a possible infective agent. A prudent orthopedic surgeon must always have MRSA on his/her proverbial radar screen, regardless of how many (or how few) infections with this organism he/she has personally seen in his/her own patient population.* MRSA is an organism which is harder to treat once it becomes a deep infection, and certainly harder to treat if it seeds into bone (osteomyelitis). *It is necessary to always have MRSA in the differential diagnosis once the typical signs of infection are evident*, because MRSA is associated with tremendous morbidity/mortality"

(emphasis added).

The plaintiff's expert opined that Macaulay departed from the accepted standard of orthopedic care by failing immediately to direct the plaintiff to come into his office on June 4, 2016 for examination of, and the culturing of fluid from, the tibial incision site, as "a small tibial wound should have stopped draining (and should have scabbed over) within the first two days after surgery." As the expert phrased it, "[d]rainage on Day #10 should have set off alarm bells." The expert orthopedic surgeon faulted Macaulay for simply calling in a prescription for a 10-day course of Augmentin, an antibiotic that does not treat MRSA, and for discounting the possibility of MRSA solely because, as Macaulay testified at his deposition, "it's very rare." The expert asserted that, at that juncture, "the wrong choice of antibiotic was akin to playing with fire, given that MRSA is always a possible infector and given the proximity of the wound to a portal into the tibial bone."

The surgeon expressed his opinion that the presence of an open wound with purulent drainage on June 7, 2016, the thirteenth day after the operation, "was clear evidence of a deep infection," and should have been interpreted as such, until proven otherwise. In this regard, the surgeon pointed out that although Macaulay, at his deposition, denied the necessity of culturing the wound at the June 7, 2016 appointment, he admitted that it would have been possible for a localized skin infection at the tibial pin insertion site to have spread by way of the channel in the tibial bone that had been created by the insertion of the pin. As the surgeon phrased it,

> "[t]he wound should not have been open two weeks out from the surgery, it should not have been draining purulent material at that time, and although a culture should have been performed three days earlier, it was still indicated that a culture be done on June 7th, in order to identify the infecting organism."

The expert thus expressly disagreed with Dr. Cushner's contention that "swabbing a pin tract site to obtain fluid for a culture" could cause an infection by "introducing bacteria," characterizing that conclusion as "simply untrue," and that "there was drainage available to swab for a culture on June 4th and there was purulent drainage to swab for a culture on June 7th, and one would not introduce anything into the pin tract by having performed a culture of the drainage itself."

The plaintiff's expert orthopedic surgeon thus concluded that Macaulay also departed from the standard of care on June 7, 2016 in failing to culture fluid from the wound and in continuing to rely on Augmentin, without ascertaining the identity of the infecting organism, in the face of what he admitted later was a concerning finding, thus creating a situation where the infecting organism in the tissue of the wound was given the opportunity to persist and multiply, and to travel into the bone by way of the pin tract. The expert asserted that the longer that Macaulay failed properly to treat the infection, "the worse it was going to get, and indeed, this is what eventually occurred," as it was allowed to fester until the next visit to Macaulay's office on June 14, 2016. Inasmuch as Doctor documented a "still open tibial wound" on that date, the expert concluded that it was a continuing deviation from the standard of care to be "reassured"

that there was no MRSA infection at that time, despite the fact that the wound had decreased in redness and warmth. The expert asserted that

> "[t]he decision on June 14th to order Mr. Miele to follow-up in three to four weeks' time demonstrates that Emily Doctor (who was always under the supervision of Dr. Macaulay, per his testimony) failed to appreciate that the still open tibial wound was a most concerning finding. Ms. Doctor noted that the course of antibiotic (Augmentin) would be finished 'tomorrow' without understanding that, at that juncture, if the antibiotic had been effective, the wound would have already entirely scabbed over."

The expert thus disagreed with Dr. Cushner's statement that, on June 14, 2016, the wound had improved, thus suggesting that Macaulay's treatment plan was effective, particularly in light of the June 17, 2016 findings of the plaintiff's primary care physician, Dr. Strongwater, which noted significant erythema about hole in the size of a half-dollar coin and cellulitis in the leg. The expert noted that, at that point, the plaintiff continued to complain of "yellow drainage," and that Dr. Strongwater prescribed sulfamethoxazole (Bactrim), an antibiotic which is known to eradicate MRSA.

In addition, the plaintiff's surgical expert opined that Macaulay deviated from good practice by failing to refer the plaintiff to an infectious disease specialist as of June 14, 2016. Moreover, the expert expressly disagreed with Dr. Cushner's implied opinion that Macaulay's treatment on July 1, 2016 was adequate and within the standard of care, and concluded that the presence of "occasional serous fluid draining" was not a reassuring finding, as the wound was still open. The expert surgeon further disagreed with Dr. Cushner's statement that "it can take a few weeks for the wound to epithelialize when it is healing" to the extent that such a conclusion pertained to the plaintiff's tibial wound, which, according to the surgeon, should have healed in a matter of two days given its small size. The expert continued that

> "Dr. Cushner's contention that where a patient has a superficial infection postoperatively it is expected that the drainage would continue longer, makes no sense to me and does not correspond with my clinical experience. It should be noted that July 1st was Day #37 post-op. In view of the fact that the tibial wound had failed to close by that time, it is apparent that there was a deep infection preventing the wound from closing. Dr. Macaulay's assessment (in the July 1st note) that 'the patient needs no more pain medicine or antibiotics' and

> his description of the tibial wound as 'one slow healing pin tract which is not infected' demonstrates his apparent refusal to accept the possibility of an ongoing and serious infectious process,"

particularly in light of Dr. Strongwater's July 1, 2016 note indicating that the plaintiff "stated he had a fever and feels lethargic," a report in stark contrast to Macaulay's note of the same day that the plaintiff "is doing well [and] denies . . . any constitutional symptoms."

The plaintiff's expert orthopedic surgeon further criticized Dr. Cushner's positive characterization of Macaulay's change of treatment plan on July 8, 2016, inasmuch as it should not have gotten to the point where the plaintiff complained of "significant pain of the tibial insertion site" before performing a wound culture. In this regard, the expert stated that Macaulay should have realized long before July 8, 2016 that the non-healing tibial wound signified the presence of a deep infection.

In light of the July 9, 2016 notes of a Lawrence Hospital triage nurse that the plaintiff reported that his knee replacement resulted in a staph infection to the lower shin, that "the pain has gotten severe," that the area was too tender to touch, and that the pain was causing him difficulty in ambulating, as well as a physician's note that the plaintiff's left leg was swollen, the plaintiff's expert orthopedic surgeon asserted that, after Spicehandler diagnosed with cellulitis due to MRSA, and had begun administration of intravenous Vancomycin, she should not have switched him over to oral Doxycycline, a drug that proved to be ineffective in eradicating the organism. The expert surgeon further asserted that the plaintiff should not have been discharged from the hospital on July 12, 2016.

The expert orthopedic surgeon thus came to the conclusion that

> "Macaulay's early post-operative departures and then his continuing departures from the prevailing orthopedic standards of care created a situation in which the MRSA was not discovered as the organism which initially caused a superficial wound.at the tibial array pin insertion site of Mr. Miele's left leg. It is my opinion that, due to the length and negligent delay in identifying the MRSA as the infecting organism, and the concomitant failure to treat this patient with the appropriate antibiotic, at some point prior to July 8th, the superficial infection had spread to bone, resulting in osteomyelitis.

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> "Dr. Macaulay's continued failure to do the appropriate testing and his failure to recognize the clear signs of an ongoing infectious process made it so that Mr. Miele was not administered the proper antibiotic until such time as the infection had already reached the bone. My years of orthopedic education, training and clinical experience have informed me that osteomyelitis is much harder to treat and control than is a superficial infection. Within a reasonable degree of medical certainty, had a culture been performed, per the standard of care, on June 4th 2016, plaintiff's superficial MRSA infection would have been treated with an appropriate antibiotic and eradicated before it ever had the chance to spread to bone."

The plaintiff's expert orthopedic surgeon did not address Dr. Cushner's opinion concerning the qualitative sufficiency of the consent obtained in connection with the administration of antibiotics.

With respect to the plaintiff's claims against Macaulay, the plaintiff's expert infectious disease specialist reiterated the conclusions reached by the plaintiff's expert orthopedic surgeon, and incorporated them by reference, adding, among other things, that the plaintiff's "occasional serous fluid draining," as Macaulay characterized it, was not at all a reassuring finding, as the tibial wound was still open more than one month after the arthroscopic surgery. As the infectious disease specialist explained, "July15th was Day #37 post-op; with a tibial wound which had failed to close by that time. Superficial wounds do not remain open for 37 days after an operation, and this duration indicates, . . . that a deep wound remained present. Moreover, Dr. Macaulay, at that point, negligently continued to fail to consider a MRSA infection."

With respect to the plaintiff's claims against Spicehandler, the plaintiff's infectious disease specialist expert asserted that Spicehandler's failure to recognize osteomyelitis, and her consequent failure to provide therapy for osteomyelitis, was inappropriate and constituted a departure from the prevailing standard of care. As the expert explained, Spicehandler diagnosed cellulitis, an infection of the skin, due to MRSA, and ordered the administration of intravenous Vancomycin for only three days, discharging the plaintiff on July 12, 2016

on oral Doxycycline, with instructions to follow up with his primary-care physician, as well as with Macaulay. According to the plaintiff's expert, she failed to order the proper imaging, such as a CT or MRI scan, which would likely have revealed the presence of osteomyelitis and, thus, "she completely missed the diagnosis," failing to institute a prolonged course of the appropriate intravenous antibiotics. The infectious disease expert asserted that, "[s]ubsequently, and predictably, the oral Doxycycline was insufficient to eradicate the organism and Mr. Miele, in terrible pain, presented to the Emergency Room at Phelps Hospital on July 17, 2016, only to be referred back to his physicians." The expert consequently opined that, had Spicehandler ordered an MRI on July 9, 2016, the plaintiff's regimen would have been altered to treat for presumptive osteomyelitis at that time, but that it instead took until August 4, 2016 before another infectious disease specialist correctly diagnosed subacute osteomyelitis of the left tibia and began the plaintiff on the appropriate course of the proper antibiotics, wound care, and hyperbaric oxygen therapy.

The infectious disease expert reiterated the conclusion of the expert orthopedic surgeon that Macaulay's delay in recognizing the severity of the infection, culturing the wound fluid to determine that the organism was MRSA, and promptly commencing a long regimen of Vancomycin or other similar drug, caused the infection to spread into the plaintiff's tibia and caused osteomyelitis. The infectious disease expert explained that "[b]one, being without an abundant blood supply, is a difficult tissue to FULLY eradicate embedded bacteria from, including Staph aureus. Although Mr. Miele is ostensibly 'cured' at this point, he remains at risk for future relapse months, years or even decades into the future." The expert also opined that the "further delay in proper treatment occasioned by the separate departures by defendant Dr. Spicehandler, allowed the osteomyelitis to spread further into the tibial bone and more likely than not lengthened the time required for Mr. Miele to fully heal," which increased the extent of Macaulay's August 2016 debridement procedure.

The plaintiff's infectious disease expert did not address the informed consent claims against either Macaulay or Spicehandler.

In their reply papers, both the NYPH defendants and Spicehandler essentially reiterated their prior arguments, now contending that the plaintiff's expert affirmations failed to raise a triable issue of fact as to whether they departed from accepted practice or proximately caused the plaintiff's injuries. They repeated their arguments concerning the alleged vicarious liability of Lawrence Hospital, claiming that relevant precedent imposing vicarious liability applies only to emergency situations.

A. SUMMARY JUDGMENT STANDARDS

It is well settled that the movant on a summary judgment motion "must make a prima facie showing of entitlement to judgment as a matter of law, tendering sufficient evidence to eliminate any material issues of fact from the case" (*Winegrad v New York Univ. Med. Ctr.*, 64 NY2d 851, 853 [1985] [citations omitted]). The motion must be supported by evidence in admissible form (*see Zuckerman v City of New York*, 49 NY2d 557, 562 [1980]), as well as the pleadings and other proof such as affidavits, depositions, and written admissions (*see* CPLR 3212). The facts must be viewed in the light most favorable to the non-moving party (*see Vega v Restani Constr. Corp.*, 18 NY3d 499, 503 [2012]). In other words, "[i]n determining whether summary judgment is appropriate, the motion court should draw all reasonable inferences in favor of the nonmoving party and should not pass on issues of credibility" (*Garcia v J.C. Duggan, Inc.*, 180 AD2d 579, 580 [1st Dept 1992]). Once the movant meets his or her burden, it is incumbent upon the non-moving party to establish the existence of material issues of fact (*see Vega v Restani Constr. Corp.*, 18 NY3d at 503). A movant's failure to make a prima facie showing requires denial of the motion, regardless of the sufficiency of the opposing papers (*see id.; Medina v Fischer Mills Condo Assn.*, 181 AD3d 448, 449 [1st Dept 2020]).

"The drastic remedy of summary judgment, which deprives a party of his [or her] day in court, should not be granted where there is any doubt as to the existence of triable issues or the

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

Although the affidavit of the plaintiff's expert orthopedic surgeon was executed in New Jersey, it was not accompanied by the certificate of conformity required by CPLR 2309. A certificate of conformity is a written instrument, pursuant to which a person qualified by the laws of the country or state in which an affidavit or affirmation is executed and notarized, or by the laws of New York, certifies that the out-of-state affidavit or affirmation has indeed been drafted, executed, and notarized in conformity with the laws of that country or state. The absence of the certificate of conformity, however, does not require the court to disregard the affidavit or reject the plaintiff's papers, as the failure to include a certificate of conformity is a mere irregularity that may be cured by the submission of the proper certificate nunc pro tunc (*see Parra v Cardenas,* 183 AD3d 462, 463 [1st Dept 2020]; *Bank of New York v Singh*, 139 AD3d 486, 487 [1st Dept 2016]; *DaSilva v KS Realty, L.P.,* 138 AD3d 619, 620 [1st Dept 2016]; *Diggs v Karen Manor Assoc., LLC*, 117 AD3d 401, 402-403 [1st Dept 2014]; *Matapos Tech., Ltd. v Compania Andina de Comercio Ltda.*, 68 AD3d 672, 673 [1st Dept 2009]).

B. MEDICAL MALPRACTICE BASED ON DEPARTURE FROM ACCEPTED PRACTICE

"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). Thus, the affirmation of a plaintiff's expert should not be credited where it completely "is contradicted by the record" (*Mulroe v New York-Presbyt. Hosp.*, 203 AD3d 665, 665 [1st Dept 2022]). The term "record," in this context, refers to medical records, charts, test results, and notes, or party admissions by the plaintiff (*see Wong v Goldbaum*, 23 AD3d 277, 280 [1st Dept 2005] [plaintiff's expert's opinion contradicted by defendant's notes and plaintiff's own testimony]).

The NYPH defendants established, prima facie, that Macaulay did not depart from good and accepted medical practice, as their expert unambiguously concluded that Macaulay provided proper post-operative care and properly followed up with the plaintiff by addressing his complaints, and that Macaulay did not depart from accepted practice in declining to culture the wound during May and June 2016. They further made a prima facie showing that, in light of the plaintiff's signs and symptoms, it was appropriate for him initially to rule out MRSA infection and

osteomyelitis at that early stage, and appropriate for him to prescribe Augmentin in June and early July 2016. The NYPH defendants also demonstrated, prima facie, based on their expert's affirmation, that the delay in culturing the wound, diagnosing MRSA, and prescribing Vancomycin or other similar drugs did not cause or contribute to the plaintiff's injuries. Spicehandler also established, with her own testimony and the affirmation of the NYPH defendants' expert, that she did not depart in failing to diagnose osteomyelitis, inasmuch as she recognized the presence of MRSA and began the plaintiff on a short regimen of intravenous Vancomycin. She also demonstrated, prima facie, that she did not depart from accepted practice by switching the plaintiff to oral Doxycycline after only three days and discharging him from Lawrence Hospital, and that the change of antibiotics did not cause, contribute to, or worsen the MRSA infection and concomitant osteomyelitis between July 2016 and August 2016.

In opposition to the defendants' showing, however, the plaintiff, through his own testimony, medical records, and expert affidavit and affirmation, raised a triable issue of fact as to whether Macaulay departed from good and accepted practice in delaying a culture of the wound fluid, failing to be concerned about the presence of MRSA, failing to diagnose MRSA at the earliest possible juncture in light the plaintiff's ongoing signs and symptoms, and failing to prescribe an appropriate antibiotic to treat what he conceded was an infection. The plaintiff further raised a triable issue of fact as to whether those departures caused the infection to invade the bone and resulted in the onset of osteomyelitis. The plaintiff also raised a triable issue of fact as to whether Spicehandler departed from good and accepted practice in failing to diagnose osteomyelitis in light of her finding of MRSA, and in prematurely discontinuing the administration of Vancomycin or other drugs that could treat MRSA, instead replacing it with Doxycycline. In addition, the plaintiff raised a triable issue of fact as to whether those departures permitted the MRSA infection to spread into the bone, thus exacerbating his osteomyelitis.

Consequently, that branch of the NYPH defendants' motion seeking summary judgment dismissing the medical malpractice cause of action against Macaulay, and that branch of Spicehandler's separate motion seeking summary judgment dismissing the medical malpractice cause of action against her, must both be denied.

C. LACK OF INFORMED CONSENT

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

> "(1) that the person providing the professional treatment failed to disclose alternatives thereto and failed to inform the patient of reasonably foreseeable risks associated with the treatment, and the alternatives, that a reasonable medical practitioner would have disclosed in the same circumstances, (2) that a reasonably prudent patient in the same position would not have undergone the treatment if he or she had been fully informed, and (3) that the lack of informed consent is a proximate cause of the injury"

(*Spano v Bertocci*, 299 AD2d 335, 337-338 [2d Dept 2002]; *see Zapata v Buitriago*, 107 AD3d 977, 979 [2d Dept 2013]; *Balzola v Giese*, 107 AD3d 587, 588 [1st Dept 2013]; *Shkolnik v Hospital for Joint Diseases Orthopaedic Inst.*, 211 AD2d 347, 350 [1st Dept 1995]). For a statutory claim of lack of informed consent to be actionable, a defendant must have engaged in a "non-emergency treatment, procedure or surgery" or "a diagnostic procedure which involved invasion or disruption of the integrity of the body" (Public Health Law § 2805-d[2]). The Appellate Division, First Department, has recognized that a lack of informed consent cause of action may be predicated on a physician's failure to obtain a patient's fully informed consent to the administration of drugs or medications where the physician failed to reveal all of the anticipated adverse side effects of such administration (*see Halloran v Kiri*, 173 AD3d 509, 510 [1st Dept 2019]; *Farkas v Saary*, 191 AD2d 178, 178-179, 181 [1st Dept 1993] ["No basis exists to dismiss plaintiffs' lack of informed consent claim against defendant (physician) given his conceded failure to issue any warning whatsoever concerning possible birth defects potentially caused by the hormone."]; *Oley-Trojanowska v Kelley*, 2022 NY Slip Op 34049[U], *26-27, 2022 NY Misc LEXIS 7404, *46-47 [Sup Ct, N.Y. County, Nov. 23, 2022 [Kelley, J.]).

Nonetheless, "[a] failure to diagnose cannot be the basis of a cause of action for lack of informed consent unless associated with a diagnostic procedure that 'involve[s] invasion or disruption of the integrity of the body'" (*Janeczko v Russell*, 46 AD3d 324, 325 [1st Dept 2007], quoting Public Health Law § 2805-d[2][b]; *see Lewis v Rutkovsky*, 153 AD3d at 456), and that invasion or disruption is claimed to have caused the injury. Moreover, a claim to recover for lack of informed consent cannot be maintained where the alleged injuries resulted either from the failure to undertake a procedure or the postponement of that procedure (*see Akel v Gerardi*, 200 AD3d 445 [lack of informed consent cannot be based on failure to perform procedure or administer drug]; *Ellis v Eng*, 70 AD3d 887, 892 [2d Dept 2010]; *Jaycox v Reid*, 5 AD3d 994, 995 [4th Dept 1994]).

Both the NYPH defendants and Spicehandler established that the plaintiff's lack of informed consent claim was based solely on the alleged failure to diagnose osteomyelitis and the failure timely or properly to administer the proper drugs to treat the MRSA that caused the osteomyelitis. They also established, prima facie, that the consent that they obtained from the plaintiff was qualitatively sufficient. The plaintiff did not address the issue in opposition to those showings and, thus, did not raise a triable issue of fact as to whether any failures in this regard involved some intrusion upon his bodily integrity and, if so, whether the consent obtained by the defendants was qualitatively insufficient. Hence, all of the defendants must be awarded summary judgment dismissing the lack of informed consent cause of action.

D. VICARIOUS LIABILITY

"'In general, under the doctrine of respondeat superior, a hospital may be held vicariously liable for the negligence or malpractice of its employees acting within the scope of employment, but not for negligent treatment provided by an independent physician, as when the physician is retained by the patient himself'" (*Valerio v Liberty Behavioral Mgt. Corp*., 188 AD3d 948, 949 [2d Dept 2020], quoting *Seiden v Sonstein*, 127 AD3d 1158, 1160 [2d Dept 2015]; *see Hill v St. Clare's Hosp*., 67 NY2d 72, 79 [1986]; *Dupree v Westchester County Health Care*

Corp., 164 AD3d 1211, 1213 [2d Dept 2018]). However, "'vicarious liability for the medical malpractice of an independent physician may be imposed under a theory of apparent or ostensible agency'" (*Valerio v Liberty Behavioral Mgt. Corp*., 188 AD3d at 949, quoting *Keesler v Small*, 140 AD3d 1021, 1022 [2d Dept 2016]; *see Hill v St. Clare's Hosp*., 67 NY2d at 79).

> "'In order to create such apparent agency, there must be words or conduct of the principal, communicated to a third party, which give rise to the appearance and belief that the agent possesses the authority to act on behalf of the principal. The third party must reasonably rely on the appearance of authority, based on some misleading words or conduct by the principal, not the agent. Moreover, the third party must accept the services of the agent in reliance upon the perceived relationship between the agent and the principal, and not in reliance on the agent's skill'"

(*Keesler v Small*, 140 AD3d at 1022, quoting *Dragotta v Southampton Hosp*., 39 AD3d 697, 698 [2d Dept 2007]; *see Valerio v Liberty Behavioral Mgt. Corp*., 188 AD3d at 949; *Loaiza v Lam*, 107 AD3d 951, 952 [2d Dept 2013]). "'In evaluating whether a doctor is the apparent agent of a hospital, a court should consider all attendant circumstances to determine whether the patient could properly have believed that the physician was provided by the hospital'" (*Valerio v Liberty Behavioral Mgt. Corp*., 188 AD3d at 949, quoting *Loaiza v Lam*, 107 AD3d at 952-953).

Additionally, "[a]n exception to this general rule exists where a plaintiff seeks to hold a hospital vicariously liable for the alleged malpractice of an attending physician who is not its employee where a patient comes to the [hospital] seeking treatment . . . [but] not from a particular physician of the patient's choosing" (*Muslim v Horizon Med. Group, P.C*., 118 AD3d 681, 683 [2d Dept 2014] [internal quotation marks omitted]; *see Valerio v Liberty Behavioral Mgt. Corp*., 188 AD3d at 949). Stated another way,

> "'a hospital may be held vicariously liable, based on the principle of agency by estoppel, for the acts of an independent physician where the physician was provided by the hospital or was otherwise acting on the hospital's behalf, and the patient reasonably believed that the physician was acting at the hospital's behest'"

(*Malcolm v Mount Vernon Hosp*., 309 AD2d 704, 705 [1st Dept 2003], quoting *Sarivola v Brookdale Hosp. & Medical Ctr*., 204 AD2d 245, 245-246 [1st Dept 1994] [citation omitted]).

"'Thus, in order to establish its entitlement to judgment as a matter of law defeating a claim of vicarious liability, a hospital must demonstrate that the physician alleged to have committed the malpractice was an independent contractor and not a hospital employee, and that the exception to the general rule did not apply'" (*Valerio v Liberty Behavioral Mgt. Corp*., 188 AD3d at 949-950, quoting *Muslim v Horizon Med. Group, P.C*., 118 AD3d at 683 [some internal quotation marks omitted]).

In *Sklarova v Coopersmith* (180 AD3d 510, 510 [1st Dept 2020]), for example, although the plaintiff there retained a particular surgeon to perform a shoulder procedure, that surgeon did not choose the anesthesiologist who would assist with the surgery that was performed at the defendant hospital. It turned out that the hospital did not employ or control the anesthesiologist who it ultimately assigned to the procedure. Nonetheless, the Appellate Division, First Department, reinstated the plaintiff's claims against the hospital, concluding that there were triable issues of fact as to whether the anesthesiologist was negligent, and whether the doctrine of ostensible agency rendered the hospital vicariously liable for the anesthesiologist's conduct. Similarly, in the instant dispute, Dr. Strongwater did not refer the plaintiff to any one infectious disease specialist, let alone refer him to Spicehandler in particular, but only referred him to Lawrence Hospital, where he presented for treatment of his tibial infection. Lawrence Hospital chose Spicehandler as an appropriate specialist who was then on duty and could examine and treat the plaintiff, without any input from him as to which physician he wished to see.

Moreover, "a defendant who employs an independent contractor to perform services that the defendant has undertaken to perform, is liable for the negligence of the independent contractor" (*Mduba v Benedictine Hosp.,* 52 AD2d 450, 453 [3d Dept 1976]). Hence, a

> "defendant hospital, having held itself out to the public as an institution furnishing doctors, staff and facilities for emergency treatment, was under a duty to perform those services and is liable for the negligent performance of those services by the doctors and staff it hired and furnished to [a patient]. Certainly, the person who avails himself of hospital facilities has a right to expect satisfactory treatment from any personnel who are furnished by the hospital"

(*id.*; *see A.A. v St. Barnabas Hosp.*, 176 AD3d 582, 583 [1st Dept 2019]; *Malcolm v Mount Vernon Hosp.*, 309 AD2d at 705-706). Contrary to the defendants' contention, *Mduba* has not been limited by the courts to emergency treatment (*see A.A. v St. Barnabas Hosp.*, 176 AD3d at 583; *Schacherbauer v University Assoc. in Obstetrics & Gynecology, P.C*, 56 AD3d 751, 752 [2d Dept 2008]; *Galina v Lewis*, 2020 NY Slip Op 32276[U], *5, 2020 NY Misc LEXIS 3262, *10-11 [Sup Ct, N.Y. County, Jul. 1, 2020])

Consequently, Lawrence Hospital failed to meet its prima facie burden on this issue, as it failed to demonstrate that both exceptions to the general rule concerning vicarious liability were inapplicable (see *Valerio v Liberty Behavioral Mgt. Corp.*, 188 AD3d at 950; *Diller v Munzer*, 141 AD3d 628, 629 [2d Dept 2016]; *Keitel v Kurtz*, 54 AD3d 387, 390 [2d Dept 2008]; *Welch v Scheinfeld*, 21 AD3d 802, 808-809 [1st Dept 2005]; *Filemyr v Lombardo*, 11 AD3d 581, 581 [2d Dept 2004]). Specifically, it failed to demonstrate that the plaintiff came to its facilities seeking treatment from Spicehandler in particular, rather than, as the plaintiff contended, simply presenting himself to the hospital at Dr. Strongwater's suggestion for treatment by any qualified physician who was working at the hospital on that date.

Since the NYPH defendants essentially conceded that Macaulay was an employee of NYPH, and that branch of their motion seeking summary judgment dismissing the medical malpractice claim insofar as asserted against Macaulay was denied, it may be held vicariously liable for his negligence, and the court must deny their request for summary judgment dismissing that cause of action against NYPH as well. Moreover, inasmuch as the court denied hat branch of Spicehandler's motion seeking summary judgment dismissing the medical malpractice cause of action against her, it must deny that branch of Lawrence Hospital's motion seeking summary judgment dismissing that cause of action insofar as asserted against it, based on its potential vicarious liability for her acts and omissions as its ostensible agent.

V. CONCLUSION

In light of the foregoing, it is

ORDERED that the motion of the defendants William Macualay, M.D., Lawrence Hospital, and New York Presbyterian Hospital is granted only to the extent that they are awarded summary judgment dismissing the lack of informed consent cause of action insofar as asserted against them, and the motion is otherwise denied; and it is further,

ORDERED that the separate motion of the defendant Debra Spicehandler, M.D., is granted only to the extent that she is awarded summary judgment dismissing the lack of informed consent cause of action insofar as asserted against her, and the separate motion is otherwise denied.

This constitutes the Decision and Order of the court.

1/27/2023
DATE

JOHN J. KELLEY, J.S.C.

MOTION:		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
MOTION 2:		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