Lee v Berkeley

2023 NY Slip Op 31318(U)

March 27, 2023

Supreme Court, New York County

Docket Number: Index No. 805059/2018

Judge: Judith N. McMahon

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SUPREME COURT OF THE STATE OF NEW YORK
NEW YORK COUNTY

PRESENT: HON. JUDITH N. MCMAHON **PART** 30M

Justice

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CHRISTOPHER LEE, FALAN LEE,

Plaintiff,

- v -

ANTOINETTE BERKELEY, BERNARD FAGIN, EAST HUDSON UROLOGY GROUP, P.C.,WESTCHESTER PUTNAM UROLOGY, L.L.C., ANDREW MELTZER, THE NEW YORK AND PRESBYTERIAN HOSPITAL

Defendant.

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INDEX NO. 805059/2018

MOTION DATE 03/20/2023

MOTION SEQ. NO. 002

DECISION + ORDER ON MOTION

The following e-filed documents, listed by NYSCEF document number (Motion 002) 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82

were read on this motion to/for DISMISSAL.

Upon the foregoing documents, it is ordered that the motion of defendants Andrew Meltzer, M.D. and The New York and Presbyterian Hospital (hereinafter "NYPH") for summary judgment pursuant to §CPLR 3212[1] is granted to the extent that plaintiffs' complaint against NYPH is dismissed, together with all claims surrounding plaintiff's pre-operative treatment and treatment for skin rashes he suffered post-operatively. The balance of the motion is denied.

This matter arises out of alleged medical malpractice rendered to 59-year-old Christopher Lee between September 11, 2015, when he began intravesical treatments for bladder cancer with the defendant urologists[2], and February 1, 2017, when he was discharged from NYPH following

[1] Defendants Antoinette Berkeley, M.D., Bernard Fagin, M.D., East Hudson Urology Group, P.C. and Westchester Putnam Urology, LLP have not sought summary judgment.

[2] Plaintiff underwent two six-week courses of BCG infusions (Bacillus Calmette-Guerin), an immunotherapy that involves a live attenuated strain of Mycobacterium bovis—the bacterium that causes TB—and is used to treat bladder cancer (*see* NYSCEF Doc. No. 64, para. 9). The package insert for M. Bovis BCG warns that the "instillation of BCG with an actively bleeding mucosa may promote systemic BCG infection [and] treatment should

a January 23, 2017 surgery performed by Dr. Meltzer to: (1) repair the abdominal aorta below the level of the renal arteries using a frozen cadaver aorta, and (2) debride the retroperitoneum of a severe infection likely caused by the bladder treatments/infusions. It is alleged that Dr. Meltzer negligently compromised and impaired circulation to plaintiff's lower left extremity intraoperatively, ultimately requiring an above the knee amputation of Mr. Lee's left leg in September of 2017.

Plaintiffs claim, *inter alia*, that Dr. Meltzer's debridement of plaintiff's retroperitoneal cavity caused him to suffer lumbosacral plexopathy, and that Dr. Meltzer (1) failed to obtain informed consent for the debridement portion of the surgery; (2) failed to perform an appropriate pre-operative workup; (3) failed to employ the appropriate surgical technique during surgery; (4) failed to restore adequate blood flow to the lower extremities; (5) failed to manage plaintiff postoperatively based on his left lower extremity deficits and, as for NYPH, that it (6) failed to post operatively examine plaintiff and failed to inform the attending physicians of post operative deficits in the left leg.

The moving defendants maintain that plaintiff's post operative lumbar plexopathy was a result of an unavoidable neurological injury, an accepted complication of the debridement procedure and a known risk of this life-saving surgery.

In addition to lack of informed consent, the complaint (*see* NYSCEF Doc. No. 3) alleges causes of action for medical malpractice and loss of services on behalf of Falan Lee.

FACTUAL BACKGROUND

It appears undisputed that Mr. Lee started treating with defendant Antoinette Berkeley, M.D. in February of 2015 for complaints of burning and pain during urination, with blood in the

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be postponed for at least one week following...traumatic catheterization" (*see* NYSCEF Doc. No. 71). Plaintiffs attest that catheterization(s) involved bleeding and trauma.

urine. A workup identified high-grade bladder cancer for which Dr. Berkely recommended a six-week course of BCG. Mr. Lee underwent the first series of BCG infusions from September through October 2015, and another series was completed in late May of 2016. Dr. Berkeley continued to follow plaintiff for an additional year, but transferred his care to non-party uro-oncologist, Matthew O'Shaughnessy, M.D., at Memorial Sloan-Kettering ("MSK") when bladder cancer was still present in October of 2016.

Imaging and CT scans performed at MSK on December 15, 2016 reflected retroperitoneal adenopathy with mycotic (*i.e.*, infected) aortic aneurysms (*see* NYSCEF Doc. No. 60). Accordingly, on December 22, 2016, Mr. Lee presented to vascular surgeon Dr. Meltzer at NYPH for an evaluation. A CT angiogram identified four saccular aneurysms within the infra-renal abdominal aorta that were related to "adjacent metastatic adenopathy" and were possibly mycotic (*see* Dr. Meltzer's office records; NYSCEF Doc. No. 47). Based on the foregoing, Dr. Meltzer noted an extensive discussion he had with plaintiffs regarding the urgency of these findings and his opinion that the sudden onset and appearance was highly suspicious for a mycotic process, specifically an ascending aortic infection. Dr. Meltzer obtained a consultation from infectious disease specialist, Dr. Barry Hartman, who initiated antibiotic therapy for several weeks before the planned surgical procedure to treat the infection.

On January 23, 2017, plaintiff was admitted to NYPH for a repair of the abdominal aorta below the level of the renal arteries and above the level of the iliac arteries using a segment of a frozen cadaver aorta, and a wide retroperitoneal debridement. The surgical plan was to remove the infected portion of the aorta, replace it with a cadaveric graft, and debride the surrounding and adjacent areas containing infection. During the surgery, a tear in the cadaveric graft was observed, and Dr. Meltzer resected and fashioned a new segment from the unused portion of the

original graft specimen. After this was performed and blood flow through the aorta was restored, Dr. Meltzer turned his attention to the retroperitoneal debridement of the infected area. On the left side there was a deep cavity and the doctor saw material that had a consistency and appearance of what he described as "cottage cheese". He debrided the area, removing the infected tissue, and the remainder of the surgery was completed.

Following the surgery plaintiff had minimal movement of his lower left extremity. Nursing staff performed hourly neurovascular checks and Doppler signals were detectable in the right distal pulses but not in the left. When Dr. Meltzer saw plaintiff on January 24, 2017, he noted no sensory or motor sensory function in Mr. Lee's left leg, although the leg was warm, and a Doppler signal was purportedly obtained. Neurosurgery noted that plaintiff's left lower extremity strength was 0/5, while his right was 5/5 and recommended a stat MRI of the lumbar and thoracic spine as well as a CT scan to rule out acute hematoma, although that was less likely given that only his left leg was affected. Subsequent neurological studies (*i.e.*, an MRI of the brain that ruled out stroke, infarct, and compressive hematoma) revealed no actionable neurosurgical findings and there was no evidence of cord injury. Dr. Meltzer formed the opinion that the deficits were secondary to lumbosacral plexopathy, or peripheral nerve injury sustained during debridement[3].

On February 1, 2017, plaintiff was discharged from NYPH and admitted to Burke Rehab Center where he remained until February 24, 2017. He did not regain function of his left leg.

On April 3, 2017, plaintiff presented to Yale-New Haven. A CT angiogram on March 28, 2017 identified a pseudoaneurysm of the distal aorta and the right superficial femoral artery

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[3] During his deposition, Christopher Lee testified that on the third day post-surgery Dr. Meltzer told plaintiff: "I think I know what happened. I think I know what I did wrong. I think I oversewed a blood vessel in your lumbar plexus that feeds a nerve that goes into your spinal column that comes out and goes to your leg" (*see* NYSCEF Doc. No. 70, pp. 144-145).

("SFA") indicating that the infection had returned (*see* NYSCEF Doc. No. 62). He ultimately underwent a resection of the infected aortic graft, debridement of the retroperitoneum and bilateral common artery enterectomy at Yale-New Haven Hospital on April 17, 2017 (*see* Doc. No. 62).

Plaintiff was discharged from Yale-New Haven on May 1, 2017. He had ongoing complications related to the neurological deficits affecting his left leg and developed gangrene within that extremity. Accordingly, on September 28, 2017 Mr. Lee underwent an above the knee amputation of the left leg at Yale-New Haven.

MOTIONS FOR SUMMARY JUDGMENT AND EXPERT OPINIONS

Defendants move for summary judgment pursuant to CPLR §3212 relying in part upon the expert affirmations of a vascular surgeon, Todd Berland, M.D. (*see* NYSCEF Doc. No. 45) and a neurologist David M. Kaufman, M.D. (*see* NYSCEF Doc. No. 46), both of whom explain that the deficits in plaintiff's left leg were not caused by any vascular complication during surgery (including an alleged failure to adequately restore blood flow) but rather were the result of unavoidable manipulation to the plexus nerves on the left side of the body during the debridement portion of the procedure.

Specifically, Dr. Berland opines to a reasonable degree of medical certainty that Dr. Meltzer: (1) appropriately recommended surgery to remove the infected aorta and to debride the surrounding areas of the infection "as there was no other viable option to save [Mr. Lee's] life apart from this type of surgery"; (2) appropriately disclosed the risks, benefits and alternatives associated with the surgery in accordance with the standard of care; (3) appropriately prepared plaintiff for the surgery; (4) appropriately chose an open technique to surgery rather than an endovascular approach, thereby allowing the use of a cadaveric instead of synthetic graft (the

latter posing a risk of further infection and clotting), and removal of the entire infected area, and (5) appropriately employed the proper surgical techniques in performing the January 23, 2017 surgery. According to this expert, Dr. Meltzer is not responsible for the graft failure that occurred during surgery since failure is not an indication of negligence but rather a known risk of using a cadaveric graft. Dr. Berland further notes that Dr. Meltzer immediately and appropriately exercised sound medical judgment in attempting to repair the graft and, when it could not be repaired, he carefully fashioned a new one from the unused portion of the original. The expert concludes that Dr. Meltzer appropriately performed extensive debridement of the retroperitoneal space and safely removed the extensive infected area, which can result in damage to adjacent structures and is not tantamount to negligence since the surgeon must manipulate the area to completely remove the infected portions.

Dr. Kaufman emphasized that part of the surgery performed by Dr. Meltzer included the extensive debridement of the infection near or within the lumbosacral plexus, and that manipulation of the nerves and plexus during the debridement was a part of this complex surgery and was not evidence of malpractice. He opines within a reasonable degree of medical certainty that (1) plaintiff's post-operative left leg weakness was the result of infection of the lumbosacral plexus and neurological damage that occurred during surgery and not the result of vascular compromise as alleged by plaintiff; (2) neurologically, all appropriate examinations were performed hourly by the NYPH nursing staff, who acted in accordance with the standard of care in performing their neurovascular assessments and in recording their findings, and (3) if the left leg deficit was truly caused by a lack of blood flow, then both legs would have been compromised since the aorta branches off to both lower extremities. Dr. Kaufman is unequivocal that "[d]espite the temporary lack of flow to the legs while the aortic repair was being performed,

both before and after the graft repair, there is no indication that lack of flow or ischemia was the cause of the left leg deficit" (*see* NYSCEF Doc. No. 46, para 32). The expert further opines that plaintiff's above the knee amputation was necessary because of recurrence of the infection in April of 2017 and that the need for additional surgeries was due to the inherent difficulty in controlling and eradicating a BCG infection, which in this case was already severe when plaintiff first presented to Dr. Meltzer.

Plaintiffs oppose the motion arguing that moving defendants failed to meet their *prima facie* burden and notwithstanding, that numerous questions of fact preclude summary judgment. Through the redacted affirmations of their medical experts in neurosurgery (*see* NYSCEF Doc. No. 66), vascular surgery (*see* NYSCEF Doc. No. 67) and neuroradiology (*see* NYSCEF Doc. No. 68), plaintiffs have alleged specific departures made by Dr. Meltzer and attest that plaintiffs' injuries and sequalae were proximately caused by these departures from the standard of care.

Specifically, plaintiffs' neurologist (*see* NYSCEF Doc. No. 66) opines that Dr. Meltzer departed from the standard of care by failing to (1) identify, isolate and avoid the neural structures while performing the January 23, 2017 surgery; (2) order/obtain CT scans of the abdomen, pelvis and retroperitoneum on January 25, 2017; (3) order/obtain emergent MRI scans of the lumbosacral plexus on January 25, 2017, and (4) order/obtain a neurological (rather than neurosurgical) consult on January 25, 2017.

Plaintiffs' vascular surgeon (*see* NYSCEF Doc. No. 67) is emphatic that debridement of Mr. Lee's retroperitoneal cavity[4] was a cause of lumbosacral plexopathy, and that debridement of the area was "deficient and in fact dangerous...[because] a surgeon cannot debride or cut out infection. That is medically impossible [and] to do so is unsafe and contraindicated" (*id.*, para

[4] Treatment of the infection with IV antibiotics was the safer and preferred method, according to plaintiffs' expert vascular surgeon.

37). This expert sets forth that Dr. Meltzer departed from the accepted standard of care when he (1) "negligently created a surgical plan that was doomed to fail from its inception;" (2) failed to properly inspect the graft; (3) negligently used a defective graft; (4) negligently damaged the graft; (5) negligently damaged the left iliac artery during surgery; (6) "improperly debrided Mr. Lee's retroperitoneum, as it is not a proper way to treat a mycotic infection"; (7) failed to identify, isolate and avoid the neural structures during surgery; (8) negligently severed the left lumbosacral plexus; (8) negligently oversewed a vessel of the lumbar plexus and then failed to recognize and repair the oversewn vessel, and (9) failed to obtain informed consent for the retroperitoneal debridement portion of the surgery.

Plaintiffs' expert neuroradiologist (*see* NYSCEF Doc. No. 68) reviewed the December 22, 2016 CT Angiography performed at NYPH in order to identify the "deep cavity" (*i.e.*, the location of the greatest infection), compared that study with the post-surgical CT Angiography dated March 28, 2017, and opined that the infectious process ran parallel to the aorta from L2 to L4 (*id.*, para 4) necessitating the debridement at the L2 to L4 levels. This expert found that postoperatively plaintiff's left iliac artery showed severe stenosis and a focal occlusion, while the right iliac artery (which was not affected by the debridement) remained unchanged.

Inasmuch as the expert affirmations are silent as to plaintiff's pre-operative treatment and post-surgical rash, those claims are severed and dismissed.

APPLICABLE LAW AND ANALYSIS

In considering a motion for summary judgment, the Court is required to review the record in the light most favorable to the non-moving party (*Dallas-Stephenson v. Waisman,* 39 AD3d 303, 308 [1st Dept. 2007]). Summary judgment proceedings are for issue spotting, not issue determination (*Suffolk County Dept. of Soc. Servs. v. James M.*, 83 NY2d 178, 182 (1994) and a

motion for summary judgment must be denied where facts are shown "sufficient to require a trial of any issue of fact" (*see* CPLR 3212[b]). Critically, "it is not the court's function on a motion for summary judgment to assess credibility" (*Ferrante v. American Lung Assn.*, 90 NY2d 93 [1997]). "Credibility determinations, the weighing of the evidence and the drawing of legitimate inferences from the facts are jury functions, not those of a judge, whether her [or she] is ruling on a motion for summary judgment or for a directed verdict" (*Anderson v. Liberty Lobby, Inc.*, 477 US 242, 255 [1986]).

"The essential elements of medical malpractice are (1) a deviation or departure from accepted medical practice, and (2) evidence that such departure was a proximate cause of injury" (*Hayden v. Gordon*, 91 AD3d 819, 820 [2d Dept. 2012]; [*internal quotation marks omitted*]).

A defendant physician moving for summary judgment in a medical malpractice action must make a *prima facie* showing of entitlement to judgment as a matter of law by showing that "in treating the plaintiff there was no departure from good and accepted medical practice or that any departure was not the proximate cause of the injuries alleged" (*Roques v. Noble,* 73 AD3d 204, 206 [1st Dept. 2010]). To satisfy this burden, a defendant must present expert opinion testimony that is based on 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 (*Joyner-Pack v. Sykes,* 54 AD3d 727, 729 [2d Dept. 2008]). "Failure to make such a showing requires denial of the motion, regardless of the sufficiency of the opposing papers" (*Perre v. Vassar Bros. Hosp.*, 52 AD3d 670 [2d Dept. 2008], *quoting Winegrad v. New York Univ. Med. Ctr.*, 64 NY2d 851, 853 [1985]).

Once a defendant has met his or her burden on the motion, the plaintiff must "submit evidentiary facts or materials to rebut the *prima facie* showing by the defendant-physician that he

was not negligent in treating plaintiff, so as to demonstrate the existence of a triable issue of fact. General allegations of medical malpractice, merely conclusory and unsupported by competent evidence tending to establish the essential elements of medical malpractice, are insufficient to defeat [the physician's] summary judgment motion" (*Alvarez v. Prospect Hospital*, 68 NY320, 324-325 [1986]). Thus, in opposing the motion, plaintiff's expert "must demonstrate 'the requisite nexus between the malpractice allegedly committed' and the harm suffered" (*Dallas-Stephenson v. Waisman*, 39 AD3d 303 [1st Dept. 2007], *quoting Ferrara v. South Shore Orthopedic Associates, P.C.,* 178 AD2d 364, 366 [1st Dept. 1991]). Moreover, plaintiff's expert must address and refute the specific assertions of defendants' experts with respect to negligence and causation (*see Janelle M. v. New York City Health & Hospitals Corp.*, 148 AD3d 519 [1st Dept. 2017]).

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 defeat summary judgment. Where the parties' conflicting expert opinions are adequately supported by the record, summary judgment must be denied (*Frye v. Montefiore Med. Ctr.,* 70 AD3d 15 [1st Dept. 2009]).

"To establish a cause of action for malpractice based on lack of informed consent, [a] plaintiff must prove (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]; [*internal quotation marks omitted*]; see Public Health Law §2805-

d[1]). "To state it in other terms, the causal connection between a doctor's failure to perform his [or her] duty to inform and a patient's right to recover exists only when it can be shown objectively that a reasonably prudent person would have decided against the procedures actually performed. Once that causal connection has been established, the cause of action in negligent malpractice for failure to inform has been made out and a jury may properly proceed to consider plaintiffs' damages" (*Trabal v. Queens Surgic-Center,* 8 AD3d 555 at 557 [2d Dept. 2004], *quoting Dries v. Gregor*, 72 AD2d 231, 236-237 [4th Dept. 1980]).

Here, the defendants Andrew Meltzer, M.D. and NYPH have made a *prima facie* showing of entitlement to judgment dismissing the complaint through the affirmations of Dr. Todd Berland and Dr. David M. Kaufman, both of whom attest that these defendants' management of Mr. Lee's dire physical condition was within the acceptable standard of care, that debridement of plaintiff's retroperitoneal cavity was necessary to save plaintiff's life, and that the neurological deficits to plaintiff's left leg resulting in amputation were an unavoidable consequence of this life saving surgery in which manipulation of the nerves in the retroperitoneum was required.

In opposition to that branch of the summary judgment motion by NYPH, the Court notes that none of plaintiffs' experts opposed Dr. Berland's or Dr. Kaufman's findings that the staff, including nursing staff, appropriately and timely investigated the cause of plaintiff's left leg weakness, conducted hourly neurovascular checks postoperatively, and appropriately cared for the rashes to plaintiff's left leg and buttocks. Inasmuch as plaintiffs' experts failed to identify any specific deviations made by the NYPH staff and no proof is presented that Dr. Meltzer was an employee of NYPH during the relevant time-period, NYPH is awarded summary judgment dismissing the complaint.

Plaintiffs have, however, successfully opposed Dr. Meltzer's branch of the summary judgment motion by raising triable issues of fact through the affirmations of their board-certified neurologist, vascular surgeon and neuroradiologist, each of whom set forth detailed opinions supported by factual references to the record to explain how Dr. Meltzer departed from the applicable standard of care and why those departures were a substantial contributing factor to plaintiff's post-surgical complications and injuries. Plaintiff's neurosurgeon sets forth that the standard of care required Dr. Meltzer to: (1) "isolate and identify the neural structure," by tying strings on the nerves, especially in this case, where heparin creates excessive bleeding making it visually difficult to avoid the neural structures, and (2) order an MRI and CT scan of the non-vascular structures of the abdomen on January 25, 2017, to identify a hematoma which then could have been drained before causing permanent damage to the plexus. Likewise, plaintiff's vascular surgeon raised a triable issue of fact through, *inter alia,* his opinion that a proximate cause of the nerve damage giving rise to plaintiff's left leg amputation was Dr. Meltzer's attempt to "cut out" the infection, which in this case was too deep and too wide, when he should have arranged for long-term antibiotic treatment of the infected retroperitoneal tissues.

Plaintiffs have likewise successfully opposed that branch of defendants' motion for dismissal of plaintiffs' cause of action for failure to provide informed consent. While Dr. Meltzer clearly documented that he informed plaintiffs of the risks and benefits surrounding surgical repair of the mycotic aorta, the record is silent as to whether plaintiffs were informed of the risks inherent in an open debridement [5]of the retroperitoneum. Plaintiff testified that he was not advised of the risks to his neural structures during debridement, and his expert vascular surgeon was unequivocal that (1) debridement is not a treatment for mycotic infection (*see* NYSCEF

[5] In fact, the consent form signed by plaintiff (*see* NYSCEF Doc. No. 47, p. 012) does not mention debridement of the peritoneum.

Doc. No. 67, para 44), and (2) "had Dr. Meltzer avoided his meddlesome, unconsented retroperitoneal debridement, Mr. Lee would not have incurred his catastrophic lumbar plexus injury to his left leg" (*id.*, para 37). "Where a plaintiff fails to adduce expert testimony establishing that the information disclosed to the patient about the risks inherent in the procedure is qualitatively insufficient, the cause of action for medical malpractice based on lack of informed consent must be dismissed, particularly where plaintiff has failed to prove that a reasonably prudent person in his position would not have undergone the procedure had he been fully informed of the risks of the procedure" (*Rodriguez v. New York City Health and Hospitals Corp.*, 53 AD3d 464, 465 [1st Dept. 2008]; [*internal citations omitted*]). Here, plaintiff's deposition testimony coupled with the affidavit of his expert vascular surgeon serves to raise an issue of fact as to whether Dr. Meltzer's purported disclosure of the risks of the debridement were qualitatively sufficient. Thus, plaintiffs have sufficiently raised an issue of fact to defeat defendant's motion to dismiss the second cause of action for lack of informed consent.

Accordingly, it is

ORDERED that the motion for summary judgment of defendant NYPH to dismiss the complaint is granted; and it is further

ORDERED that all of plaintiffs' claims relating to Dr. Meltzer's pre-operative care and his treatment of plaintiff's post-surgical development of skin rashes are severed and dismissed; and it is further

ORDERED that the balance of the motion is denied; and it is further

ORDERED that the Clerk is directed to enter judgment dismissing the complaint and all cross claims against the defendant New York and Presbyterian Hospital; and it is further

ORDERED that the parties appear for a pre-trial conference via Microsoft Teams on **June 1, 2023 at 11:00 a.m.**

3/27/2023
DATE

JUDITH N. MCMAHON, J.S.C.

Hon. Judith N. McMahon
J.S.C.

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