SUPREME COURT OF THE STATE OF NEW YORK
NEW YORK COUNTY

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

Justice

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ALEXANDER MIRETSKY and NINA MIRETSKY,

Plaintiffs,

- v -

WILLIAM MACAULAY, M.D., COLUMBIA DOCTORS-ORTHOPEDICS, COLUMBIA UNIVERSITY MEDICAL CENTER, and NEW YORK AND PRESBYTERIAN HOSPITAL,

Defendants.

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INDEX NO. 805252/2018

MOTION DATE 02/14/2023

MOTION SEQ. NO. 001

DECISION + ORDER ON MOTION

The following e-filed documents, listed by NYSCEF document number (Motion 001) 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 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 JUDGMENT - SUMMARY.

I. INTRODUCTION

In this action to recover damages for medical malpractice based on alleged departures from good and accepted medical practice and lack of informed consent, the defendants move for summary judgment dismissing the complaint. The plaintiffs oppose the motion. The motion is granted only to the extent that the defendants are awarded summary judgment dismissing (a) so much of the medical malpractice cause of action as was based on alleged departures from good practice made in the course of providing post-operative care and (b) the lack of informed consent cause of action. The motion is otherwise denied.

II. FACTUAL BACKGROUND

The crux of the plaintiffs' claims is that the defendant orthopedic surgeon William Macaulay, M.D., negligently performed a total left hip replacement on the plaintiff Alexander Miretsky (the patient) by incorrectly positioning the prosthetic hip components, thus causing metal wear and trunnionosis, and that he departed from good and accepted practice in his

provision of postoperative care to the patient. They further asserted that Macaulay failed to obtain the patient's fully informed consent to the procedure by failing to inform him of all of the risks and benefits of a hip-replacement procedure, or of the reasonable alternatives thereto.

The patient first presented to Macaulay's office on May 8, 2015, complaining of worsening left-sided hip and groin pain that was radiating to his knee. The patient reported that the pain had been present for two years and was getting progressively worse, that it was affecting his quality of life, and that he experienced limitations in walking and dressing himself. The patient also reported no success with conservative management options, including activity modification, weight loss, and administration of non-steroidal anti-inflammatory drugs (NSAIDs), and indicated that he was considering surgical intervention. As Macaulay memorialized it, the patient's past medical history included a left inguinal hernia repair in April 2014 and a left knee arthroscopy in 2012. Upon examination, Macaulay noted that the patient walked with an antalgic gait, and that his right leg was four millimeters longer than his left leg. In addition, Macaulay documented that the patient's left hip was tender to palpation with decreased range of motion, and that X-rays showed advanced degenerative changes in the left hip. According to Macaulay, the patient was an "excellent candidate" for a left total hip replacement.

Macaulay recounted that he informed the patient that there was a 1% to 2% risk of significant complications associated with the proposed surgery, and that the risks and benefits of, and alternatives to, the surgery were discussed at length, specifically the risks of dislocation and instability, periprosthetic fracture, component loosening, component malposition, leg-length discrepancy, nerve and artery damage, reactive bone formation, stiffness, and infection.

The patient returned to see Macaulay on October 2, 2015, at which time Macaulay conducted a physical examination, and documented that the patient had limited range of motion of the left hip, an antalgic gait, and left-sided Trendelenburg lurch, which is a lurching of the trunk over the affected leg. Macaulay reported that X-rays showed bone-on-bone osteoarthritis. Macaulay formulated a plan to perform a total left hip arthroplasty. Approximately one or two

weeks later, the patient attended a discussion at Lawrence Hospital, at which some details of the procedure and anticipated issues concerning recovery were discussed, and representatives from that hospital reviewed the informed consent form with the patient by explaining the contents of each paragraph prior to the patient's execution of the form.

On October 21, 2015, Macaulay performed a total left-hip replacement on the patient at Lawrence Hospital, assisted by orthopedic fellow Stephen Johnstone, M.D. The pre-operative and post-operative diagnoses were severe osteoarthrosis of the left hip. The plan was for the implantation of a Stryker cementless total hip replacement system, a left-sided 54-millimeter external diameter anatomic dual mobility (ADM) shell, and a size-three extended offset femoral stem with a 28+ 12-millimeter cobalt-chrome LFIT V40 femoral head inside a polyethylene "sandwich," with a 48 mm diameter.

The patient first was taken to the operating room, and placed left-side up on the hip table. A curvilinear incision then was made "en route" to a posterolateral approach to the left hip, with enhanced posterior soft tissue repair. After the short external rotators and U-shaped posterior cap were tagged and tacked, the femoral head was dislocated and templated, then removed and sent to the pathology department. Exposure of the surgical site was improved, and the implantation device shell was press-fit in at 40 degrees of abduction and 20 degrees of anteversion. According to the operative report, there was no need for augmented fixation after the cup was seated, and no need to insert a plastic liner. The operative report indicated that, after the placement of rasps, the hip was reduced back into the socket, and Macaulay reported that "[e]xcellent stability and range of motion were obtained." The final stem thereafter was sunk into the femur, with no visible cracks, and the femoral head was reduced back into the socket, with "excellent stability," in Macaulay's words. The wound was then closed, and the patient was sent to the recovery room in "excellent condition." The relevant Implant Documentation Sheet indicated that the reference/catalogue number and lot number for the Stryker LFIT V40 Femoral Head were 6290-9-428 and 42941401, respectively.

Macaulay formulated a plan for the patient to begin weight-bearing activities on post-operative "day 0," to the extent that he could tolerate it, with a potential discharge in one to two days, and the provision of home services to the patient. Immediately following the surgery, the patient reported acute pain. At 10:49 a.m. on the morning following the surgery, however, he was reporting a 1 out of 10 on the pain scale while at rest. Macaulay indicated in an October 22, 2015 note that the post-operative X-ray demonstrated a "perfect" total hip replacement and that the patient was "doing great." On October 23, 2015, the patient reported pain of 0 out of 10 while at rest. At 1:33 p.m. on that date, Dr. Johnstone certified that the patient would receive wound care nursing service and physical therapy upon his discharge. The patient was discharged to his home on October 23, 2015, with instructions to follow up at Macaulay's office at Columbia Doctors Orthopedics (CDO) four weeks later, and to engage in weight-bearing activities to the extent that he could tolerate such activities, ambulate as much as possible, and practice posterior hip dislocation precautions. The patient, accompanied by a visitor, left the hospital with a rolling walker and evinced what was described as a "steady gait."

On November 20, 2015, the patient followed up with Macaulay at CDO. Macaulay concluded that the patient was doing well, and reported that he had no complaints of pain or signs or symptoms of infection, while displaying good "supple" range of motion of the left hip, no antalgic gait, an no Trendelenburg lurch. According to Macaulay, the patient's leg lengths were unchanged. The plaintiff returned to see Macaulay on February 12, 2016, and purportedly was doing well, with no complaints. According to the defendants, X-rays taken the previous day at Hudson Valley Radiology Associates showed that the arthroplasty was well positioned and essentially unchanged from prior films. The plaintiffs countered that there is no way to tell perfectly if the angle of the acetabular component is correct by looking at a post-operative X-ray, considering the anatomic shape of the shell, which is not symmetrical, and that Macaulay admitted as much at his deposition.

Macaulay's plan was to increase the patient's activity, including walking, and to have the patient return in eight months for follow-up X-rays. At his deposition, the patient testified that he was feeling "very well" at this time and that everything was going fine. The patient did not return to CDO until March 28, 2017. Inasmuch as Macaulay was by then no longer working at CDO, the patient presented to Herbert Cooper, M.D., and, according to Dr. Cooper's notes, he complained of burning and right hip pain, as well as night pain, that he had been experiencing since March 2016. Dr. Cooper concluded that the implant was well fixed with a very high offset head, and saw no evidence of osteolysis in the relevant imaging. Dr. Cooper ordered blood work, including serum cobalt testing, and advised the patient to follow up in one week. As Macaulay interpreted it, the patient testified at his deposition that he did not actually begin experiencing any hip pain until October 2016, or approximately one year following the surgery.

The patient returned to Dr. Cooper at CDO on April 11, 2017. Blood work had revealed a cobalt level greater than 2 parts per billion (ppb, which is equal to 2 micrograms per liter, or µ/L). The patient reported persistent lateral and posterior pain, affecting his quality of life. Personnel at CDO conducted a Metal Artifact Reduction (MARS) magnetic resonance imaging (MRI) study that, according to Dr. Cooper, reflected the presence of a moderate-sized cystic posterior pseudotumor, with fluid collection communicating with the patient's hip joint. Dr. Cooper's assessment was that the patient had sustained an adverse local tissue reaction in the left hip, along with taper corrosion at the modular head-neck junction of the left hip replacement. Dr. Cooper recommended surgical revision of the total hip replacement procedure, with a head exchange so as to avoid issues with discrepancies in the length of the patients' legs.

The patient next saw Macaulay on April 17, 2017, at the latter's new New York University office, which was approximately 18 months after the left total hip arthroplasty. Macaulay's chart recorded that the patient complained of discomfort about the hip over several months that was exacerbated after walking for a prolonged period. The patient also reported the presence of a nodule at the lateral aspect of the hip. Laboratory studies reflected a blood

cobalt level of 2.2 µg/L. According to Macaulay's records, a physical examination of the patient was essentially within normal limits, his motor strength was graded at 5/5, sensation was intact, range of motion was within normal limits, there was no pain on palpation, and the patient did not present with an antalgic gait. Macaulay palpated a small to moderately sized superficial cyst over the left greater trochanter. Macaulay's records reported that X-rays showed that the total hip replacement was "well positioned" and unchanged from prior films. Macaulay spoke with Dr. Cooper, and they concurred that the proper diagnosis was a small pseudotumor secondary to taper corrosion at the junction of the femoral titanium stem and the skirted neck of the femoral head. Macaulay characterized the situation as "not drastic or dangerous," based on the extent of the elevation of cobalt blood levels. Macaulay nonetheless revised his original recommendation that the patient wait for three to six months to repeat the cobalt blood serum testing, and instead recommended revision surgery for taper corrosion.

Macaulay also documented his plan to speak with a representative of the implant manufacturer, Stryker, to see if it could create a custom ceramic titanium thimble to make up some of the leg length that might be lost, so that an otherwise obligatory stem revision might be avoided. The patient did not return to see or treat with Macaulay after April 17, 2017.

On May 19, 2017, the patient presented to orthopedic surgeon Calin Moucha, M.D. Dr. Moucha documented that patient initially did well after his hip replacement, but had developed progressively worsening pain. When the patient first saw Dr. Moucha, he was taking the NSAID Advil, had not undergone physical therapy, and was not employing assistive devices for ambulation. On physical examination, the patient ambulated with a slight antalgic gait, referable to the left hip. Dr. Moucha noted the presence of a cystic mass on the patient's left hip, along with tenderness to deep palpation around the piriformis external rotator region. According to Dr. Moucha, X-rays showed lucency, but he could not be sure if neutral acetabular version was suggested on the cross table lateral. His impression was an elevated cobalt blood level, with pseudotumor visible on MRI, status post Stryker ADM construct, and he posited that the

elevated cobalt level could be either from trunnionosis or from the Stryker liner. Dr. Moucha discussed treatment alternatives with the patient, and recommended repeat blood work, a computed tomography (CT) scan, and revision of the acetabular component. The patient underwent laboratory blood testing on May 22, 2017, which revealed a chromium blood level of 1.6 µg/L and a cobalt blood level of 1.3 µg/L. This was the patient's only visit with Dr. Moucha.

On June 1, 2017, the patient presented to orthopedic surgeon Peter Sculco, M.D, at the Hospital for Special Surgery (HSS), and reported that his current surgeon was "working him up for metallosis." On examination, Dr. Sculco noted swelling around the incision site, and that range of motion was limited, with pain upon the patient's attempts to demonstrate the extent of his range of motion, although there was no tenderness over the greater trochanter. Although the defendants contended that X-rays showed that the position of the hardware was as expected, Dr. Sculco noted a prominent horizontal offset of the femoral neck, along with mild degenerative changes. Dr. Sculco sought to rule out adverse local tissue reaction as a cause of the patient's complaints, and formulated a plan to obtain an MRI to work up the soft tissue and to direct the patient return to discuss his options, including revision surgery. An MRI scan generated that day demonstrated findings consistent with a moderate to high level of adverse local tissue reaction.

On June 5, 2017, the patient presented at HSS to orthopedic surgeon Alejandro Gonzalez Della Valle, M.D., who noted that, although the patient's cobalt levels were 2.2 µg/L, there were no titanium or chromium serologic markers of infection. Dr. Della Valle noted that the patient walked with a normal gait, but also noted the presence of a firm nodule on the hip. Upon radiographic examination, Dr. Della Valle concluded that the Stryker total hip replacement had good position and fixation. Nonetheless, inasmuch as the MRI scan reflected the presence of adverse local tissue reaction secondary to trunnionosis of a cobalt-chromium head on a titanium stem, Dr. Della Valle recommended revision surgery, to which the patient agreed.

The patient was admitted to HSS from August 24, 2017 to August 27, 2017 for revision surgery. According to the operative report, which was dictated by Dr. Della Valle's assistant, Alexander Christ, M.D., and signed by Dr. Della Valle, the previous dual mobility head component was removed and significant metal wear and trunnionosis were found on the stem. The report stated that "[t]he cup was then fully exposed. Upon looking at the cup, it was extremely prominent laterally, overhanging over the interior wall and grossly retroverted. However, it was well fixed. *Given the cup's malposition*, the decision was made to revise it" (emphasis added). The revision surgery was thus performed, and included a re-reaming of the left acetabulum in order to fit a larger-sized cup during the revision. According to the surgical pathology report, the patient evinced an inflammatory (granulomatous) implant reaction, consistent with immunologic reaction. An addendum to the report speculated that the presence of the inflammatory infiltrate might have been due to a pre-existing autoimmune condition such as rheumatoid arthritis or psoriatic arthritis. The addendum recommended clinical correlation

After the revision surgery, the patient was transferred to Helen Hayes Hospital for rehabilitation, where he remained from August 27, 2017 to September 1, 2017. Upon his discharge to his home on September 1, 2017, the patient demonstrated modified independence with transfer, ambulation, stairs, curbs, and ramps. According to the defendants, no further occupational therapy was required.

On October 5, 2017, the patient returned to see Dr. Della Valle. As the defendants characterized Dr. Della Valle's notes, the patient was "pleased" with the results of the revision surgery, but was recovering slowly with a persistent limp that required him to use a cane to ambulate. They further asserted that the X-rays taken since the revision revealed an intact reconstruction. Since the patient's rehabilitation admission at Helen Hayes, he has not engaged in any more physical therapy, although Dr. Della Valle concluded that he would benefit from more intensive physical therapy. The patient again returned to Dr. Della Valle's office on January 9, 2018 and September 25, 2018, complaining at both visits of some pain in his left

groin and buttock, and decreased flexibility on the left side. Dr. Della Valle's physician's assistant, Maureen Barlow, recommended that the patient follow up with a spine specialist and engage in stretching exercises. A September 25, 2018 X-ray showed no complications with the revision hardware, and the patient agreed that he would return to see Dr. Della Valle every two to three years, with new X-rays taken at each new visit.

III. THE PLAINTIFFS' ALLEGATIONS

In their complaint, the plaintiffs alleged that that the patient was under Macaulay's care between May 8, 2015 and April 17, 2017, and that, on October 21, 2015, Macaulay performed a left total hip arthroplasty on the patient. They further alleged that Macaulay was employed by CDO at the time, and that the medical services that he rendered were provided in a careless and negligent manner that failed to conform to proper standards of orthopedic care and treatment. They further asserted that the defendants failed fully to inform the patient of the risks and benefits of that procedure, or the alternatives thereto. In addition, the plaintiffs made claim on behalf of the patient's wife for loss of consortium and companionship.

In their bill of particulars, the plaintiffs asserted that the defendants failed properly to perform a left total hip replacement on the patient, and failed properly to position and install the prosthetic hip, so that the insertion of the prosthetic components resulted in metal wear and trunnionosis. They specifically asserted that the defendants improperly placed and fixed the acetabular component of the prosthetic device. The plaintiffs further alleged that the defendants failed to heed the patient's post-operative complaints of continued pain and hip dysfunction, and also committed negligence in failing to obtain blood studies so as promptly to detect metallosis, and that they failed timely to obtain radiologic and MRI studies so as to identify the malposition of the prosthesis, thus delaying corrective revision surgery.

The plaintiffs alleged in their bill of particulars that, as consequence of the malpositioning of the prosthetic acetabular component, the patient was caused to sustain retroversion and overhanging of that component, leading to metallosis, trunnionosis with metal wear, taper

corrosion, peri prosthetic osteolysis, adverse local tissue reaction, pseudotumor formation with inflammation, and fluid collection communicating with the hip joint so as to cause pain. They further asserted that the patient developed a nodule that was palpable at the lateral aspect of the left hip, and suffered from restriction of motion, limp, burning, pain at night, interference with ambulation and activities, leg-length discrepancy, stiffness, and interference with sleep, all of which necessitated surgical intervention in the form of a revision of the left total hip replacement procedure, involving the acetabular and femoral prosthetic components, that was performed under combined spinal epidural anesthesia, and was followed with a course of rehabilitation and physical therapy. The plaintiffs alleged that patient continues to experience left hip pain, difficulty in sitting and standing for long periods of time, a restriction of motion, and the swelling of the left foot, and has sustained additional incision scarring as a result of the revision. They claim that the patient has sustained interference with activities constituted his daily living, as well as with recreational activities, employment, and his marital relationship.

IV THE SUMMARY JUDGMENT MOTION

In support of their summary judgment motion, the defendants submitted the pleadings, the bill of particulars, the parties' deposition transcripts, relevant hospital and medical records, information sheets from Stryker, which manufactures prosthetic devices and implants for the hip, a 2016 United States Food and Drug Administration (FDA) recall notice concerning one of that manufacturer's prosthetic device, and a May 2018 FDA safety notice concerning that device and certain other devices. In addition, they submitted an attorney's affirmation and the affidavit of expert orthopedic surgeon Lee Rubin, M.D., who specializes in knee and hip replacement surgeries and has performed a significant number of those procedures. Dr. Rubin asserted that the orthopedic care provided by the defendants, the left total hip replacement performed by Macaulay, and all post-operative care that the defendants rendered were well within the standard of care. He averred that the initial hip replacement was indicated, based on the patient's complaints and symptoms of hip pain. Dr. Rubin further asserted that nothing

abnormal occurred during the performance of the surgery, that the surgery was performed reasonably with the use of FDA-approved implant devices, and that post-operative imaging confirmed that the devices were correctly placed and positioned. He concluded that the failure of the plaintiff's prosthetic had nothing to do with the performance of the surgery or placement of the prosthetic devices, but, rather, was due to an unforeseeable hardware failure.

More specifically, Dr. Rubin opined that, in light of the patient's active lifestyle and young age, Macaulay's choice of a dual mobility implant was appropriate and completely within reason. He explained that a standard implant consists of several component parts, particularly, a stem, a metal femoral ball that sits on top of the stem, an acetabular cup, and a plastic liner that fits into the acetabular cup. Dr. Rubin noted that a dual mobility prosthesis does not include a plastic liner in the acetabular cup, but that, instead, a smaller metal femoral ball is employed, and a plastic "shell" fits on top of the ball. He explained that, while the ball component in the dual mobility implant is smaller than the one used for the standard implant, since the plastic shell is attached to the outside, the overall circumference of the ball assembly is larger than the ball in the standard implant. Dr. Rubin asserted that dual mobility implants are FDA indicated for primary hip replacements. He concluded that the advantage of using a dual mobility implant is that it reduces the risk of dislocation with a posterior approach, as the larger ball assembly has to travel a longer distance in order to dislocate by coming out of the cup.

Dr. Rubin averred that the posterior approach that Macaulay utilized was entirely reasonable and within the standard of care, explaining that, while hip replacements can be performed employing either a posterior or anterior approach, the posterior approach was considered the historic standard of care, although, as currently recognized in the field of orthopedic surgery, the choice of one approach over another ultimately comes down to clinical judgment and the comfort of the surgeon. He thus concluded that it is not uncommon or a deviation from the standard of care for a surgeon to choose to utilize one approach rather than the other. He further opined that the use of dual mobility implant is associated with a

decreased risk of dislocation when, as done with the patient here, it is used in conjunction with a posterior approach.

According to Dr. Rubin, the plaintiffs' allegation that the defendants failed to obtain radiology studies, including an MRI, to identify malpositioning, thus ultimately delaying the patient's corrective revision surgery, is "factually untrue and completely contradicted by the medical records." As he explained it, following the initial October 21, 2015 surgery, a post-operative X-ray was performed that demonstrated the presence of "an anatomically situated total hip replacement." He noted that, in any event, the patient subsequently underwent follow-up X-rays at Hudson Valley Radiology Associates on February 11, 2016, approximately four months after the surgery, that again revealed a well-positioned hip replacement that was essentially unchanged from the X-rays taken immediately after the surgery. Dr. Rubin further commented that the patient did not return to see any orthopedic providers until more than one year later. Specifically, he noted that the patient saw Dr. Cooper on March 28, 2017, at which time new imaging revealed a well-fixed implant.

As Dr. Rubin explained it, the frequency of imaging that should be performed after a hip replacement is dependent on the complexity of the surgery itself, the clinical judgment of the treating surgeon, and the plaintiff's post-operative course. He opined that, for standard hip replacements such as that performed on the patient here, post-operative imaging is typically undertaken first at six weeks, then at one year, and then at five years after the surgery. Dr. Rubin thus concluded that the imaging ordered by the defendants was timely, entirely appropriate, and within the standard of care for a patient with no documented post-operative complaints.

Dr. Rubin further noted that, during the patient's Spring 2017 visits, neither Dr. Moucha nor Dr. Sculco memorialized that the prosthetic was improperly positioned. He further noted that Dr. Della Valle, who ultimately performed the revision surgery, documented in a June 5, 2017 note that the implant had good positioning and fixation. Dr. Rubin thus concluded that

"[t]here is unequivocally no evidence in the medical records or on the radiology studies that the acetabular cup was in an improper position prior to the revision surgery." He pointed out that the first and only mention of improper positioning was set forth in Dr. Della Valle's operative report, which he claimed was dictated by Dr. Della Valle's assistant, Dr. Christ. As Dr. Rubin characterized it, that report simply stated that the acetabular cup was overhanging the anterior wall and retroverted. Upon his own review of the October 2015 imaging of the initial hip replacement surgery, as well as Dr. Della Valle's report and imaging studies in connection with the revision surgery, Dr. Rubin concluded that the positioning of the acetabular component was absolutely reasonable, inasmuch as there was adequate seating of the implant, with good alignment, and because the implant was properly reamed, as evinced by the lack of evidence of gaps between the shell of the femoral head and the bone. Dr. Rubin further concluded that the abduction angle of the cup was appropriate and appeared to be appropriately positioned. Inasmuch as Dr. Rubin asserted that there was no objective documentation *prior* to the actual revision surgery that the prosthesis was malpositioned, he concluded that there was no evidence that the defendants failed promptly to diagnose any such malpositioning.

As Dr. Rubin more specifically explained, the overhang that was observed would not have resulted in, nor did it have anything to do with, the type of wear, "trunnionosis" corrosion, or prosthetic failure that the patient sustained, and had no bearing on the patient's ultimate need for revision surgery. He opined that the wear suffered by the patient was considered to be in the nature of "galvanic" mechanically associated crack corrosion, which leads to fretting of the metals and deposition of metallic components into the soft tissue from the prosthetic head-neck junction or trunnion. Dr. Rubin asserted that this corrosion had nothing to do with the cup position. He further asserted that lower cup angles are often preferred, inasmuch as a lateral lip that hangs down slightly can reduce the wear at the lateral edge of the cup. As Dr. Rubin phrased it, "[I] firmly believe that the plaintiff's condition would have required surgical revision because of the hardware itself regardless of the positioning of the prosthetic."

Dr. Rubin rejected the plaintiffs' contentions that the defendants failed to order blood work to detect metallosis is a seasonable fashion, failed to order an MRI, and failed to diagnose the patient's adverse local soft tissue reaction, metallosis or trunnionosis. He asserted that blood work was ordered by Dr. Cooper on March 28, 2017, and an MRI was performed on April 11, 2017. He explained that, in cases where a dual mobility, or metal-on-metal, implant is utilized, if a patient is complaining of pain and there is concern about possible trunnion wear, the first step is to obtain blood work to evaluate for metallosis, while ordering an MRI at that point in time is entirely based on clinical judgment. Dr. Rubin further explained that, if the blood work were positive for metallosis, and the patient also were complaining of pain and a lump, the standard of care would be to order an MRI only at that time. He thus opined that there was no indication for ordering blood work to test for metallois or for ordering an MRI at any time prior to 2017, as the patient made no complaints of pain or a lump to Macaulay during either of his post-operative visits to CDO on November 20, 2015 or February 16, 2016. Rather, as Dr. Rubin characterized it, such testing only became indicated when the patient finally returned to CDO on March 28, 2017, complaining of renewed hip pain, at which point Dr. Cooper timely and properly ordered the appropriate blood work and advised plaintiff to follow up in one week. He further asserted that Macaulay timely and appropriately performed an MRI scan on April 11, 2017.

With respect to the plaintiffs' claim that the patient suffered from metallosis, Dr. Rubin explained that accumulation of metal in the soft tissue due to the type of corrosion that the patient experienced "is incredibly subtle and can take years to become obvious." He further explained that patients with this type of corrosion and wear often do not begin experiencing symptoms until approximately 18 months after surgery, which he noted was approximately when the patient first reported his symptoms in this case. Dr. Rubin opined that, while blood cobalt levels above 1.0 µ/L are considered abnormal, levels less than 5.0 µ/L are not considered dangerous or warranting immediate intervention. He averred that no evidence of corrosion was

seen on the X-rays taken prior to plaintiff's revision surgery. Dr. Rubin thus concluded that, inasmuch as the patient's cobalt blood level at the time of his March 28, 2017 appointment with Dr. Cooper was 2.2 µ/L, the patient was in a low-risk group, and Macaulay's April 17, 2017 note that the situation was not drastic or dangerous for systemic cobalt toxicity was correct.

Dr. Rubin additionally rejected the plaintiff's allegations that the defendants failed to heed the patient's post-operative complaints of continued hip pain and dysfunction, and delayed the diagnosis and performance of the revision surgery. As he noted, the patient reported a pain level of 0/10 two days following surgery, made the same report while still admitted to Lawrence Hospital, and reiterated that report during his first follow-up visit on November 20, 2015. Dr. Rubin further noted that the patient reported no pain and had good range of motion on February 12, 2016, which was approximately three months after the surgery, while the patient made his first report of pain on March 28, 2017 to Dr. Cooper. Dr. Rubin opined that, on April 17, 2017, Macaulay performed a proper and timely evaluation and work up, which included a physical examination, palpation of the relevant area, and obtaining imaging showing a well-positioned implant. Dr. Rubin asserted that, at this point, Macaulay properly conferred with Dr. Cooper, who had assumed treatment of the plaintiff at DCO, and recommended revision surgery and documented a plan to contact Stryker about the possibility of a custom implant.

Dr. Rubin asserted that Macaulay, as well as Drs. Cooper, Moucha, and Sculco, all recommended revision surgery over a period of several months during Spring 2017, but that the patient actively chose not to heed those recommendations, instead delaying his treatment. He thus concluded that it was not the defendants' failures that engendered the patient's delay undergoing revision surgery.

Dr. Rubin also rejected, as unsupported, the patient's claims regarding leg-length discrepancy, since the patient had presented with a documented 4 mm discrepancy prior to the initial surgery, as Macaulay noted during the May 8, 2015 pre-operative visit.

Dr. Rubin attributed the patient's problems to a defective prosthetic device. As he noted, on August 29, 2016, Stryker initiated a voluntary recall of certain LFIT V40 femoral heads, citing to reports of "harm secondary to taper lock failure for specific lots." Dr. Rubin explained that the recall was applicable to various catalogue numbers manufactured prior to 2011, and that Stryker issued a subsequent safety notice in May 2018 that was related to LFITTM Anatomic CoCR V40TM Femoral Heads that had been manufactured before 2011. He interpreted the 2018 safety notice as reporting a higher-than-expected number of complaints related to stem dissociation, and indicated that he personally had begun observing patients with excessive wear at the trunnion or involving the taper at the femoral head-neck interface, thus causing metallosis. Inasmuch as the femoral head that Macaulay implanted in 2015 was not the subject of the recall or safety notice, Dr. Rubin concluded that Macaulay "had no reason to be concerned, nor was he shouldered with any additional responsibility under the applicable standard of care." Despite the fact that the particular implant employed by Macaulay was not the subject of a recall, Dr. Rubin nonetheless concluded that the recall of similar devices manufactured by Stryker

> "evidences a problem with the implant itself unrelated to Dr. Macaulay's medical care. In other words, the problem here was not with regard to the surgical technique or any actions of the surgeon, but rather hardware failure. Further, plaintiff's allegation that the prosthetic component was somehow inserted in a manner so as to result in metal wear and trunnionosis is absolutely, categorically false as it is not possible to insert a prosthetic in a way that would result in abnormal or excessive wear and trunnionosis. In other words, trunnionosis is not caused by the position of the prosthesis."

With respect to the qualitative sufficiency of the consent that the defendants obtained from the patient, Dr. Rubin reported that Macaulay had documented, in his medical records, that he had engaged in a discussion with the patient about the 1% to 2% risk of significant complications associated with the surgery. According to Dr. Rubin, Macaulay documented that the relevant risks, benefits, and alternatives were discussed at length, including the risk of hardware failure, dislocation/instability, periprosthetic fracture, component loosening,

component malposition, leg-length discrepancy, nerve/artery damage, and reactive bone formation/stiffness and infection. Dr. Rubin also referred to the patient's deposition testimony, in which he testified that he had a discussion with representatives from Lawrence Hospital for about 90 minutes regarding the risks of the surgery, and had remembered having reviewed and signed consent forms after each paragraph was explained to him

Ultimately, Dr. Rubin concluded that the patient's injuries were caused by hardware failure related to the engineering and manufacturing of the head-neck junction of the prosthesis that could not have been foreseen. Hence, he opined that none of the patient's injuries could be attributed to any of the defendants and that, even if the complication had been diagnosed earlier, the patient would have required the same revision surgery to remove faulty hardware.

In opposition to the motion, the plaintiffs relied upon the defendants' submissions, and also submitted the affidavit of an expert orthopedic surgeon with 30 years of experience. The expert opined that the defendants departed from good and accepted practice in performing the hip replacement surgery and in their post-operative care, and that these departures caused or contributed to the patient's injuries and need for revision surgery.

The plaintiffs' expert, quoting from the operative report of the August 24, 2017 revision surgery, described that procedure in great detail. The expert asserted that

> "[t]he procedure was performed under combined spinal epidural anesthesia. A review of the operative report from this surgery, indicates that during the surgery, significant inflammatory tissue was identified within the hip capsule, which was identified, excised and debrided by the surgical team. Once this was done, the hip was dislocated and the previously implanted prosthesis components were examined. The operative report indicates that during this examination, 'significant metal wear and trunnionosis was found on the stem, especially at the inferomedial aspect of the trunnion.' The decision was made to remove the stem, which was subsequently loosened and extracted without causing any fractures. Attention was then turned to the cup (the acetabular component of the prosthesis). Copious amounts of fibrotic and inflammatory tissue were debrided from around the edge of the cup and sent to pathology. With a better view of the acetabulum after this was performed, the cup was exposed and evaluated. The operative report indicates that the cup '*was extremely prominent laterally, overhanging over the anterior wall and grossly retroverted. However, it was well fixed. Given the cup's malposition, the decision was made to revise it.*' The cup was extracted, the acetabulum was irrigated, and the socket was reamed to a

> size 60, before a 60-mm Trilogy acetabular cup was the impacted into the acetabulum without complication. Using an Intellijoint camera and system, the cup was placed into the acetabulum with 44 degrees of inclination and 19 degrees of anteversion. A 6.5 x 30 mm acetabular cancellous self-tapping screw was placed, for additional fixation of this component. The acetabulum was then suctioned and debrided, and the liner for a 36-mm head with 3.5-mm of offset was then placed. After removal of the Intellijoint system, attention was then turned towards revision of the femoral component."

(emphasis added).

The plaintiffs' expert asserted that Macaulay placed the acetabular component, or cup, of the Stryker cementless total hip replacement system at an excessively lateral and retroverted angle, considering the larger-diameter femoral head that Macauley chose to use in the dual mobility system that he employed. According to the expert, this created excessive torsional forces at the head-neck junction of the implant, which caused the trunnionosis that led to the patient's post-operative complaints of pain and adverse local tissue reaction (ALTR), including formation of a pseudotumor in the left hip, all of which necessitated the surgical revision of the left total hip replacement. As the expert opined, the improper angle at which the cup was placed by Macaulay during the initial surgery was an error in surgical technique that constituted a departure from good and accepted medical and surgical practice, and was a substantial factor in causing the patient's injuries.

The plaintiffs' expert described the particulars of hip replacement surgery, asserting that, during the surgery, a surgeon removes the damaged sections of the hip joint and replaces them with prostheses constructed from various materials, including different types of metal. According to the expert, the prosthetic device that Macaulay employed was a Stryker cementless, metal-on-metal hip replacement system, which included a titanium femoral component (the stem), a separate metal ball made of a cobalt-chromium alloy (the trunnion) that is seated on top of the stem to form a new femoral head, and a titanium acetabular component (the cup), with a polyethylene shell that fits on top of the ball. The expert continued that the plastic shell prevents the trunnion from articulating directly against the metal cup, while the

trunnion is seated directly on top of the stem, forming a taper that exits the top of the femur. Hence, the expert asserted that the system that Macaulay employed involved metal-on-metal articulation. The expert agreed with Dr. Rubin that, inasmuch as Macaulay elected to employ the dual mobility version of this system, the diameter of the femoral head is effectively increased, making it more difficult for the head to be dislocated from the cup, thus providing maximal range of motion. Nonetheless, because this system involves metal-on-metal articulation, the expert opined that the danger of a patient potentially developing trunnionosis, which the expert described as a form of metallosis arising from wear and corrosion of the femoral head-neck interface in a system, has been widely reported and examined in the medical literature. As the expert phrased it, "[c]ontributing factors that have been postulated as causes for trunnionosis, include wear between metal-on-metal modular junctions, corrosion, fretting damages, and the release of metal ions or particulate debris from affected components."

The plaintiffs' expert, citing to peer-reviewed medical literature addressing the size and nature of prosthetic devices for the hip, asserted that this literature indicated that the use of larger-diameter femoral heads causes an increase in the effective horizonal lever arm, thus exerting greater torsional forces at the head-neck junction of the implant, that, in turn, exacerbate the wear at this aspect of the implant system. Thus, the expert concluded that it is

> "imperative for a surgeon placing such a hip prosthesis, to place the cup component at an angle that is both tailored for the patient's anatomy and usual activities, and also considerate of the size of the femoral head being used in the system, to minimize the risk that excessive and avoidable torsion will cause unnecessary wear on the metal components, leading to trunnionosis in the patient."

According to the plaintiffs' expert, if the angle of the cup is placed improperly, the head-neck junction of the prosthesis may articulate against the rim of the cup with enough torsion and force being exerted to cause metallosis to occur in the patient, as the head-neck junction experiences excessive and avoidable wear from increased friction. The plaintiffs' expert concluded that this was exactly what happened in this case, noting that Dr. Della Valle's operative report of the

August 24, 2017 revision surgery confirmed that, when the stem and trunnion that Macaulay had placed were examined, "significant metal wear and trunnionosis was found on the stem, especially at the inferomedial aspect of the trunnion." The expert continued that the fact that more wear was noted at one specific aspect of the trunnion "is a classic sign consistent with a femoral head and neck that were continually scraping against the rim of the cup at an improper angle that exerted an excessive amount of torsion on the edge of the cup component of the prosthesis." The expert further explained that, in light of the "copious amounts of further fibrotic and inflammatory tissue" that needed to be "debrided from around the edge of the cup," and the presence of a pseudotumor, he was convinced that the patient suffered from ALTR secondary to trunnionosis. The expert went on to opine that it was proper for Dr. Della Valle to re-ream the patient's left acetabulum to a larger size that he felt was more appropriate to the patient's anatomy, and to implant a larger sized cup.

The plaintiffs' expert asserted that Dr. Della Valle's operative reported confirmed that Macaulay had placed the cup component at an incorrect angle, specifically, that it was placed too prominent laterally, and that it was also grossly retroverted, meaning that it was tilted too far toward the patient's posterior. The expert further asserted that, although the cup was indeed malpositioned, it was not unusual that the malpositioning was not visible on any of the imaging studies undertaken after the initial surgery. As the plaintiffs' expert explained it, "[w]hile improperly positioned prosthetic components can sometimes be visualized on radiologic imaging like X-rays, this is not always the case." The expert cited Macaulay's own deposition testimony, in which he testified that there is no way to perfectly determine the angle of the acetabular component by viewing a post-operative X-ray, "considering the anatomic shape of the shell, which is not symmetrical." Rather, according to the plaintiffs' expert, operative findings like the ones found by Dr. Della Valle during his revision surgery constitute objective signs that provide an evaluation of the positioning of a cup in a system like the one implanted into the patient's hip that is superior to radiologic imaging, "which is a modality that can

only provide so much information."

The plaintiffs' expert asserted that there was no evidence in the record supporting the notion that the cup shifted inside the patient's anatomy following the initial surgery, as Dr. Della Valle noted that the cup was "well fixed" into place at the time he found it malpositioned, Macaulay testified at his deposition that he had "never seen" a cup shift after he pressed it into place during a procedure such as the one he performed on the patient, and the series of X-rays following the initial surgery did not demonstrate any shift of the positioning of the cup.

The plaintiffs' expert thus concluded that the malpositioning of the prosthetic system constituted a departure from the standard of care, and was a substantial factor in causing the patient's injuries. The expert asserted that it was uncontroverted that the sole source of the cobalt-chromium alloy that caused the patient's metallosis and ALTR, necessitating the revision surgery and physical therapy, was the trunnion placed during Macaulay's procedure. As the expert characterized it,

> "[t]he wear that Dr. Gonzalez Della Valle noted on the trunnion when he removed it, which was noted especially at the inferomedial aspect of the trunnion, is a classic sign of a trunnion that was scraping along the rim of the cup component with excessive torsional force, which led directly to the trunnionosis suffered by Mr. Miretsky. Indeed, had the cup component been placed at a proper angle in light of the size of the femoral head used in this system, this trunnionosis and its sequelae could have been avoided entirely by Mr. Miretsky."

With respect to the defendants' contention that the trunnionosis that the patient sustained was caused by a defective product, the plaintiffs' expert asserted that there is no evidence supporting this theory. The expert noted that the prosthetic system that Macaulay employed was not actually a part of either of the FDA Class Device Recalls that Dr. Rubin "inexplicably brings up" in his affidavit, as the FDA recalls that Dr. Rubin cited "were irrelevant to the actual system placed in Mr. Miretsky by Dr. Macaulay in this case." The expert expressly rejected Dr. Rubin's opinion that the "plaintiff's allegation that the prosthetic component was somehow inserted in a manner so as to result in metal wear and trunnionosis is absolutely, categorically false as it is not possible to insert a prosthetic in a way that would result in

abnormal or excessive wear and trunnionosis," in light of the fact that that opinion disregarded Dr. Della Valle's operative findings in connection with the revision surgery, which found wear "consistent with components that were placed at an angle which subjected them to excessive torsional forces." The expert averred that Dr. Rubin's opinion defied basic physics, inasmuch as an improperly placed cup can transform the rim or edge of the cup into a "fulcrum," and the head-neck junction into a "lever," over which torsional forces can and are known to exert excessive friction on the head-neck junction, leading to trunnionosis. The expert thus rejected Dr. Rubin's opinion that trunnionosis cannot be caused by the positioning of the prosthesis.

Finally, the plaintiffs' expert disagreed with Dr. Rubin's conclusion that the wear in this case "is considered galvanic mechanically associated crack corrosion, which has nothing to do with the cup position." As the plaintiffs' expert described it, galvanic corrosion is corrosion caused by an electrochemical transfer of electrons between dissimilar metals. The expert dismissed this conclusion as a "convenient reading of the facts of this matter, and it ignores the operative findings by Dr. Gonzalez Della Valle of wear on the trunnion, 'especially at the inferomedial aspect of the trunnion' which is consistent with friction caused by a malpositioned cup component." The expert thus opined that the patient's trunnionosis was caused by "Fretting Corrosion," which he characterized as "corrosion from relative micromotion between the two metals in the prosthesis," that caused "exactly the type of wear that Dr. Gonzalez Della Valle detected during his revision surgery."

The plaintiffs' expert did not address whether the defendants departed from good and accepted post-operative care, as the expert did not comment upon the nature or propriety of the frequency of blood and radiologic testing that the patient underwent in 2016 and 2017. Nor did the expert address the qualitative sufficiency of the consent that the defendants obtained from the patient.

In reply, the defendants submitted an attorney's affirmation, along with two articles from medical journals. In his affirmation, counsel challenged the qualification of the plaintiffs' expert

because the expert did not indicate that he had ever employed the particular Stryker implant that Macaulay employed on the patient. He further referred to the expert as a "so-called" expert. Counsel further reiterated Dr. Rubin's conclusion that the placement of the prosthesis had nothing to do with the injuries sustained by the patient. Counsel also characterized the articles relied upon by the plaintiffs' expert as irrelevant to whether the mispositioning of a cup can cause trunnionosis, and described the articles as addressing only other factors that could lead to the type of "debris release" that causes trunnionosis, such as the design and characteristics of various implant systems, the smoothness or ridged nature of trunnion surfaces, and the size of the femoral head, but not the positioning of the acetabular cup and whether malpositioning can cause wear and debris release. The defendants' counsel quoted from one of the articles relied upon by the plaintiffs' expert, in which the authors concluded that "[n]o significant relationship was identified between cup inclination or anteversion and taper wear. This was consistent with the lack of correlation between surface wear and taper wear." According to the defendants' counsel, the article "presents clear scientific data that fully contradicts the plaintiffs' expert's opinion, and which supports the correct conclusion of defendants' expert, Dr. Rubin, that acetabular cup positioning does not cause taper junction failure and trunnionosis." Counsel further asserted that, in another one of the articles relied upon by the plaintiffs' expert, the authors did indeed look into torsional forces, and wrote that

> "[a]n explanation for the damage observed at the modular junctions of large diameter hip systems could be the increased frictional torque that is generated by the bearing surfaces . . . However, we can offer no physical evidence of a force from *this series* of M[etal-o[n-]M[etal] explants"

(emphasis added).

The defendants' attorney also argued that, inasmuch as the plaintiffs' expert did not address the qualitative sufficiency of the consent given by the patient, the defendants should be awarded summary judgment dismissing that cause of action.

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 plaintiffs' expert orthopedic surgeon was executed Kansas, 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. MEDICAL MALPRACTICE BASED ON DEPARTURE FROM GOOD AND ACCEPTED STANDARDS

"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]).

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).

Based on Dr. Rubin's affidavit, the defendants made a prima facie showing that Macaulay did not depart from good and accepted medical practice in connection with the positioning of the acetabular cup and that the manner in which the cup was positioned did not cause or contribute to the patient's trunnionosis or metallosis. Dr. Rubin explicitly averred that the acetabular cup was properly placed, that imaging did not depict any malpositioning, and that the patient did not complain of any pain or discomfort for approximately 17 months after the initial surgery, thus warranting the inference that there was some other cause of the patient's maladies. The defendants did not, however, establish that the Stryker prosthetic system that Macaulay employed was defectively designed or that such a defect caused or contributed to those medical conditions. Rather, Dr. Rubin's opinion in this regard was speculative and based only on the fact that other, similar devices that Stryker manufactured during the relevant time period were the subject of FDA recalls and safety notices. Dr. Rubin's affidavit did, however, make a prima facie showing that Macaulay and other CDO physicians provided proper post-

operative care to the patient, in that they immediately undertook all necessary blood and radiologic testing in 2017 when they first were presented with the patient's complaints.

In opposition to that showing, the plaintiffs raised a triable issue of fact as to whether Macaulay departed from good and accepted practice by malpositioning the acetabular cup, and whether that departure cause or contributed to the patient's trunnionosis and metallosis which, in turn, necessitated revision surgery. The plaintiffs' expert explicitly stated that Macaulay malpositioned the cup, and that this malpositioning created torsional forces that wore down the cobalt-chromium alloy in the prosthetic device, thus leading to trunnionosis and metallosis.

This case presents the classic situation in which two experts explicitly disagree on whether a physician properly performed a type of orthopedic surgery and whether, if the surgery were in fact improperly performed, the surgery itself caused a later injury. It is of no moment that the plaintiffs' expert never implanted the specific Stryker prosthetic system into a patient. The expert is board certified in orthopedic surgery, and averred to having had performed approximately 1,250 hip replacement surgeries. The plaintiffs' expert and Macaulay practice in the same field of medicine, are licensed to perform the same types of surgeries, and actually perform the same types of surgeries, one of which is the subject of this action. The plaintiffs' expert is thus qualified to submit an affidavit opining on the appropriate standard of care, whether Macaulay breached it, and whether that breach was the proximate cause of the patient's injuries (*see generally Escobar v Allen*, 5 AD3d 242, 243 [1st Dept 2004]).

Moreover, the defendants incorrectly characterize the articles cited by the plaintiffs' expert for the proposition that certain physical attributes of a prosthetic device cause a wearing down of the constituent metals and consequent trunnionosis and metallosis. Contrary to the defendants' contention, those article do not "disprove" the contention that the mispositioning of an acetabular cup creates torsional forces that leads to the same type of metallic wear as other causes. In those articles, the authors simply stated that, in their case studies, they did not find such a correlation, not that it was impossible to establish such correlation or causation or that

the plaintiffs' theory must be ruled out in every case. "The logical fallacy here is so blatant as to hardly require explication: the absence of evidence is not the evidence of absence" (*Walter v Blaine*, 60 Misc 3d 1210[A], 2017 NY Slip Op 52008, *14, 2017 Misc LEXIS 5447, *42 [Sup Ct, Rensselaer County, Mar. 29, 2017]). In any event, the plaintiffs' expert provided his or her own expert opinion, based on 30 years of experience and 1,250 procedures, that torsional forces of malpositioned cups do indeed cause metallic wear, with concomitant trunnionosis and metallosis. The plaintiffs' expert further noted that there is no dispute that the acetabular cup never shifted inside the patient's body, and cited to Dr. Della Valle's post-operative report in connection with the revision surgery, in which the latter expressly observed malpositioning of the cup.

The plaintiffs' expert, however, did not address the sufficiency of the post-operative care rendered to the patient by Macaulay and other CDO physicians.

In light of the foregoing, that branch of the defendants' motion seeking summary judgment dismissing the medical malpractice cause of action against Macaulay must be granted to the extent of dismissing so much of that cause of action as is premised upon departures from good practice occurring during post-operative care, and that branch of the motion must otherwise be denied.

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]).

In opposition to the defendants' prima facie showing that the consent that Macaulay obtained to perform the hip replacement surgery on the patient was qualitatively sufficient, the plaintiffs did not address that issue. Hence, the plaintiffs failed to raise a triable issue of fact, and Macaulay must be awarded summary judgment dismissing the lack of informed consent cause of action insofar as asserted against him.

C. 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]). 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 Macaulay committed malpractice by malpositioning the acetabular cup, it also concludes that both CDO and the defendants Columbia University Medical Center and New York and Presbyterian Hospital, as his joint employers, may be held vicariously liable for that malpractice. Hence, summary judgment is awarded to those defendants only to the extent that this court is awarding summary judgment to Macaulay, that is, to the extent of dismissing so much of the medical malpractice cause of action as was premised upon post-operative care and the lack of informed consent

cause of action insofar as asserted against them. The motion is otherwise denied as to those defendants.

VI CONCLUSION

In light of the foregoing, it is

ORDERED that the defendants' motion is granted only to the extent that they are awarded summary judgment dismissing (a) so much of the medical malpractice cause of action as was premised upon alleged departures from good and accepted care purported committed during the course of post-operative care referable to the initial hip replacement surgery and (b) the lack of informed consent cause of action, and the motion is otherwise denied; and it is further,

ORDERED that the parties shall appear for a pre-trial conference on July 27, 2023, at 9:00 a.m.

This constitutes the Decision and Order of the court.

6/7/2023
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