King v Bitan
2023 NY Slip Op 31320(U)
April 20, 2023
Supreme Court, New York County
Docket Number: Index No. 805255/2019
Judge: John J. Kelley
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SUPREME COURT OF THE STATE OF NEW YORK
NEW YORK COUNTY

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

Justice

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DONNA KING and ROY KING,

Plaintiffs,

- v -

FABIEN BITAN, M.D., VICKEN PAMOUKIAN, M.D., MANHATTAN ORTHOPEDIC SPINE, PLLC, LENOX HILL HOSPITAL, and NORTHWELL HEALTH,

Defendants.

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INDEX NO. 805255/2019

MOTION DATE 02/15/2023

MOTION SEQ. NO. 004

DECISION + ORDER ON MOTION

The following e-filed documents, listed by NYSCEF document number (Motion 004) 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, 160, 161, 162, 164, 166, 168, 169, 170, 171

were read on this motion to/for SUMMARY JUDGMENT (AFTER JOINDER).

I. INTRODUCTION

In this action to recover damages for medical malpractice based on alleged departures from good and accepted practice, lack of informed consent, and vicarious liability, the defendants Fabian Bitan, M.D., and Manhattan Orthopedic Spine, PLLC (MOS), together move pursuant to CPLR 3212 for summary judgment dismissing the complaint insofar as asserted against them. The plaintiffs oppose the motion. The motion is granted to the extent that the movants are awarded summary judgment dismissing the lack of informed consent cause of action, and so much of the medical malpractice cause of action as was premised on (a) Bitan's alleged departures in recommending a discectomy, spinal fusion, and artificial disc replacement to the plaintiff Donna King (the patient) (b) Bitan's alleged departures in performing the actual discectomy, spinal fusion, and artificial disc replacement phases of the subject surgical procedure, (c) any alleged delay in recognizing, responding to, or diagnosing a thrombosis in the patient's left leg, and (d) any claim to recover for the patient's ongoing lower-back problems. The motion is otherwise denied, inasmuch as there are triable issues of fact as to whether Bitan

departed from good and accepted practice in overseeing and monitoring the intra-operative use and placement of retractors on the patient's blood vessels and the blood flow to the patient's left leg. In addition, there are triable issue of fact as to whether the patient's development of thrombosis in her left leg during the spinal surgery was caused by those departures and whether she developed an infection, sepsis, and permanent weakening of her left leg and foot as a consequence of the thrombosis and concomitant thrombectomy.

II. FACTUAL BACKGROUND

The gist of the plaintiffs' contention is that, on February 15, 2017, Bitan, an orthopedic surgeon, negligently performed a contraindicated anterior lumbar discectomy, spinal fusion, and artificial disc implantation upon the patient, thereupon damaging her left femoral artery. They further asserted that Bitan departed from good and accepted practice in delaying the issuance of orders for a left femoral artery exploration, a thrombectomy of the iliac vessels, and a completion angiography. The plaintiff averred that, as a consequence of this negligence, the patient suffered from infections, the "ruination" of the spinal surgery itself, the exacerbation of existing adverse lumbar conditions, a blood clot, unnecessary additional surgery, and the need for the implantation of a spinal cord stimulator. In addition, the plaintiffs asserted that Bitan failed to obtain the patient's fully informed consent to the spinal surgery. Furthermore, they alleged that MOS, the medical practice that employed Bitan, is vicariously liable for his negligence and failure to obtain informed consent.

The patient sustained lower-back injuries in a December 12, 2013 motor vehicle accident. She was first seen by Bitan on July 30, 2015, complaining of continuing lower-back pain radiating down her left leg, and the inability to sit or stand for long periods of time. Bitan concluded that the patient was suffering from a left sacroiliac disruption, secondary to the accident. Bitan suggested that the patient undergo sacroiliac fixation and fusion employing iFUSE rods. The patient agreed and, on August 12, 2015, Bitan performed the procedure at the defendant Lenox Hill Hospital, a facility owned and operated by Northwell Health (Northwell), at

which he had admitting privileges. The patient was discharged to her home on August 13, 2015, and saw Bitan for a follow-up visit on September 10, 2015, at which time she was partially weight-bearing. Bitan recommended that the patient attempt to put a little more weight on her left side when she walked. At her next visit, on October 22, 2015, Bitan characterized the patient's condition as "okay," and authorized her to put more weight on her left leg. Bitan saw the patient again on January 7, 2016, at which time he concluded that she was doing better, despite some discomfort on the left side of her groin area. Bitan's examination of the patient was characterized as normal, and the X-ray imaging was described as good. On that date, Bitan referred the patient for physical therapy, and concluded that she was "probably able to resume her professional activities within a month or so." The patient next saw Bitan on November 17, 2016, and reported that, after a period of relief, the pain in her lower back had returned, along with the pain radiating down her left leg.

On November 25, 2016, the patient presented to Caremount Medical, P.C. (Caremount), in Brewster, New York, for a computed tomography (CT) scan, which revealed that she was "status post left sacroiliac joint fusion" with "no evidence of fracture or suspicious osseous lesion." On December 6, 2016, the patient returned to Caremount to meet with pain management specialist Jacob Handszer, M.D., and complained of pain in the buttocks subsequent to the previous sacroiliac joint fusion, upon whch Dr. Handszer administered a sacroiliac joint injection of the painkiller bupivacaine. This treatment apparently was ineffective.

The patient next saw Bitan on December 15, 2016 at MOS's offices, complaining of lower back stiffness and pain, and reporting that she only obtained three hours of pain relief from Dr. Handszer's injection. Bitan's examination reflected that the patient's lumbosacral region was tender upon palpation, upon which Bitan recommended a discogram of the L5-S1 level of the patient's spine. On January 23, 2017, pain management specialist Sathish R. Modugu, M.D., ordered a lumbar discogram at the patient's L5-S1, L4-L5, and L3-L4 spinal levels. Dr. Modugu reported that there was a severe degenerative disc pattern at the L5-S1

level, despite the fact that the patient did not report pain at that site, and a degenerative disc pattern at the L4-L5 level, with the patient reporting concordant low back pain with minimal contrast, albeit with pain relief after the administration of Lidocaine. In addition, Dr. Modugu reported that there was a degenerative disc pattern at the L3-L4 level, but that the patient did not report pain at that site. Dr. Modugu concluded that the imaging revealed strongly concordant pain at the L4-L5 level.

On February 2, 2017, the patient returned to see Bitan. At that visit, Bitan offered to perform an epidural injection of steroids and painkillers, which she declined. Bitan then recommended that she undergo a hybrid discectomy, along with a spinal fusion at the L5-S1 level of the spine, and the implantation of an artificial disc at the L4-L5 level. According to Bitan, he discussed all of the anticipated risks of the procedure with the patient, which included recurrent herniation, failure of the surgery to relieve the pain, worsening pain, the need for additional surgery, durotomy, infection, and damage to the neural structure, causing permanent pain, numbness, weakness, disability, and damage to great blood vessels. The patient initialed a detailed consent form referable to the surgery.

On February 15, 2017, at Lenox Hill Hospital, Bitan performed an anterior discectomy at the L5-S1 and L4-L5 levels, with a fusion at the L5-S1 level, and the implantation of an artificial disc at the L4-L5 level. According to Bitan, the defendant Vicken Pamoukian, M.D., a Northwell surgeon and vascular surgeon, provided “the approach” for the surgery. In this respect, Pamoukian, while employing a hand-held retractor, dissected specific blood vessels that needed to be moved temporarily to one side or another so that Bitan could access the exposed spinal area that was the target of the procedure. Specifically, Pamoukian made a paramedian incision down to the retroperitoneum, reported that he visualized a significant number of small blood vessels, and asserted that he clipped them with hemoclips. According to the operative report, dissection was then continued between the iliac arteries, and the L5-S1 disk was visualized, after which Bitan took over and performed a spinal fusion at that level. According to

Pamoukian, the iliac vessels on the left side and the aorta were moved medially, the iliolumbar vessels were ligated, L4-L5 spinous processes were exposed, and the artificial disk was placed there. Also according to Pamoukian, both he and Bitan examined the wound at the completion of the surgery, made sure that there was no bleeding or injuries to adjacent structures, checked the pulse rates in the iliac vessels at the inguinal ligament, and closed the patient's wounds and openings in multiple levels. The procedure took approximately three hours to complete.

Subsequent to the spinal procedure, the patient reported both decreased sensation and pain in her left foot. Bitan asserted that dorsalis pedis and posterior tibial pulses were not palpable on that foot. Shortly thereafter, Pamoukian performed an emergency left femoral artery exploration, finding a blood clot in the iliac artery, and immediately performed a thrombectomy of the iliac vessels, and a completion angiography for left iliac thrombus. Acute ischemic limb of the left limb and foot was confirmed. To complete this procedure, Pamoukian made an incision in the patient's groin down to her femoral artery, a vessel that was approximately 5 mm in size. The deep femoral artery and the superficial femoral artery were situated 3 mm to 4 mm either side. These vessels were looped, the patient was administered 5,000 units of heparin bolus, and an arteriotomy was performed over the femoral artery, indicating that there was only minimal blood flow through that area. A number 4 Fogarty catheter was taken up into the iliac vessels, upon which Pamoukian reported that he felt a junction where there was difficulty and a resistance. Once this was crossed, an embolectomy was performed so as to remove a 5 mm blood clot from that area, which Pamoukian reported as having both a dark and a whitish look to it. Once the clot was removed, blood began to flow again, after which the arteriotomy was closed.

On February 16, 2017, Pamoukian performed a venous duplex doppler examination of the patient's legs, and did not observe any deep-vein thrombosis. Although the patient developed a fever on February 22, 2017, some diagnostic studies were negative for infection, while others reflected the onset of bacteremia.

On February 23, 2017, the patient reported that her left foot was 97% back to normal, with minimal numbness at the tip of her toes, although she continued to complain of back pain and shaking episodes, which were reportedly relieved by the administration of Dilaudid. By February 24, 2017, the patient reported that her left foot felt fine, with no numbness or tingling. A February 26, 2017 magnetic resonance imaging (MRI) scan revealed "no definite residual/ recurrent disc or spinal canal/neural foraminal narrowing," while Lenox Hill medical personnel could not determine a definitive cause for the patient's shaking episodes. The patient was started on the anti-depressant and anxiolytic Zoloft for anxiety.

On March 8, 2017, Northwell internist and attending neurologist Ira J. Wagner, M.D., noted that the patient felt better with no more spasms, albeit with some abdominal bloating, at which point the patient was discharged to her home.

On March 13, 2017, Dr. Handszer again saw the patient at his office in Brewster, New York, and prescribed the patient two-milligram tablets of Dilaudid every four hours to treat pain. The patient next saw Bitan in his office on March 16, 2017, at which time she reported that she still had some shaking episodes, but that they were settling. X-rays taken that day were normal.

The patient was readmitted to Lenox Hill Hospital on April 4, 2017 for follow-up evaluation and treatment of her unresolved lower back pain, where she was placed under Wagner's care, as well as that of internist Dhanashri P. Miskin, M.D. She underwent numerous tests, scans, and evaluation regimens. An MRI of the lumbar spine without contrast was performed that date as well. The MRI report stated as follows:

> "S/P lower lumbar spine surgery with radiopaque intervertebral disc spacers at L4-5 and L5-S1 levels with fixation at L5-S1 level which creates ferromagnetic artifact that obscures evaluation of the central canal in the lower lumbar spine region.
>
> "Prior left sacroiliac joint fusion with radiopaque hardware creating ferromagnetic artifact.
>
> "Diffuse disc bulge L3-4 with no significant foraminal stenosis or central canal stenosis."

Physicians from the Lenox Hill Hospital neurosurgery, neurology, orthopedics, and psychiatry departments all provided consultations with respect to the patient, referable to her episodes of back pain and leg spasm. A physician from Lenox Hill's internal medicine department opined that the etiology of the patient's low back pain and spasm episodes was not likely to be organic. The MRI scan did not reveal any "acute abnormalities," although reports from the neurology department indicated that the patient might have been suffering from lumbar radiculopathy, after which she was started on a course of the neuro-pain blocker Gabapentin. Dr. Wagner saw the patient on April 9, 2017, and documented in his note that the patient's pain and spasms had improved significantly and that she and her husband would like for her to go home. The patient was discharged on April 9, 2017, with a diagnosis of acute bilateral tow back pain with bilateral sciatica, and a discharge plan involving the oral administration of one baby aspirin per day as needed, and follow-up appointments with Drs. Wagner and Miskin.

On June 16, 2017, Dr. Handszer administered medial branch nerve-block injections to the patient's lower back, at the L3-L4 and L4-L5 levels, employing the painkiller bupivacaine and the steroid depo-medrol. The patient continued to complain of back pain and spasms, and has been following up with both Dr. Handszer in Brewster and pain management specialist David Kloth, M.D., in Danbury, Connecticut. On July 21, 2017, the patient reported a 40% improvement in pain, upon which Dr. Handszer recommended conservative treatment. Dr. Kloth recommended both medication and a trial of spinal cord stimulator. The patient was again prescribed the painkiller Dilaudid, along with the nerve pain blocker Neurontin, the muscle relaxant Tizanidine, and the antidepressant Zoloft. On December 29, 2017, the patient underwent a surgical implant of spinal cord stimulator at OrthoCT Pain Center.

A CT myelogram of the patient's lumbar spine with contrast was performed on June 21, 2018, which found "no significant degenerative disc disease, spinal stenosis, or neural foraminal narrowing." On August 29, 2018, Dr. Kloth concluded that the patient's severe back and buttock

pain was the result of left sacroiliitis, chronic lumbar radiculopathy, and post laminectomy syndrome.

III. THE PLAINTIFFS' ALLEGATIONS

In their complaint, the plaintiffs simply alleged that Bitan departed from good and accepted medical practice in the manner in which he performed the surgical procedures upon the patient, that he failed to obtain the patient's fully informed consent to the procedure by failing fully to explain all of the risks and benefits of the procedure that he recommended, and that MOS was vicariously liable for Bitan's negligence and failure to obtain the patient's informed consent. In their bill of particulars as to the movants, the plaintiffs alleged that Bitan departed from good and accepted practice in improperly performing the anterior lumbar discectomy, fusion, disc removal, and artificial disc implantation of artificial disc under fluoroscopy, in performing that procedure despite the fact that it was unnecessary and contraindicated, and in damaging the patient's left femoral artery during the course of the procedure.

The plaintiffs further alleged that Bitan was negligent in delaying his referral for a left femoral artery exploration, thrombectomy of the iliac vessels, and a completion angiography. In this regard, the plaintiffs alleged that Bitan failed promptly to discover and diagnose the thrombosis prior to its progression, or to provide the patient with appropriate surgical and post-operative care, attention, and treatment. In addition, the plaintiffs averred that Bitan failed to perform necessary and required tests, examinations, and evaluations prior to the spinal procedure, and failed to administer proper instructions to the various physicians and other hospital and medical personnel who were caring for the patient, both operatively and post-operatively.

The plaintiffs also faulted Bitan for neglecting to take or record proper medical histories and in neglecting to make use of the histories that were taken or recorded. They asserted that Bitan failed to heed the patient's signs and symptoms, including, but not limited to, significant pain in the legs, numbness, and her inability to walk. They asserted that Bitan failed to

understand that the etiology of patient's symptoms was vascular in nature or to recognize the significance of the difficulty in ascertaining detected pulses in her lower extremities, and in failing to appreciate that the patient was susceptible to thromboses, based on her medical history. In addition, the plaintiffs contended that, in light of the patient's history, Bitan departed from good practice in failing to refer her for a pre-operative aortagram and magnetic resonance angiography (MRA) of her lower extremities, and in failing to order a consultation with a vascular surgeon.

Furthermore, the plaintiffs asserted that Bitan failed to formulate a differential diagnosis to determine the cause of the patient's pain and numbness and, thus, failed to consider and diagnose the patient with an aortic thrombosis. They asserted that Bitan failed to order and perform other proper diagnostic testing, including further Doppler scans, an aortogram, CT, MRA, and other vascular testing.

As a proximate result of Bitan's alleged malpractice, the plaintiffs alleged in their bill of particulars that the patient underwent a contraindicated and unnecessary L4-L5 disk replacement and L5-S1 fusion, suffered from a methicillin-resistant staphylococcus aureus (MRSA) infection, other infections and sepsis necessitating the placement of a PICC line, the ultimate "ruination" of the February 15, 2017 L4-L5 disk replacement and L5-S1 fusion, and the exacerbation and aggravation of prior lumbar injuries. They further asserted that she sustained a blood clot and damage to the left femoral artery, necessitating an emergency left artery exploration, thrombectomy, and angioplasty, all of which nonetheless caused a residual left artery hemorrhage. They asserted that, when the patient's lower-back pain did not abate, she required a surgical implant of spinal cord stimulator. The plaintiffs contended that the patient also suffered from difficulty in walking, nerve damage, uncontrollable muscle spasms and other movement disorders, and uncontrollable seizure-like episodes. In addition, the plaintiffs alleged that the patient suffered from anxiety and depression.

The plaintiff claimed that the movants' malpractice caused her to lose $500,000 in earnings as a realtor and personal trainer.

The plaintiffs explicitly asserted that, although the alleged malpractice occurred during the course of a surgery, they were not alleging that it occurred during the course of an emergency treatment, procedure, or surgery.

IV. THE SUMMARY JUDGMENT MOTION

In support of their motion, Bitan and MOS submitted the pleadings, the plaintiffs' bills of particulars as to them, the transcripts of the parties' depositions, relevant medical and hospital records, an attorney's affirmation, and a statement of undisputed material facts, along with the expert affirmation of board-certified neurosurgeon Alan Mechanic, M.D.

Dr. Mechanic opined that the applicable standard of care in 2017 mandated that a surgeon give a patient the option of surgery, provided that there were no contraindications to performing surgery. As he explained it, contraindications to disc replacement surgery included central or lateral recess stenosis, facet arthrosis, spondylolysis, herniated nucleus pulposus with radiculopathy, scoliosis, osteoporosis, and post-surgical pseudarthrosis. He averred that the patient had been diagnosed with none of those conditions. Dr. Mechanic further asserted that contraindications to spinal fusion surgery included osteoporosis, a history of smoking, malnutrition, systemic infection, anemia, chronic hypoxemia, and severe cardiopulmonary disease, and that the patient had not been diagnosed with any of those conditions either. He explained that there are various modalities for the treatment of complaints of back and leg pain in a patient, including the administration of medications, physical therapy, and epidural injections, but that when those modalities failed to alleviate a patient's pain, the last option available is surgery. Based on his review of the patient's medical records, Dr. Mechanic concluded that the patient had attempted these other modalities to alleviate her pain, but that none was successful. Dr. Mechanic thus concluded that the February 15, 2017 procedure constituted a necessary step in attempting to relieve or minimize the patient's pain.

Dr. Mechanic opined that the standard of care dictated that a surgeon use his or her best judgment in deciding on the best option available to address a patient's condition and complaints. He asserted that, in this case, the options included the performance of a two-level fusion. He noted, however, that in light of the patient's career as a personal trainer, the two-level fusion would have adversely affected her mobility and that she may not have been able to move as well as she needed to. The alternative, which Bitan ultimately performed, was to perform a fusion at only one level, and to install an artificial disc at the other level, inasmuch as the artificial disc would retain some of the patient's mobility at that level of the spine.

Dr. Mechanic thus opined that not only was surgery indicated for the patient, but that a single-level fusion, with the installation of an artificial disc at the adjacent spinal level, was an appropriate type of surgery that was well within the standard of care.

With respect to the surgical techniques that Bitan employed, Dr. Mechanic asserted that, for artificial disc replacement surgery, an anterior approach must be used to access the spine. He asserted that Bitan properly requested that Pamoukian, a vascular surgeon, expose the spine before Bitan himself could perform the surgery, and that this exposure involved the dissection of blood vessels. Dr. Mechanic opined that Bitan properly performed the surgery,

> "as is evident from the subsequent diagnostic studies that revealed that the fusion was solid and the hardware in good position. The studies did not reveal any pinching or compressing of a nerve to indicate that the plaintiff may be suffering from nerve damage. No part of the surgery that Dr. Bitan performed involved manipulating or cutting the plaintiff's vasculature. No complications were encountered by Dr. Bitan during February 15, 2017 surgery."

He further contended that Bitan timely notified Pamoukian and his vascular team that, shortly after the surgery, the patient claimed problems with her leg, and that Pamoukian emergently brought the patient back for surgery on February 15, 2017, and performed a left femoral artery exploration, thrombectomy of the iliac vessels, and completion angiograph for left iliac artery thrombus.

Dr. Mechanic conceded that, approximately three days after Pamoukian performed the thrombectomy, the patient developed a fever, and that blood cultures revealed the presence of bacteremia, but he noted that the source of the infection was never found and that infection is a known risk of any surgical procedure in any event. He concluded that, inasmuch as the patient evinced no signs of infection after her discharge from Lenox Hill, “any infection the plaintiff may have had while confined to the Lenox Hill Hospital during her admission of February 15, 2017 did not cause or contribute to any of her alleged injuries.” He did not, however, proffer an opinion as to whether any such infection could be considered, in and of itself, to be one of the injuries that the patient claimed was caused by Bitan’ alleged malpractice.

Ultimately, Dr. Mechanic opined that, in light of the foregoing, Bitan's care and treatment of the patient was proper at all times, that he did not deviate from the standard of care, and that he did not cause or contribute to her alleged injuries. He also asserted that the consent given by the patient to Bitan in connection with the spinal surgery was qualitatively sufficient.

In opposition to the motion, the plaintiff relied on the same documentation as the movants, and also submitted an attorney’s affirmation and the expert affidavit of a board-certified orthopedic surgeon. The plaintiff’s expert asserted that, contrary to Pamoukian’s allegations, “[t]he rnedical records do not contain any references to checking the work for bleeds or signs of potential occlusion prior to closing up the surgical field. As we now know from her subsequent medical history, occlusion of the common iliac artery was not ‘avoided.’”

The plaintiff’s expert opined that Bitan, MOS, Pamoukian, and Lenox Hill Hospital departed from accepted standards of medical care in performing the spinal disc replacement and fusion surgery, specifically in the manipulation and monitoring of the retractors employed to keep open the visual field. As the expert explained it,

> “it is clear that shortly after surgery, while still in the hospital, Mrs. King suffered an urgent and dangerous reduction in blood flow to her left leg and foot. Thrornbosis caused by surgery is a complication for anterior approaches at that level because it requires retraction.

> "While not a rare complication, bleeds and resulting clots are not a foregone conclusion, and the surgeon is responsible to not use undue force on blood vessels."

As the expert described it, the common iliac artery is a large vessel that an experienced surgeon, when operating or placing retractors. should be able easily to visualize and avoid damaging. The expert asserted that it requires quite a significant amount of force for the blood in this vessel to start coagulating, and that the fact that the patient suffered a thrombosis "indicated that the physicians did not take an appropriate level of care to protect the vessel."

After describing the nature of thrombosis and the severe consequences of failing to treat it, the expert noted that, while the patient had suffered from prior problems with her back, she had no history of vascular issues, including thrombosis or clots. The expert asserted that the clot and thrombosis that the patient developed "were clearly related to and caused by the surgical procedure," in that Pamoukian improperly operated the surgical retractors while assisting Bitan in this early phase of the surgery, thus exerting undue pressure on the patient's blood vessels, and that this improper technique was a deviation from accepted standards of medical care that proximately caused the patient's injuries. The expert opined that both Bitan and Pamoukian deviated from accepted standards of medical care in failing properly to employ or promptly to monitor the retractors that they utilized during the surgery, causing excessive and unnecessary damage to the patient's blood vessels and tissues. According to the expert, the dangers that the retractors posed, and the obligation to avoid using excessive force in employing them, is known to all surgeons, whether they be orthopedic, neurosurgical, or vascular surgeons. Since, as the expert characterized it, a surgeon's duty to a patient does not diminish even outside of the specific time that he or she allotted to the patient, Bitan and Pamoukian should have known that a bleed and clot were likely in this patient's case, based upon the three-hour length of surgery, and the amount of force generated by the use of the retractors. The expert further concluded that both Bitan and Pamoukian failed to appreciate the

signs and symptoms of thrombosis, failed timely to evaluate the paitent, and failed to diagnose and treat her.

The plaintiff's expert further asserted that, inasmuch as the development of thrombosis causes several acute and chronic vessel complications, and puts patients at risk of subsequent sepsis, under the circumstances presented here, the clot and thrombosis caused and contributed the patient's bacteremia and sepsis.

The expert ultimately opined that Bitan's and Pamoukian's deviations from good and accepted practice caused the patient's "left leg and foot ischemia and lack of mobility and sensation, and attendant pain and suffering."

The plaintiffs' expert did not address whether the consent given by the patient was qualitatively sufficient or not. Neither did the expert address whether Bitan departed from good and accepted practice in the manner in which he performed the discectomy, spinal fusion, and artificial disc placement phases of the surgery, adverting only to his failure properly to monitor the placement of and force exerted by the retractors on the patient's blood vessels, and the related issue of the blood flow to the patient's left leg. Nor did the expert address whether any of the patient's ongoing back problems were proximately caused by Bitan's alleged departures from good practice in connection with the use of the retractors, discussing only the ongoing problems with, and limitations to, the mobility of her left leg and foot.

In reply, the movants submitted an attorney's affirmation, in which they noted the limited nature of the plaintiff's opposition papers, and argued that, in any event, the plaintiffs' expert's opinion was insufficient to rebut any of the prima facie showings that the movants made in connection with the motion. With respect to the latter issue, the movants primarily asserted that the development of thrombosis during spinal surgery, as well as the development of an infection after a thrombectomy, are known risks of each respective procedure, and that the plaintiffs' expert's opinion with respect to proximate cause was conclusory and speculative.

V. 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 apparently was executed in Illinois, 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]).

A. <u>MEDICAL MALPRACTICE BASED ON DEPARTURE FROM ACCEPTED PRACTICE</u>

"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]). Where a physician fails properly to diagnose a patient's condition, thus providing less than optimal treatment or delaying appropriate treatment, and the insufficiency of or delay in treatment proximately causes injury, he or she will be deemed to have departed from good and accepted medical practice (*see Zabary v North Shore Hosp. in Plainview,* 190 AD3d 790, 795 [2d Dept 2021]; *Lewis v Rutkovsky*, 153 AD3d 450, 451 [1st Dept 2017]; *Monzon v Chiaramonte*, 140 AD3d 1126, 1128 [2d Dept 2016] ["(c)ases . . . which allege medical

malpractice for failure to diagnose a condition . . . pertain to the level or standard of care expected of a physician in the community"]; *O'Sullivan v Presbyterian Hosp. at Columbia Presbyterian Medical Ctr.*, 217 AD2d 98, 101 [1st Dept 1995]). Where a plaintiff alleges that a defendant negligently failed or delayed in diagnosing and treating a condition, a finding that the negligence was a proximate cause of an injury may be predicated on the theory that the defendant thereby diminished the plaintiff's chance of a better outcome (*Majid v Cheon-Lee*, 147 AD3d 66, 71 [3d Dept 2016]; *Clune v Moore*, 142 AD3d 1330, 1331 [4th Dept 2016]; *Wolf v Persaud*, 130 AD3d 1523, 1525 [4th Dept 2015]; *Goldberg v Horowitz*, 73 AD3d 691, 694 [2d Dept 2010]; *Borawski v Huang,* 34 AD3d 409, 410 [2d Dept 2006]).

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]). Moreover,

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/or 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).

Even where an adverse outcome is a known risk of a surgical procedure, a plaintiff may raise a triable issue of fact as to whether a physician committed malpractice by showing that the outcome was caused by improper surgical or medical technique, rather than by an unexplained or incidental event (*see Bengston v Wang*, 41 AD3d 625, 626 [2d Dept 2007]; *see also Hoffman v Taubel*, 2021 NY Slip Op 31523[U], *4-5, 2021 NY Misc LEXIS 2379, *8-9 [Sup Ct, N.Y. County, Apr. 30, 2021] [Kelley, J.], *affd* 208 AD3d 1099 [1st Dept 2022]; *Mathias v Capuano*, 2015 NY Slip Op 32160[U], *5-6, 2015 NY Misc LEXIS 4141, *12-14 [Sup Ct, Suffolk County, Nov. 5, 2015]; *cf. Henry v Duncan*, 169 AD3d 421, 421 [1st Dept 2019] [plaintiff failed to raise

triable issue of fact in opposition to physician's showing that injury was a "known risk that may occur despite competent surgical care having been provided"]).

The movants established, prima facie, that Bitan did not depart from good and accepted practice in his determination to recommend and proceed with one-level fusion and disc replacement surgery, in the manner in which he performed any aspect of that surgery, and in the manner in which he provided post-operative care. The movants also established that he did not delay in suspecting a thrombosis, calling in appropriate specialists to diagnose it, or ordering emergent exploratory surgery and a thrombectomy. In addition, the movants made a prima facie showing that none of the steps that he took or did not take caused or contributed to the patient's injuries. In opposition to those showings, the plaintiffs' expert did not render an opinion as to whether Bitan departed from good and accepted practice in recommending the surgery or in the manner in which he performed the discectomy, spinal fusion, or artificial disc replacement phases of the surgery. Nor did the expert address whether Bitan's alleged departures in connection with any aspect of the surgery caused or contributed to the patient's continuing lower-back problems and her need for additional lower-back treatments. Moreover, the patient's hospital and medical records unambiguously refuted and contradicted the expert's opinion that Bitan delayed in suspecting, diagnosing, or ordering tests to ascertain a left-leg thrombosis (*see Attia v Klebanov*, 192 AD3d 650, 652 [2d Dept 2021]; *Mignoli v Oyugi*, 82 AD3d 443, 444 [2011]), and the plaintiffs' expert did not express a founded opinion that any minimal delay defeated an opportunity for a better outcome. Contrary to the movants' contentions, however, the opinions of the plaintiffs' expert raised a triable issue of fact as to whether Bitan departed from good and accepted medical practice in overseeing and monitoring the use and placement of retractors on the patient's blood vessels, and in monitoring blood flow to her leg during the surgery, whether the patient's development of thrombosis in her left leg during the spinal surgery was caused by those departures, and whether she developed an infection, sepsis, and

permanent weakening of her left leg and foot as a consequence of the thrombosis and concomitant thrombectomy.

Consequently, summary judgment must be awarded to the movants dismissing so much of the medical malpractice cause of action, insofar as asserted against them, as was premised on (a) Bitan's alleged departures in recommending discectomy, spinal fusion, and artificial disc replacement, (b) Bitan's alleged departures in performing the actual discectomy, spinal fusion, and artificial disc replacement phases of the subject surgical procedure, (c) any alleged delay in diagnosing or addressing a thrombosis in the patient's left leg, and (d) any claim to recover for the patient's ongoing lower-back problems.

B. 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]).

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]).

Inasmuch the movants established, prima facie, their entitlement to judgment dismissing the lack of informed consent cause of action, and the plaintiffs' expert did not address the qualitative sufficiency of that consent in his or her affidavit, summary judgment must be awarded to the movants dismissing that cause of action insofar as asserted against them.

C. VICARIOUS LIABILITY

Where a physician working for a professional corporation renders medical care to a patient "within the scope of his or her employment" for that corporation, the corporation may be held vicariously liable for the negligence of the physician (*Petruzzi v Purow*, 180 AD3d 1083, 1084-1085 [2d Dept 2020]). Inasmuch as this court has concluded that there are triable issues of fact as to whether Bitan committed malpractice, it also concludes that MOS, as his employer, may be held vicariously liable for that malpractice. Hence, summary judgment is awarded to MOS only to the extent that this court is awarding summary judgment to Bitan.

VI. CONCLUSION

In light of the foregoing, it is

ORDERED that the motion of the defendants Fabian Bitan, M.D., and Manhattan Orthopedic Spine, PLLC, for summary judgment dismissing the complaint insofar as asserted against them is granted to the extent that they are awarded summary judgment dismissing, insofar as asserted against them, the lack of informed consent cause of action, and so much of the medical malpractice cause of action as was premised on

(a) the alleged departures of Fabian Bitan, M.D., in recommending a discectomy, spinal fusion, and artificial disc replacement to the plaintiff Donna King,

(b) the alleged departures of Fabian Bitan, M.D., in performing the actual discectomy, spinal fusion, and artificial disc replacement phases of the subject surgical procedure upon Donna King,

(c) any alleged delay by Fabian Bitan, M.D., in recognizing, ordering tests to ascertain the presence of, calling in specialists to consult on, and diagnosing a thrombosis in the left leg of Donna King,

(d) any claims asserted against Manhattan Orthopedic Spine, PLLC, that are premised upon these alleged departures by Fabian Bitan, M.D., and

(e) any claim to recover for ongoing lower-back problems alleged by Donna King,

and those claims are dismissed insofar as asserted against Fabian Bitan, M.D., and Manhattan Orthopedic Spine, PLLC, and the motion is otherwise denied.

This constitutes the Decision and Order of the court.

4/20/2023
DATE

JOHN J. KELLEY, 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**