SUPREME COURT OF THE STATE OF NEW YORK

COUNTY OF RICHMOND

----------x

MADELINE BUONPANE,

Plaintiff,

-against-

ANTHONY ALASTRA, M.D., JOHN REILLY, M.D.,

HEALTHCARE ASSOCIATES IN MEDICINE, P.C. and

STATEN ISLAND UNIVERSITY HOSPITAL

Defendants.

----------x

IAS PART 1

Present:

HON. CHARLES M. TROIA

DECISION and ORDER

Index No. 152289/2019

Motion Sequence 001

The following papers numbered 1 to 3 were marked fully submitted on the 10th day of March 2023:

Notice of Motion by Defendants, ANTHONY ALASTRA, M.D. and HEALTHCARE ASSOCIATES IN MEDICINE, P.C. with Supporting Papers and Exhibits.....1

Affirmation in Opposition by Plaintiff with Supporting Papers and Exhibits.....2

Defendants' Affirmation in Reply.....3

In this alleged medical malpractice action, the defendants, ANTHONY ALASTRA, M.D. (hereinafter "Alastra") and HEALTHCARE ASSOCIATES IN MEDICINE, P.C. (hereinafter "HCA") move for an order, pursuant to Rule 3212, granting partial summary judgment and dismissing those claims and allegations as to which there are no triable issues of fact; and for such other relief as this court deems just and proper. Defendants have limited their request for relief from claims pertaining to treatment rendered prior to May 30, 2017, and from claims pertaining to a delayed diagnosis and treatment of cauda equina syndrome (CES). The summary judgment motion made on behalf of JOHN REILLY, M.D. was granted, without opposition, by a separate Order dated March 10, 2023 (NYSCEF Doc. No. 97).

Defendants support their motion, inter alia, with the expert affirmation of Jeffrey Degen, M.D., a physician duly licensed to practice medicine in New York and New Jersey and who is board certified in neurological surgery.

Plaintiff opposes defendants' summary judgment motion and has submitted, inter alia, an expert affidavit (name redacted) of a physician duly licensed to practice medicine in Illinois and Indiana and who is board certified in orthopedic surgery.

Upon the foregoing papers, defendants' motion is granted with respect to the plaintiff's claims stemming from treatment rendered prior to May 30, 2017, and claims pertaining to a delayed diagnosis and treatment of cauda equina syndrome (CES). Claims for lack of informed consent and the negligent performance of surgery continue. The court's decision is outlined below.

FACTS

Plaintiff began treating with co-defendant orthopedic surgeon John Reilly, M.D. at Healthcare Associates in Medicine, P.C., in 2003. In 2012, Ms. Buonpane presented to the office with pain in her left hip, which was subsequently treated with a total hip replacement. On January 13, 2015, Ms. Buonpane consulted co-defendant neurosurgeon, Anthony Alastra, M.D., for lower back pain. She was referred by codefendant, John Reilly, M.D., for consideration of surgical intervention after having failed conservative therapy.

On March 27, 2015, Dr. Alastra performed a decompressive lumbar laminectomy with L4-L5 and L5-S1 discectomies at SIUH due to the plaintiff's history of back pain, neurogenic claudication, and paresthesia down the legs, especially the left leg. Thereafter, Ms. Buonpane continued to treat with Dr. Alastra and Dr. Reilly during 2015 and 2017.

On April 23, 2017, EMS responded to a 911 call and found Ms. Buonpane sitting on her couch screaming in pain. She reported that she had woken up with lower left back pain which had worsened throughout the day to the point where she could barely move. She stated the pain was "worse than giving birth." An exam revealed left and right sided lower back pain, 10/10, radiating to the left leg. Ms. Buonpane denied oxygen treatment and a stretcher, and stated she felt better sitting on her own. She was transferred to SIUH.

At approximately 5:21 p.m. on April 23, 2017, Mrs. Buonpane presented to the SIUH ED via FDNY ambulance with a chief complaint of left flank pain. At approximately 5:30 p.m., treatment was initiated by the ED attending, Dr. Joshua D. Greenstein, and Will Panzo, P.A. Mr. Panzo documented that Mrs. Buonpane was a 62-year-old female who presented from home with left flank pain for one day. She reported her pain was severe, intermittent, and localized to the left side of her lower back/flank with radiation to the left leg. A review of systems revealed complaints of flank pain and back pain and was otherwise unremarkable. Mr. Panzo performed a physical examination which revealed that Ms. Buonpane was a well-developed, elderly female complaining of discomfort due to left flank pain. Her neurological examination was otherwise grossly unremarkable.

Dr. Greenstein performed an evaluation of Ms. Buonpane and documented that she presented with complaints of left flank pain since the day before. Her pain was severe, intermittent, and located to the left lower back that radiated to her legs. She had a history of incontinence as baseline. On exam, she was screaming in a chair. Her abdomen was noted to be obese, soft, non-tender and non-distended. A urinalysis was without hematuria. Dr. Greenstein ordered an abdominal CT with contrast, lab work, additional pain medication (IV Morphine and Dilaudid) and IV fluids. Ms. Buonpane had an elevated lactate level and an elevated white blood cell count. The impression of the CT scan was no acute intra-

abdominal pathology. The plaintiff was admitted to Dr. Seth Brum's service at 10:55 p.m. on April 23, 2017. The admitting diagnosis was intractable abdominal pain.

The CT of the lumbar spine, performed on April 23, 2017, revealed moderate lumbar levoscoliosis with multilevel degenerative changes producing varying degrees of spinal canal and neural foraminal stenosis. The spinal stenosis at L2-3, L3-4 and L4-5 was most likely moderate to severe, due to the disc bulging with associated endplate spurring. At the L5-S1 level, there was a bony spur impinging the left lateral recess and proximal foramen and facet arthropathy, left greater than right. An MRI was recommended for better evaluation. According to a handwritten note on the radiology report, Ms. Buonpane was going to be discharged home to undergo an outpatient open MRI because she was unable to tolerate a closed machine.

On April 25, 2017, a resident documented Ms. Buonpane continued to feel better with ambulation with a walker and she had no decrease in sensation while wiping when going to the bathroom. Dr. Alastra evaluated Ms. Buonpane on April 25, 2017, and documented that he previously performed a decompression laminectomy on March 27, 2015 and that she was last seen in his office in March 2016. The note details that Ms. Buonpane had chronic lower back pain and lower extremity numbness, and the CT obtained on April 23rd revealed degenerative changes of the spine. Dr. Alastra noted that Ms. Buonpane felt better and requested an open MRI. Dr. Alastra cleared her for discharge on April 26, 2017, and ordered an open MRI to be done as an outpatient. The discharge summary documents that Ms. Buonpane refused the MRI in the hospital and would follow for the open MRI as an outpatient. On discharge, her symptoms had improved with pain control, she ambulated with pain control, and she was instructed to follow-up with her neurosurgeon as an outpatient.

On May 2, 2017, accompanied by her husband, Ms. Buonpane presented to HCA and saw Irina Richardson, PA. She had not been seen in the office since 2016. Ms. Buonpane reported that she had lower back pain subsequent to the March 2015 decompression procedure, but it was tolerable. She was status-post a four-day hospitalization at SIUH for low back pain. Initially, her pain traveled across her lower back, but at the time of this visit, her pain was mostly left-sided. The pain was not as severe as it had been two weeks before, but it still limited her activities and required the use of a walker at home. She reported weakness and occasional electric-like shooting pain down her legs, but her back pain was the most bothersome. She denied bladder or bowel incontinence. Motrin and Robaxin provided some pain relief.

On exam, Ms. Buonpane was in moderate distress. She had pain on palpation of her left paraspinal musculature, which was exacerbated with flexion and left lateral rotation. Her lower extremity strength was intact. She walked with an antalgic gait and required assistance from her husband. P.A. Richardson's assessment was low back pain, other intervertebral disc degeneration in the lumbar region, spondylosis without myelopathy or radiculopathy in the lumbar region and muscle spasm of the back. P.A. Richardson believed that her symptoms were likely musculoskeletal in nature. She recommended following-up with pain management for lumbar trigger point injections, to which Ms. Buonpane agreed. P.A. Richardson prescribed a Medrol Dosepak and lidocaine ointment and instructed her to stop taking Motrin. Flexion-extension x-rays of the lumbar spine were recommended to rule out instability. Ms. Buonpane was instructed to return in four weeks.

On May 11, 2017, Ms. Buonpane presented to Dr. Reilly for a follow-up visit. Steroids provided moderate relief, but she continued to have weakness in the left leg and was using a walker. X-rays revealed severe degenerative changes at L5-S1 and L4-5. Ibuprofen helped her knee pain. She had good motion

with both legs, but positive straight leg test on the left. She had a follow-up appointment with Dr. Alastra, who noted a fusion may be considered. Dr. Reilly instructed Ms. Buonpane to return in six weeks and recommended physical therapy.

On May 23, 2017, P.A. Richardson documented that she received a phone call from Ms. Buonpane's primary care physician, Dr. Racco, who advised that Ms. Buonpane followed-up in his office and complained of left leg weakness and urinary incontinence. P.A. Richardson documented that Ms. Buonpane must be seen in the emergency department to rule out cauda equina syndrome. At about 3:00 p.m., PA-C Richardson spoke with Ms. Buonpane, who refused to go to the hospital because Dr. Alastra was out of town and claimed she did not trust any other neurosurgeons. She also stated that she would not undergo an MRI at the hospital, due to claustrophobia. P.A. Richardson explained to Ms. Buonpane that her symptoms were worrisome and that an MRI of the lumbar spine, with and without contrast, was needed Stat. It would be arranged at Stand-Up MRI, once she was approved. Ms. Buonpane was advised that if her symptoms became worse, she should go to the emergency department immediately. It was noted that Ms. Buonpane was very upset on the phone and was crying much of the time. P.A. Richardson sent a message to Dr. Reilly regarding Ms. Buonpane's condition.

On May 30, 2017, Ms. Buonpane presented to Dr. Alastra, accompanied by her husband. She reported significant lower back pain with left lower extremity radiculopathy due to severe progression of her lumbar spondylosis, especially at the L4-L5 and L5-S1 regions. She continued to use a walker and had difficulty ambulating. A repeat MRI, performed on April 29th revealed severe continued degeneration across the L2-3 and L3-4, as well as progressive continued collapse at L4-L5 and L5-S1, with significant stenosis and left foraminal narrowing. Dr. Alastra noted there was a questionable difficulty with urination due to severe stenosis at L4-L5 and L5-S1. The flexion-extension x-rays revealed no instability. Dr. Alastra documented that it appeared her progressive arthritic condition was not amenable to simple decompression surgery. Given the progression of her symptoms and neurologic compromise, a discussion was held regarding the surgical options, including a fusion and full decompression of the region in the form of a two-level direct lateral interbody fusion at L2-3 and L3-4 and a transforaminal lumbar interbody fusion of L4-L5 and L5-S1. A posterior pedicle screw fixation from L2-S1 was also contemplated to treat the arthritic condition. Dr. Alastra testified that Ms. Buonpane did not have urinary incontinence or retention during the visit and therefore did not have a structural cauda equina compression. Ms. Buonpane understood that she would continue to have a modicum of lower back pain even with surgical intervention. Future spinal stimulation treatment could be warranted. Dr. Alastra noted that he had a long discussion regarding the risks and benefits and answered all of the plaintiff's questions. She wished to proceed as planned.

The surgery was initially scheduled for July 7, 2017. On June 5, 2017, Ms. Buonpane called Dr. Alastra's office stating that she could not wait until July 7th for surgery because she could barely walk, and her pain was becoming worse. Her surgery was advanced to June 28, 2018, as a result.

On June 28, 2017, Dr. Alastra performed an L2-L3 and L3-L4 indirect decompression discectomy via a direct lateral interbody fusion technique; posterior decompressive laminectomy left side with medial facetectomy, foraminotomy and discectomy with transforaminal lumbar interbody fusion technique, L4-L5, L5-S1; posterior pedicle fixation L2, L3, L4, L5, S1; SSEP, EMG and pedicle screw stimulation. According to the operative report, Ms. Buonpane had back pain and a progressive worsening weakness in the lower extremities, especially on the left side with severe left lower extremity radiculopathy. She also had

difficulty ambulating. Due to her severe degenerative spondylosis above the level of the surgical decompression, a four-level decompression and fusion was required. The pre- and post-operative diagnoses were left lower extremity weakness and radiculopathy secondary to severe lumbar spondylosis, stenosis, and degenerative disc disease.

The SIUH chart reflects that, postoperatively, the plaintiff had an overall improvement of her pain and left lower extremity strength after the surgery, although she continued to have some numbness and pain in the left leg. By post-op day 6 (July 4), she was able to stand on her own and move around in her chair. Per the hospital record, she had improved motor strength distally in lower left leg and ankle. On post-op day 8 (July 6), she was discharged to the rehab floor where her medical course was complicated by fever, an elevated white count, and some drainage from the left paraspinal incision. She underwent a fever workup and an MRI and CT scan of the lumbar spine. She was found to have a urinary tract infection and enterococcus bacteremia (a bacterial infection of the blood), for which she was started on IV antibiotics. The MRI revealed a subcutaneous fluid collection in the paraspinal area, without extension of fluid into the operative site.

On July 12, 2017, Ms. Buonpane was transferred to the neurosurgical floor for a surgical washout and debridement of the lumbar wound by Dr. Alastra. During the surgery, Dr. Alastra encountered a mixture of old blood and purulent fluid, which he irrigated away and cultured. On July 18, 2017, the plaintiff was discharged to the rehab unit. During her two-week rehab stay, she completed a course of antibiotics and had a successful voiding trial, resulting in her Foley catheter being removed. At the time of her discharge on August 1, 2017, her motor strength was graded as 4+ of 5 in the right lower extremity, except for right hip flexion, which was 4-. In the left lower extremity, motor strength was 2 - 3 in left hip flexion, 4 in the left quadriceps, and 4- in dorsiflexion.

DISCUSSION

Summary judgment is a drastic remedy that deprives litigants of their day in court, and it "should only be employed when there is no doubt as to the absence of triable issues." *Andre v Pomeroy*, 35 NY2d 361 (1974); *Bonaventura v Galpin*, 119 AD3d 625 (2d Dept 2014); *Stukas v Streiter*, 83 AD3d 18 (2d Dept 2011). The function of the court on a motion for summary judgment is not to resolve issues of fact or to determine matters of credibility, but merely determine whether such issues exist. *Guadalupe v New York City Tr. Auth.*, 91 AD3d 716 (2d Dept 2012); *Kolivas v Kirchoff*, 14 AD3d 493 (2d Dept 2005). Importantly, in determining a motion for summary judgment, evidence must be viewed in the light most favorable to the nonmoving party. *Pearson v Dix McBride, LLC*, 63 AD3d 895 (2d Dept 2009). The proponent of a summary judgment motion is required to tender sufficient evidence to demonstrate the absence of any material issues of fact, and the failure to do so requires denial of the motion regardless of the sufficiency of the opposing papers. *Alvarez v Prospect Hosp.*, 68 NY2d 320 (1986).

A physician moving for summary judgment dismissing a complaint alleging medical malpractice must establish, *prima facie*, either that there was no departure from accepted standards of medical care or that any departure was not a proximate cause of plaintiff's injuries. *Mackauer v Parikh*, 148 AD3d 873 (2d Dept 2017); *Stukas v Streiter*, 83 AD3d 18 (2d Dept 2011). To sustain this burden, the defendant must address and rebut any specific allegations of malpractice set forth in the plaintiff's bill of particulars. *Mackauer v Parikh*, 148 AD3d 873 (2d Dept 2017); *Schwartzberg v Huntington Hospital*, 163 AD3d 736 (2d Dept 2018). Once the showing has been made, the burden shifts to the plaintiff to submit evidentiary facts

or materials to rebut the defendant's *prima facie* showing, but only as to those elements on which the defendant met the *prima facie* burden (*see Mackauer*; *Schwartzberg*).

The defendants have satisfied their burden and have established their *prima facie* entitlement to summary judgment regarding the plaintiff's claims pertaining to treatment rendered prior to May 30, 2017, and claims pertaining to a delayed diagnosis and treatment of cauda equina syndrome. Upon this showing, the burden shifted to the plaintiff to submit evidentiary facts or materials to rebut the defendant's *prima facie* showing. The plaintiff has failed to do so.

Plaintiff and her expert have not raised any triable issue of fact with respect to the treatment and care rendered by the defendants prior to May 30, 2017. The events preceding May 30, 2017, were discussed and analyzed in detail by defendants' expert, Dr. Degen, who opined that: Dr. Alastra (and by extension, HCA) comported with accepted standards of care during plaintiff's admission to SIUH from April 23, 2017 through April 26, 2017; Dr. Alastra and PA Irina Richardson (and by extension, HCA) met the standard of care during plaintiff's office visit of May 2, 2017, in that (1) it was reasonable for Dr. Alastra and P.A. Richardson to believe that plaintiff's recent exacerbation in pain was musculoskeletal in nature and (2) there was no neurosurgical emergency or reason to send plaintiff to the hospital; and, P.A. Richardson (and by extension, Dr. Alastra and HCA) met the standard of care and provided appropriate instructions/counseling to plaintiff on May 23, 2017 with regard to her acute left lower extremity weakness and urinary incontinence, her need to go to the hospital to rule out cauda equina syndrome, and her need for a stat MRI. Neither plaintiff's counsel nor her expert opposed or even addressed Dr. Degen's opinions as noted above. The plaintiff's orthopedic surgery expert states that Dr. Alastra and HCA deviated from accepted standards of care beginning May 30, 2017. A party is deemed to abandon or concede points not opposed or addressed on a motion. See *Josephson LLC v Column Fin., Inc.*, 94 AD3d 479 (1st Dept 2012) ("Plaintiffs abandoned their remaining claims by failing to oppose the parts of defendants' motion that sought summary judgment dismissing those claims"). See also *Elstein v Hammer*, 192 AD3d 1075 (2d Dept 2021). As such, Dr. Alastra and HCA are entitled to partial summary judgment dismissing all claims of malpractice pre-dating May 30, 2017.

Significantly, plaintiff's expert fails to address the events of May 23, 2017, at which time plaintiff developed acute urinary incontinence and left lower extremity weakness. As recounted in Dr. Degen's affirmation and in the HCA record, both plaintiff's primary doctor (Dr. Racco) and P.A. Irina Richardson urged plaintiff to go to the Emergency Room to obtain a stat MRI and to rule out CES, but the plaintiff refused. Based upon the foregoing facts, which are wholly ignored by the plaintiff's expert, Dr. Degen concluded that the acute onset of CES occurred on May 23, 2017 and that the plaintiff, by refusing to go to the hospital, deprived herself of the opportunity of undergoing surgery during the window of time when it potentially could have been curative.

Plaintiff's expert's failure to acknowledge the events of May 23, 2017, is a significant omission, particularly given his emphasis on the importance of rapid diagnosis and surgical intervention within 48 hours of the onset of CES symptoms.

In addition, plaintiff's expert failed to address Dr. Degen's arguments concerning the timing of the onset of CES symptoms and the timeframe in which surgery might have been curative. Plaintiff's expert's failure to address significant contentions advanced by Dr. Degen in support of the defendants' motion renders the expert affidavit conclusory. See, e.g., *Tsitrin v New York Comm. Hosp.*, 154 AD3d 994 (2d Dept 2017) ("In order not to be considered speculative or conclusory, expert opinions in opposition should

address specific assertions made by the movant's experts, setting forth an explanation of the reasoning and relying on specifically cited evidence in the record.") See also *Messeroux v. Maimonides Med. Ctr.*, 181 AD3d 583 (2d Dept 2020); *Choida v Schirripa*, 188 AD3d 978, (2d Dept 2020); *Lowe v. Japal*, 170 AD3d 701 (2d Dept 2019).

It is well-established that "[g]eneral allegations of medical malpractice, merely conclusory and unsupported by competent evidence tending to establish the essential elements of medical malpractice, are insufficient to defeat defendant physician's summary judgment motion." *Arocho v Kruger*, 110 AD3d 749 (2d Dept 2013). Plaintiffs' expert provides only generalized and conclusory assertions regarding defendants' alleged deviations from accepted standards of care. In conclusory fashion, plaintiff's expert alleges that defendants negligently failed to treat CES "upon its initial presentation" while failing to identify when the initial presentation of CES occurred.

Clearly, the timing of the initial presentation is of significance given the limited period of time in which surgical decompression can be expected to provide a reasonable chance for a cure. It seems the plaintiffs' expert is claiming that, based upon the presence of severe back pain, urinary incontinence, lower extremity weakness, and difficulty ambulating, the plaintiff had CES at the time of the May 30, 2017, office visit with Dr. Alastra. However, all of those symptoms had been present on May 23, 2017, one week prior. As such, Mrs. Buonpane was outside of the 24-to-48-hour treatment window, the ideal time window for the institution of treatment according to the plaintiff's expert, at the time of the visit. As Dr. Degen explained (and the plaintiff's expert concedes), after the 48-hour treatment window has closed, the situation is no longer emergent.

These opinions are not refuted by plaintiff's expert, who in fact concedes that significant improvement is unlikely when surgery is performed more than 48 hours after the onset of symptoms. Thus, plaintiff's expert's opinions concerning Dr. Alastra's alleged deviations on or about May 30, 2017, are too conclusory and speculative to create a triable issue of fact. The plaintiff has failed to provide any basis upon which one could conclude that surgery around that time, 7-plus days after the acute onset of CES symptoms, would have had any appreciable benefit in terms of plaintiff's neurologic outcome and functioning. The same argument applies with respect to Mrs. Buonpane's June 21, 2017 hospitalization. Plaintiff's expert contends that Mrs. Buonpane presented with "clear symptoms of CES," but the affidavit fails to establish that surgery on or about June 22, 2017 to June 23, 2017 would have altered the outcome or increased Mrs. Buonpane's chance for a cure. According to Dr. Degen, by the time Mrs. Buonpane was admitted to SIUH on June 21, 2017, her symptoms had been present for more than a month, making it was even less likely that the timing of surgery would have had any impact on the neurologic outcome. In sum, plaintiff's expert affidavit is insufficient to raise a triable issue of fact as to defendants' alleged failure to timely diagnose and treat CES.

CONCLUSION

Dr. Alastra and HCA have made the requisite *prima facie* showing of entitlement to partial summary judgment. Accordingly, dismissal of all allegations pertaining to plaintiff's delayed diagnosis and treatment of cauda equina syndrome is warranted. Furthermore, the plaintiff has abandoned all allegations of malpractice as they relate to defendants' treatment and care occurring prior to May 30, 2017. Thus, all allegations pre-dating May 30, 2017, are dismissed.

Accordingly, it is hereby,

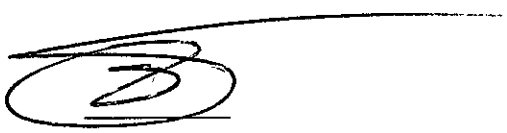
ORDERED, that defendants' motion is granted with respect to the plaintiff's claims stemming from treatment rendered prior to May 30, 2017; and it is further,

ORDERED, that defendants' motion is granted with respect to the plaintiff's claims pertaining to a delayed diagnosis and treatment of cauda equina syndrome (CES); and it is further,

ORDERED, that any additional requests for relief are hereby denied.

Dated: April 27, 2023

ENTER



A.J.S.C.

Hon. Charles M. Troia
Justice of the Supreme Court