SUPREME COURT OF THE STATE OF NEW YORK
NEW YORK COUNTY

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

Justice

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BRIAN RENZETTI,

Plaintiff,

- v -

SHAKIL AHMED, M.D. and THE NEW YORK AND PRESBYTERIAN HOSPITAL, doing business as NEW YORK-PRESBYTERIAN HOSPITAL, doing business as WEILL CORNELL MEDICINE,

Defendants.

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INDEX NO. 805148/2019

MOTION DATE 01/27/2025

MOTION SEQ. NO. 001

DECISION + ORDER ON MOTION

The following e-filed documents, listed by NYSCEF document number (Motion 001) 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67

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

In this action to recover damages for medical malpractice based on alleged departures from good and accepted medical practice, and for lack of informed consent, the defendants move pursuant to CPLR 3212 for summary judgment dismissing the complaint. The plaintiff opposes the motion. The motion is granted only to the extent that the defendants are awarded summary judgment dismissing so much of the medical malpractice cause of action as was premised upon the defendants' alleged failure to diagnose the plaintiff's condition, and the motion is otherwise denied.

The crux of the plaintiff's claim is that the defendant anesthesiologist and pain management specialist Shakil Ahmed, M.D., with whom he had been treating since September 2, 2016, committed malpractice on December 8, 2016, when that physician improperly performed a permanent percutaneous spinal cord stimulator implant procedure upon him at the defendant The New York and Presbyterian Hospital, doing business as New York-Presbyterian Hospital, doing business as Weill Cornell Medicine (NYPH). In addition, the plaintiff alleged that

the defendants negligently provided him with follow-up care and treatment, up to and including February 2, 2017. He further alleged in his complaint that Ahmed failed to obtain his fully informed consent to the procedure by failing to inform him of the risks and benefits of, and the alternatives to, that procedure.

In his complaint, the plaintiff specifically alleged that the defendants neglected to use reasonable care in the services rendered to him by failing to heed his complaints, failing promptly and properly to diagnose his condition, in failing to employ the proper technique in performing the subject procedure, and in incorrectly placing the spinal cord stimulator leads during the procedure. He further averred that these departures led to "markedly inadequate relief of the thoracic pain" caused by, among other things, the malrotation of the spinal cord stimulator that, in turn, caused the implant device to be insufficiently charged for therapeutic purposes. The plaintiff also alleged in his complaint that the defendants failed timely or properly to diagnose the cause and etiology of his thoracic pain. In addition, the plaintiff asserted that the defendants failed to inform him of the misplacement or displacement of the leads, so that he only was informed of that problem after seeking help from other surgeons. He further contended that the defendants departed from good and accepted care

> "in that they lacked the experience and expertise necessary to treat plaintiff's condition; in attempting to treat plaintiff's condition without having the requisite degree of knowledge, education and experience necessary to do so; in failing to monitor the plaintiff's condition; . . . in failing to properly and in a timely manner perform remedial and consultative procedures; [and] in negligently causing emotional damage and other damage to the plaintiff."

In his bill of particulars, the plaintiff reiterated, almost verbatim, the allegations of medical negligence set forth in his complaint, and further specified that the defendants deviated from good and accepted practice by

> "failing to apply the proper technique due to incorrect placement of the spinal cord stimulator leads slightly right of midline with top T9 and bottom T8; in negligently causing plaintiff to require a second surgery on January 19, 2017 to properly affix the stimulator; [and] in negligently causing plaintiff to require a third surgery on October 2, 2017 to remove the stimulator."

The plaintiff asserted, in his bill of particulars that, as a consequence of these departures from good and accepted practice, and the failure to obtain his fully informed consent, he was compelled to undergo two additional surgeries to correct the misplacement of the implant device and leads so as to reorient the battery pack and leads, and that the surgeries caused concomitant scarring. He also averred that, as a consequence of the defendants' tortious conduct, he suffered from severe, constant, and sharp back pain in the lower thoracic region of his spine that was exacerbated by movement, particularly in the mornings, as well as right leg sciatic pain. He characterized these conditions as representative of failed back surgical syndrome. In addition, the plaintiff asserted that, as a consequence of his conditions, he had been prescribed a high-risk medication for long-term usage.

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]).

"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 Foster-Sturrup v Long,* 95 AD3d 726, 727 [1st Dept 2012]; *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 Perez v Fitzgerald,* 115 AD3d 177, 178 [1st Dept 2014]; *Perlin v King*, 36 AD3d 495, 495 [1st Dept 2007]; *see generally 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 Med. Ctr.*, 217 AD2d 98, 101 [1st Dept 1995]).

To make a prima facie showing of entitlement to judgment as a matter of law, a defendant physician moving for summary judgment must establish 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]; *Barry v Lee*, 180 AD3d 103, 107 [1st Dept 2019]; *Frye v Montefiore Med. Ctr*., 70 AD3d at 24) or establish that the plaintiff was not injured by such treatment (*see Pullman v Silverman,* 28 NY3d 1060, 1063 [2016]; *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 this 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, as noted, 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).

In support of their motion, the defendants submitted the pleadings, the plaintiff's bill of particulars, transcripts of the parties' depositions, relevant medical and hospital records, the note of issue, a statement of allegedly undisputed material facts, an attorney's affirmation, and the expert affirmation of neurosurgeon Konstantin Vladimirovich Slavin, M.D. Dr. Slavin opined that neither defendant departed from good and accepted practice in treating the plaintiff and that nothing that they did or did not do caused or contributed to the injuries claimed by the plaintiff.

Based on records maintained by the Hospital for Special Surgery (HSS) and NYPH, Dr. Slavin first set forth a history of the plaintiff's treatment for back pain. He noted that the plaintiff had a longstanding history of lower back pain, beginning five years before the plaintiff first saw Ahmed. In this respect, Dr. Slavin asserted that, beginning in 2011, the plaintiff began complaining of lower back pain, and had undergone extensive failed conservative care. On September 23, 2013, physiatrist and spine specialist Christopher G. Lutz, M.D., administered the plaintiff a bilateral S1 transforaminal epidural steroid injection at HSS. Imaging studies performed at HSS in October 2013 revealed disc degeneration at the L5-S1 region of the plaintiff's spine, while a discogram showed severe concordant pain with an annular tear. On November 25, 2013, James Farmer, M.D., performed a posterior lumbar spinal fusion procedure

at HSS on the L5-S1 region of the plaintiff's spine, with instrumentation, local bone graft, a left iliac crest bone graft, and interbody fusion, with an interbody cage. According to Dr. Slavin's interpretation of the HSS records, the plaintiff tolerated the surgery well with no complications, and was discharged to his home on November 29, 2013.

According to Dr. Slavin's interpretation of the plaintiff's medical records, the plaintiff, however, continued to treat with Dr. Farmer from June 11, 2014 through August 30, 2016, reporting ongoing and constant low back pain that radiated to his right leg, despite taking Oxycodone for the pain. At his June 11, 2014 visit with Dr. Farmer, the plaintiff reported that the onset of the new pain had started in March 2014, and had moderately limited his ability to perform activities, while Dr. Farmer reported that a physical examination indicated a severely limited range of motion and flexion in the lumbar region of the plaintiff's side, with moderately decreased left and right lateral tilts. The report of a magnetic resonance imaging (MRI) scan taken that day described herniated nucleus pulposus at L3-4, L4-5, and L5-S1, after which Dr. Farmer discussed the possibility of performing a lumbar discectomy. According to Dr. Slavin, a new MRI was performed and indicated post-surgical changes at L5-S1, some degenerative disc disease at T12-L1, and a mild disc bulge at L4-L5, after which Dr. Farmer discussed with the plaintiff the potential need for an anterior lumbar fusion procedure, and the plaintiff indicated that he wished to consider the implantation of a spinal cord stimulator. When the plaintiff returned to see Dr. Farmer in the following months, and continued to complain of lower back pain, Dr. Farmer formulated a plan to proceed with a repair of pseudoarthrosis at the L5-S1 level of the plaintiff's spine. On October 27, 2014, the plaintiff was admitted to HSS for a posterior lumbar discectomy, removal of interbody cage, and placement of a new interbody cage, with iliac crest bone graft, and Dr. Farmer performed that procedure. According to Dr. Slavin's reading of the relevant records, the plaintiff suffered no complications from the surgery, and was discharged to his home on October 30, 2014.

In February 2015, the plaintiff told Dr. Farmer that his back pain had improved. In May 2015, he returned to Dr. Farmer, complaining of lower thoracic pain, after which that physician recommended that the plaintiff consult with a pain management physician for possible injections or other conservative care. At the plaintiff's last appointment with Dr. Farmer on August 30, 2016, the plaintiff purportedly reported that his lower back pain was "significantly" improved, but that his mid-back pain was severe. According to Dr. Slavin, the plaintiff continued to suffer from lumbar, thoracic, and sciatic pain, radiating to his right leg, which he described as a constant, sharp, burning pain, that caused many tingling sensations, and interfered with his ability to walk.

Dr. Farmer referred the plaintiff to Ahmed. The plaintiff, who was then 25 years old, first met with Ahmed on September 2, 2016, complaining of ongoing, constant, mid-to-low back pain, which he allegedly described as non-migrating but "achy" in nature, and located exactly in the midline of the spine, with an intensity of 6 on a scale of 10 while at rest and 10 out of 10 during activity such as dressing and walking for prolonged periods of time. The plaintiff completed a patient questionnaire form, on which he reported that he could not sit or stand for more than 15 minutes, could not walk more than a few blocks, and was unable to look down by bringing his chin to his chest. He also checked off boxes indicating that he felt weakness, sharp pain, and numbness, and reported that his pain was worse in the morning than at other times of day, and that the pain also interfered with his sleep, sex, cooking, self-care, job performance, household chores, hobbies, exercise, lifting, and shopping.

According to Dr. Slavin's summary of relevant medical records, the plaintiff also reported to Ahmed that he had undergone extensive physical therapy, and had exhausted other treatment options such as the painkillers Oxycodone and Percocet and several epidural nerve blocks, all without relief. Ahmed noted that a thoracic MRI performed on that same date showed small multi-level disc herniations at the T6-7, T8-9, T10-11, and T12-L1 levels of the plaintiff's spine, with no significant spinal stenosis or foraminal narrowing. Ahmed thus diagnosed the plaintiff with symptomatic small disc herniations at those levels and, at the

plaintiff's request, discussed the placement of a spinal cord stimulator, and formulated a plan for the plaintiff to undergo a trial with a stimulator in connection with the plaintiff's lower back. Dr. Slavin averred, however, that Ahmed did not discuss stimulator therapy for the thoracic region of the spine, inasmuch as he opined that, in 2016, spinal cord stimulation therapy could not be used for thoracic spine pain. Prior to undergoing the trial, the plaintiff underwent a neuropsychological evaluation by Edward Robins, M.D., on October 10, 2016, at which the plaintiff reported nerve pain at a level of 9 out of 10, and severe levels of pain-induced depression. According to Dr. Slavin, Dr. Robins showed the plaintiff a DVD of the proposed procedure, after which Dr. Robins cleared the patient for the spinal cord stimulator implantation.

On October 13, 2016, Ahmed, upon memorializing a diagnosis of lumbar radiculopathy in a 25-year-old patient with a history of intractable lumbar pain, secondary both to that radiculopathy and chronic pain syndrome, implanted percutaneous spinal cord stimulator trial leads into the plaintiff's back. According to Dr. Slavin, Ahmed implanted the leads, under fluoroscopic guidance, by entering the epidural space at the L2-3 level and advancing a Medtronic-brand single percutaneous lead with eight contact points into the inferior border of the T7 level. Ahmed reported that the leads were anchored and secured, and that the position of the leads was rechecked and confirmed by fluoroscopy again before closure. Ahmed testified at his deposition that the placement location covered the lower back and, if needed, the legs, but did not cover the patient's thoracic spine. The positioning of the test stimulator reportedly was confirmed on fluoroscopy and by test stimulation. As set forth in the test records, the plaintiff reported a "good response" to the stimulation in his lower back and legs. On October 19, 2016, the plaintiff returned to Ahmed's office, and reported a 70% diminution of his pain, but that he continued to have mild sharp and constant mid-back pain, with a pain level of 3 on a scale of 10 on average, occasionally increasing to 6 out of 10. The plaintiff purportedly denied numbness, tingling, or weakness, upon which Ahmed noted significant improvement since the plaintiff's last

visit, including with respect to the plaintiff's activities of daily living. At that juncture, the plaintiff told Ahmed that he wanted to proceed with a permanent implantation procedure.

According to Ahmed's notes, at a follow-up visit on November 30, 2016, the plaintiff reported that his pain relief was unchanged, but also asserted that his pain was slowly worsening from 4 on a scale of 10 to 8 out of 10, and occasionally would radiate down his right leg. Ahmed thus scheduled the implantation of procedure for December 8, 2016. As Dr. Slavin explained it, the permanent stimulator would be placed in a similar location as the trial stimulator, with final placement determined on the basis of an x-ray, the efficiency of the stimulation during the test stimulation, and the plaintiff's response to that stimulation.

As Dr. Slavin described it, on December 8, 2016, Ahmed performed the implantation procedure, under fluoroscopic guidance, and implanted a Medtronic-brand percutaneous lead model 977A260, first by advancing it to the top of the T8 vertebral body, then placing another lead at the bottom of the T8 vertebral body, and reportedly confirming the position of both leads via fluoroscopy and by test stimulation. According to the operative report, the plaintiff reported a "good response" covering the area of his back and leg pain. Ahmed created a pocket for the generator at the plaintiff's right flank, approximately 2.5 centimeters (cm) below the skin, and after "interrogation" with impedance, Ahmed placed the generator into the subcutaneous pocket, and secured it with size 2.0 sutures to prevent migration. As the operative report stated, Ahmed conducted intraoperative programming, rechecked the position of the leads and generator under fluoroscopy before closing the surgical incisions, and ultimately closed those incisions.

On December 23, 2016, the plaintiff met with Ahmed for his first postoperative follow-up examination, and allegedly reported that the stimulator had improved the sciatic pain in his right leg, which he purportedly asserted had decreased from 8 on a scale of 10 to 3 out of 10. According to Ahmed's records, the plaintiff described his pain as dull, instead of sharp, and reported improvement in his walking, but also characterized his mid-back pain as persistent and "achy" in nature, with a severity of 7 of out 10, while also describing it as "intermittent" and

"improved" with rest and medications. Those same records reported that the plaintiff stated that he no problems with activities of daily living. The plaintiff returned to Ahmed's office on December 30, 2016, complaining of persistent mid-back pain of the same severity, and reporting that increased activity worsened the pain. Ahmed wrote in his records that, upon reprogramming the stimulator, the back coverage had improved, but that the plaintiff called him later that day because the battery for the stimulator was not charging. According to Dr. Slavin, when Ahmed later examined the generator, he concluded that it "appeared to have flipped," meaning that there was no "communication" between the battery and the Medtronic charging system, even though the impedance allegedly was normal. Ahmed wrote in his notes that the problem was most likely due to battery migration or "flipping," and thus scheduled a revision procedure to adjust or replace the stimulator's generator unit.

On January 19, 2017, Ahmed performed the revision procedure at NYPH and replaced the generator, explaining in his operative report that the generator could not be charged, even though it could be "interrogated" and reprogrammed. He reported that he made several attempts to rectify this problem, including changing body positions and applying various amounts of pressure at different locations, but ultimately concluded that the generator could not be charged for more than one month. Ahmed thus created a new subcutaneous pocket approximately one-half inch below the plaintiff's skin, removed the old battery, and connected leads to the new Medtronic IPG model 97714, after which he conducted an impedance check and secured the new generator with size 2.0 sutures to prevent migration. Ahmed reported that, upon charging, he observed a level of 8 bars on the device, indicating an adequate charge, that he rechecked the positions of the leads and generator via fluoroscopy, and again rechecked the impedance and charging with Medtronic representatives at the plaintiff's bedside in the post-anesthesia care unit. According to Ahmed, the revision surgery yielded a good result.

As Dr. Slavin summarized relevant medical records and deposition testimony, after the plaintiff experienced increasing pain upon activity during January 2017, he returned to see

Ahmed on February 2, 2017, allegedly reporting a 50% reduction in his right-leg sciatic pain, but no improvement with his thoracic pain. Ahmed's records reported that there was no issue with recharging, that the stimulator was reprogrammed by the Medtronic representative in the office, and that, upon recharging, the plaintiff reported coverage of his low back and lower extremity pain. Slavin asserted, however, that it was not possible for the stimulator to provide coverage to the plaintiff's middle or upper back. The plaintiff's last visit to Ahmed's office was on February 21, 2017, at which time he reported that he was having difficulty with activities of daily living, with an onset of abdominal pain. He allegedly characterized his lower back pain as intermittent, with sharp exacerbations, particularly upon activity, with average pain of 8 on a scale of 10, increasing to 9 out of 10 at its worst. Medtronic reprogrammed the stimulator at Ahmed's office.

On March 8, 2017, the plaintiff presented to the Pain Institute of Long Island in Woodbury, New York, and saw pain management physician Samuel Brown, D.O., complaining of unchanged lower and mid-back pain. Dr. Brown formulated a plan to obtain a thoracic spine x-ray to evaluate the placement of the stimulator leads, and to arrange for a Medtronic representative to attempt another reprogramming. On March 15, 2017, the patient saw Dr. Brown following the thoracic spine x-ray, still complaining of sharp thoracic pain, and right-sided pain radiating down his right lower extremity, posteriorly from his buttocks to his knee. Dr. Brown noted that the lead placement was slightly right sided, with the top of the leads at the top of T9 and the bottom of T8. Dr. Brown planned to reprogram the stimulator with a Medtronic representative, consider thoracic medial branch block injection under fluoroscopic guidance to rule out facet-based pain, take a follow-up MRI scan of the lumbar spine, and continue pain medications. The plaintiff saw Dr. Brown each month from April 20, 2017 through August 2, 2017, with no change in upper and middle back pain.

On September 5, 2017, the plaintiff told Dr. Brown that he wanted to have his stimulator explanted, as it was painful at the generator site and not helping his pain. Dr. Brown thus referred the plaintiff to critical care surgeon Evan Geller, M.D., to remove the stimulator. On

September 13, 2017, the plaintiff met with Dr. Geller at Long Island Physician Associates in Port Jefferson, New York, and explained that, after eight reprogramming trials of the stimulator, there was no change in his mid-back pain. On October 2, 2017, Dr. Geller explanted the neurostimulator and leads at John T. Mather Memorial Hospital in Port Jefferson, reporting preoperative and postoperative diagnoses of a nonfunctioning neurostimulator. According to Dr. Slavin's reading of the relevant operative report, there was no indication as to where the leads were located when they were removed. In any event, the report did not indicate any postoperative complications, and the plaintiff was discharged on that day.

The plaintiff continued to treat with Dr. Brown until August 2018, and reported continued pain in his thoracic spine, lumbar spine, and right leg pain, with fluctuating lower-back pain severity. In his notes referable to the August 2018 examination, Dr. Brown reported that there were no clear findings on radiological imaging to correlate with the plaintiff's "subjective complaints" of increased pain, and concluded that an immune inflammatory condition known as Behcet's disease and neurologic problems may have been the underlying etiologies of the plaintiff's pain. According to Dr. Slavin, since 2018, the plaintiff has treated with various physicians for his mid- and lower-back pain. Dr. Slavin opined that, although various physicians included Behcet's disease in their differential diagnoses due to the fact that the plaintiff's functional back movement capacity was 40% or less than what it should be, MRI imaging and laboratory results remained relatively normal.

After describing the pain that can be caused by a herniated disc, and reiterating the nature of the plaintiff's 2013 spinal fusion procedure addressing the plaintiff's disc problems, Dr. Slavin asserted that, "although the spinal cord stimulator here simply did not work to provide good, long-term pain relief to the patient, it by no means evidences, as alleged by plaintiff, that the defendants were negligent." He asserted that only 60% to 70% of patients get good long-term relief with spinal cord stimulators, and that the plaintiff "fell into the 30-40% of the patient

population who do not obtain good long-term pain relief," but that this outcome did "not correlate to the performance, care and treatment provided by Dr. Ahmed and NYPH."

Dr. Slavin averred that the plaintiff was an excellent candidate for placement of a spinal cord stimulator, and that the procedure clearly was indicated, inasmuch as the plaintiff previously had undergone two failed back surgeries, and had undergone failed conservative measures, such as epidural steroidal injections and various prescription narcotics. He opined that Ahmed appropriately conducted a stimulator trial to ascertain the potential success of a permanent spinal cord stimulator, and that, following the trial, this plaintiff reported 70% relief of his lower back pain during the trial period. After explaining how a spinal cord stimulator should be implanted and how it thereafter functions, Dr. Slavin opined that Ahmed correctly performed the implantation procedure, including using the appropriate surgical techniques and proper placement of the stimulator. In connection with this opinion, Dr. Slavin explained that,

> "the leads were placed by Dr. Ahmed at the T8 and T9 levels of the patient's spine. . . . Dr. Ahmed appropriately placed the leads at this location, the T8 level, which is the standard level for placement of these leads in order to provide coverage for lower back and leg pain. Although the records indicate that the patient experienced back pain in various areas, he underwent two failed back surgeries at the lower lumbar level and presented to Dr. Ahmed to seek relief in the specific areas of his lower back and leg pain. Thus, the purpose of the S[pinal] C[ord] S[timulator] and leads were to target the primary areas of his lower back and leg pain, which plaintiff mischaracterizes within his Bill of Particulars allegations."

As he described it, the side of the back in which a patient's pain is present is extremely important in obtaining adequate coverage by a stimulator and that, since the plaintiff's pain was predominantly on his right side, "it would be standard practice to place the lead slightly to the right of the mid-line in order to steer the stimulation towards the area of pain dominance." Hence, Dr. Slavin concluded that Ahmed properly and appropriately placed the lead slightly right of mid-line in order to target the plaintiff's pain.

Dr. Slavin reiterated his opinion that spinal cord stimulators were not typically employed to address mid-back or thoracic pain in 2016, but only lower-back and leg pain, and that, hence,

treatment of mid-back or thoracic pain was not the purpose of implanting the stimulator in the first instance. He concluded that the "thoracic area was never the primary target area or even a considered area for the patient's pain relief," a conclusion that he claimed was corroborated by Ahmed's placement of the leads as part of the preimplantation trial. Dr. Slavin noted that, in fact, the stimulator did not provide relief of the plaintiff's mid-to-upper back pain, that there never was any expectation that it would address pain in those areas, and that Ahmed cannot be held liable for failing to control pain that simply could not be controlled by the stimulator.

Dr. Slavin further opined that,

> "[d]espite allegations that the leads migrated, based upon my review of the records, there is no evidence to support this allegation. In fact, there was no mention within the records or testimony of stimulation being felt in a different part of the patient's body, which would support the possibility of migration. It should also be noted that the possibility of migration was not mentioned by Dr. Geller during his pre-operative evaluation of this patient on September 13, 2017. Furthermore, the operative report by Dr. Geller in connection with the removal of the leads and the SCS did not document where the leads were located when they were removed, thereby excluding an opportunity to visualize the lead position."

He asserted that, even if the leads did, in fact, migrate, migration is a known and accepted risk of the procedure. Nonetheless, Dr. Slavin essentially conceded that, several weeks after the implantation procedure had been performed on December 8, 2016, the plaintiff reported his inability to charge the battery, and an examination during Ahmed's January 19, 2017 revision procedure revealed that "the generator appeared to have flipped, causing no communication between the battery and the Medtronic charging system" and the unit had "mal-rotated," necessitating replacement. According to Dr. Slavin, malrotation is a "fairly common occurrence amongst overweight patients, such as the patient here, because as there are thicker fat layers, there is more room for the generator to move," and also a known risk of the implantation procedure, while "flipping" also can occur in overweight patients "because the sutures used to keep the generator in place do not stay in place as well in overweight patients versus normal weight patients." He confirmed that, when a generator migrates or rotates, it no longer can be

charged and must be revised or, in some instances, it must be replaced, a situation that "is particularly true with Medtronic rechargeable generators, such as the one used here." Dr. Slavin concluded, however, that there was nothing that Ahmed or NYPH personnel could have done to prevent either of these known risks.

Ultimately, Dr. Slavin asserted that, "unfortunately, the SCS did not work to provide long term pain relief for this patient. However, by no means did the stimulator exacerbate the patient's preexisting back pain and it certainly did not cause any additional pain." Rather, he concluded that any pain that the plaintiff suffered after all of the surgeries was not "new pain," and, hence, the plaintiff could not properly allege that the procedures that Ahmed performed, or any additional procedures needed to replace the stimulator unit, caused more pain. As Dr. Slavin characterized it, the procedures related to implantation and replacement of the stimulator "only provided relief, even if temporary, to the patient's . . . lower back and leg."

In opposition to the defendants' motion, the plaintiff relied on the same submissions that the defendants made, and also submitted his own affidavit, as well as the expert affirmation of an internist and board-certified anesthesiologist and pain management specialist. The plaintiff's expert asserted that Ahmed and NYPH did indeed depart from good and accepted medical practice in failing properly to place both the spinal cord stimulator leads and the stimulator unit during the December 8, 2016 surgery, and in negligently failing to utilize proper surgical technique during that procedure. The expert asserted that these departures resulted "in markedly inadequate relief of plaintiff's thoracic and lumbar pain, malrotation of the spinal cord stimulator which prevented electric charging," and necessitated not only a second surgery on January 19, 2017 to properly affix the stimulator, but a third surgery on October 2, 2017 to remove the spinal cord stimulator, among other injuries. In this respect, the plaintiff's expert expressly disagreed with the defendants' expert that the care and treatment that they provided to the plaintiff was within the standard of care and did not injure the plaintiff.

Specifically, the plaintiff's expert averred that good and accepted medical practice required Ahmed appropriately, correctly, and firmly to place and position the permanent spinal cord stimulator battery during the December 8, 2016 surgery, and obligated Ahmed to place the permanent leads "at exactly the same position as the lead of the prior temporary spinal cord stimulator." After explaining that a spinal cord stimulator consists of thin wires, known as electrodes, and a small, pacemaker-like battery pack, known as the generator, the plaintiff's expert further explained that the electrodes are placed between the spinal cord and the vertebrae, the generator is placed under the skin, and patients employ an external remote control to communicate electrical pulses to the nerves in the affected area. Contrary to the opinion of the defendants' expert, the plaintiff's expert asserted that "[s]timulator leads can be implanted within the level of cervical, *thoracic*, lumbar vertebra, and the sacrum" (emphasis added). As the expert described it,

> "[s]timulator implantation requires fluoroscopy to determine proper lead placement. Lead placement depends on the location of the patient's back pain. A small cut is made to insert an epidural needle and to insert the leads. For example, in the case of chronic low back pain, the leads would be placed at the levels of T8 to L1. For mid back pain, the leads would be placed at the levels of T6 to T7. For neck pain, the leads are positioned above C3 in the epidural space."

The plaintiff's expert proceeded to describe the parameters of a standard one-week trial implantation period employing a temporary stimulator, which permits the physician who ultimately will perform the permanent implantation procedure to determine where the electrode should be placed along the spine. The expert opined that the trial is considered a success if a patient experiences a 50% or greater reduction in pain level. The plaintiff's expert further described the proper surgical procedures needed to place the generator underneath a patient's skin, typically along the lower abdomen or buttocks, with sutures to keep it in place, and with the permanent electrodes inserted along the spine using fluoroscopy. As the expert explained it, unlike the trial electrodes, the permanent wires are anchored by sutures to prevent and minimize movement, and that the "topography" of the patient's pain should correlate with the

placement of the lead placement. The plaintiff's expert opined that the goal of successful implantation is to achieve at least an 80% overlap with the area of the patient's pain and lead coverage. The expert further noted that a tunnel track, created during the permanent procedure, connects the generator to the leads, and that the stimulator leads are tunneled to the generator via an extension cable.

According to the plaintiff's expert, the plaintiff reported a 70% level of pain reduction in his back after the trial implantation and, contrary to Dr. Slavin's opinion, "not of just his lumbar back pain." Rather, the plaintiff's expert referred to Ahmed's own statements, which memorialized the plaintiff's 70% overall pain relief, "which included his mid back pain." The expert noted that Ahmed, at his deposition, testified that, prior the trial implantation, the plaintiff reported that 30% of his pain was in the thoracic and lumbar spine with the trial spinal cord stimulator, and that the plaintiff reported only mild mid-back pain after the trial procedure. As the plaintiff's expert characterized it, with respect to the permanent implantation, Ahmed "admittedly placed the leads in a different place than where the lead had provided plaintiff with pain relief during the trial period." In this respect, the expert asserted that,

> "[w]hile during the trial the lead was placed at the inferior border of T7, during the permanent implantation, the leads were placed, according to Dr. Ahmed's own operative report, at the top of T8 and bottom of T8. This is of critical importance. Defendants' expert completely ignores the fact that the leads were placed at a different location and in fact misstates that the leads were placed by Dr. Ahmed at the T8 and T9 levels of Mr. Renzetti's spine. The operative report from . . . December 8, 2016, clearly states that the two leads were placed at the top of the T8 vertebral body and bottom of the T8 vertebral body, not at the T9 level."

With respect to this issue, the expert explained that "[i]t was not until plaintiff's subsequent treating physician Dr. Brown performed a thoracic spine x-ray that it was discovered that the leads as of March 15, 2017 were at the top of T9 and bottom of T8." The plaintiff's expert thus concluded that Ahmed did not correctly perform the permanent spinal cord stimulator procedure on December 8, 2016, and departed from the standard of care, inasmuch as the leads were not placed properly so as to provide adequate pain relief, but, rather, were

inexplicably and negligently placed in a different position than the position which had provided pain relief during the trial implantation.

The plaintiff's expert unambiguously disagreed with Dr. Slavin's opinion that the leads did not move or migrate. Rather, the expert opined that the leads ultimately moved or migrated following the December 8, 2016 procedure, inasmuch as they were not properly anchored, and further asserted that the battery was not properly sutured in place, resulting both in the migration of the battery and the plaintiff's inability to self-charge the battery. Although the plaintiff's expert agreed that, in the October 2, 2017 operative report referable to the explantation surgery, Dr. Geller did not note where the leads were located when he removed them, he criticized Dr. Slavin for ignoring the clear import of the March 2017 x-ray scans.

Moreover, the plaintiff's expert opined that, while lead migration may be a risk of spinal cord implantation surgery, Ahmed remained obligated to do everything possible to reduce that risk, "which he did not [do] since he failed to adequately suture them in place."

The plaintiff's expert further disagreed with Dr. Slavin that the plaintiff presented to Ahmed seeking relief solely for lower back and leg pain. In this respect, the plaintiff's expert asserted that it was not until the plaintiff's February 2, 2017 postoperative visit with Ahmed, subsequent to the January 19, 2017 revision surgery, that Ahmed first wrote that the spinal cord stimulator could not be utilized for thoracic back pain. The plaintiff's expert opined that Ahmed's statement was "untrue." The expert explained that although "the most common use of the spinal cord stimulator is to treat low back pain and lower extremity radicular pain, *spinal cord stimulators can also provide thoracic back pain relief for many patients, including plaintiff who received significant thoracic back pain relief after his trial"* (emphasis added). The expert stated that, during the entire time that Ahmed was treating the plaintiff, the latter complained not only of lumbar spine pain, but of thoracic spine pain and sciatic pain as well, while Ahmed himself testified at his deposition that he was treating the plaintiff for mid-to-low-back pain involving the thoracolumbar junction. The plaintiff's expert thus concluded that, contrary to Dr.

Slavin's conclusion, the purpose of implanting a spinal cord stimulator was not solely to target the primary areas of the plaintiff's lower back and leg pain, particularly because Ahmed's office records would immediately have reflected, but did not, that the plaintiff's thoracic back pain could not be treated with the spinal cord stimulator, and they would not have reflected, as they actually did, Ahmed's attempts to reprogram the stimulator to target the mid-back pain on multiple occasions. As the expert phrased it, these records would be completely different "if the stimulator could not cover this pain and was not the reason for Mr. Renzetti's treatment." In fact, the plaintiff's expert noted that, as reflected in Ahmed's chart, the plaintiff himself specifically had reported to Ahmed that his orthopedic surgeon did not think it was a good idea for him to undergo a fusion of his thoracic spine because of the number of levels involved, which was why he sought thoracic treatment from Ahmed in the first instance. More specifically, the expert adverted to Ahmed's December 23, 2016 office notes, which reported that the plaintiff continued to have mid-back pain, and wanted his spinal cord stimulator to be reprogrammed to target the thoracic region of his spine, with no indication either in that chart or the NYPH chart at that juncture that the stimulator could not provide the plaintiff with relief for mid-back pain. The plaintiff's expert further opined that, contrary to Dr. Slavin's opinion, during the trial implantation, the stimulator did in fact provide the plaintiff with relief of mid-to-upper-back pain.

With respect to the targeted area of the plaintiff's pain, his expert asserted that, contrary to Dr. Slavin's interpretation of Ahmed's chart, that medical record did not reflect that the plaintiff's pain was predominantly right sided, and that Ahmed testified that he failed to note that plaintiff had pain radiating to his right leg. The expert noted that, while Dr. Slavin contended that Ahmed placed the leads slightly to the right of the midline of the plaintiff's back to target the relevant pain, Ahmed's records, including his December 8, 2016 postoperative report, never reflected this approach.

As with the opinion in connection with the improper placement and unexpected migration of the leads, the plaintiff's expert, while conceding that one of the risks of spinal cord

implantation surgery can be malrotation of the generator, opined that Ahmed was obligated by the standard of care to do everything possible to reduce this risk, and failed to satisfy that standard in connection with rotation of the generator. With respect to this issue, the plaintiff's expert explained that, from the day the stimulator was implanted, the plaintiff was "unable to connect to the battery." As the expert affirmation described it,

> "[a]t that time, he was told there was swelling around the battery pack which would go down and then he could connect the battery. Thereafter, he was advised that the battery pack had likely rotated and Dr. Ahmed scheduled a revision surgery. Following Mr. Renzetti's complaints, Dr. Ahmed admittedly did not even order an MRI to see the position of the battery pack after it could not connect to the charger. Dr. Ahmed testified that an MRI could have shown whether the battery was facing the right way in the skin, however, he never ordered one. . . . Dr. Ahmed further testified that the battery pack had gone deeper into the tissues, although the sutures were in place when he opened Mr. Renzetti back up on January 19, 2017."

The expert concluded that it was "unlikely" that the sutures for the generator were still in place when Ahmed performed his revision surgery on January 19, 2017, because properly affixed sutures would have prevented the battery pack from moving deeper into the tissues. Hence, the plaintiff's expert opined that Ahmed did not take all measures necessary to prevent the risk of battery migration, and did not take appropriate measures after the battery could not be charged to determine the cause. The expert expressly disagreed with Dr. Slavin that there was nothing that the defendants could have done to prevent migration of the leads and battery pack.

Ultimately, the plaintiff's expert asserted that the departures enumerated in his or her affirmation were competent contributing factors of the plaintiff's claimed injuries, including the January 19, 2017 revision surgery and the October 2, 2017 explantation surgery. The expert, however, did not address Dr. Slavin's recitation of the various diagnoses and etiologies upon which Ahmed relied.

In reply, the defendants submitted an attorneys' affirmation and an affirmation from Dr. Slavin. They argued that the plaintiff's expert misstated facts in the record, and failed to consider key medical evidence. Specifically, Dr. Slavin opined that

> "[c]ontrary to what plaintiff's expert states, plaintiff's expert's characterization of the leads being placed in a different position by Dr. Ahmed is factually incorrect. While the leads cannot be placed in the same exact location due to scar tissue, . . . Dr. Ahmed properly placed the permanent leads in the same vicinity as in the trial, which provided for the same coverage."

He further asserted that the implantation placement during the December 8, 2016 procedure did not change the area of stimulation, and that it would be virtually impossible permanently to place the lead and contacts in the same exact location as during the trial, that it was within the standard of care to place the leads in the "same anatomical area" during both procedures, and that the difference of a "few millimeters" in placement did not cause a difference in coverage. In addition, Dr. Slavin interpreted the relevant medical chart as establishing that the plaintiff only sought electrical stimulation therapy with respect to his lower back and right leg. Contrary to the opinion of the plaintiff's expert and the statements in the plaintiff's own affidavit, he concluded that there was no relief from mid-back pain as a consequence of the trial implantation.

Although the defendants established their prima facie entitlement to judgment as a matter of law in connection with the medical malpractice cause of action insofar as asserted against Ahmed, the court concludes that, notwithstanding the defendants' reply papers, the plaintiff raised triable issues of fact with his expert's affirmation. Specifically, he raised triable issues of fact as to whether Ahmed properly placed the stimulator leads during the December 8, 2016 implantation surgery, whether improper surgical technique explained that misplacement, whether the full extent of the painful regions of the plaintiff's spine, including the thoracic region, could be or were covered by the stimulator, and whether insufficient or improper suturing caused both the leads and the generator to migrate shortly after the December 8, 2016 procedure. The plaintiff further raised triable issues of fact whether these alleged departures caused the stimulator to cease functioning, whether he suffered 10 months of continued pain due to such malfunctioning, and whether he was caused to undergo other unnecessary revision and explantation procedures. Since the plaintiff's expert did not address the various diagnoses relied upon by Ahmed, the plaintiff failed to raise a triable issue of fact as to whether Ahmed's

alleged malpractice extended to a failure to diagnose his condition. Hence, that branch of the defendants' motion seeking summary judgment dismissing the medical malpractice cause of action insofar as asserted against Ahmed must be granted to the extent of dismissing so much if that cause of action as was premised upon a failure to diagnose, and must otherwise be denied.

The elements of a cause of action to recover 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]). "'[T]his showing of qualitative insufficiency of the consent [is] required to be supported by expert medical testimony'" (*King v Jordan*, 265 AD2d at 260, quoting *Hylick v Halweil*, 112 AD2d 400, 401 [2d Dept 1985]; *see* CPLR 4401-a; *Gardner v Wider*, 32 AD3d 728, 730 [1st Dept 2006]). Hence, where a defendant establishes his or her prima facie entitlement to judgment as a matter of law in connection with a lack of informed consent cause of action by submitting an expert affirmation from a physician, a plaintiff can only raise a triable issue of fact by submitting "an expert affirmation stating with certainty that the information defendant[ ] allegedly provided to plaintiff before the [medical] procedures at issue departed from what a reasonable practitioner would have disclosed" (*Leighton v Lowenberg*, 103 AD3d 530, 530 [1st Dept 2013]).

"'The mere fact that the plaintiff signed a consent form does not establish the defendants' prima facie entitlement to judgment as a matter of law'" (*Huichun Feng v Accord*

Physicians, 194 AD3d 795, 797 [2d Dept 2021], quoting *Schussheim v Barazani*, 136 AD3d 787, 789 [2d Dept 2016]; *see Godel v Goldstein*, 155 AD3d 939, 942 [2d Dept 2017]). Nonetheless, a defendant may satisfy his or her burden of demonstrating a prima facie entitlement to judgment as a matter of law in connection with such a claim where a patient signs a detailed consent form, and there is also evidence that the necessity and benefits of the procedure, along with known risks and dangers, were discussed prior to the procedure (*see Bamberg-Taylor v Strauch*, 192 AD3d 401, 401-402 [1st Dept 2021]).

The defendants established their prima facie entitlement to judgment as a matter of law in connection with the lack of informed consent cause of action insofar as asserted against Ahmed. Specifically, Dr. Slavin averred that, at the plaintiff's first preoperative visit with Ahmed on September 2, 2016, Ahmed informed the plaintiff of the risk that the stimulator leads could migrate from their initial placement. According to Dr. Slavin, "[c]onclusively, by proceeding with this procedure, this patient accepted the possible risk of lead migration in addition to 'flipping' of the spinal cord generator," despite the fact that Ahmed testified at his deposition that he never reduced to writing his alleged discussion that the generator could move. According to Dr. Slavin's interpretation of the relevant deposition testimony and medical charts, during the October 13, 2016 trial implantation, Ahmed again discussed the risks and benefits of, and alternatives to, both the trial and permanent implantation procedures with the plaintiff, including the risks of infection, epidural abscesses, bleeding, epidural hematoma, paralysis, failure of therapy, the need for long-term antibiotics, the need to switch the stimulator off while driving, lead migration, lead disconnection, and inability to remove the leads, as well as the possibility of long-term opiate therapy as an alternative to the stimulator. He noted that the plaintiff executed a "Consent for Surgical/Invasive Procedure" form consenting to the spinal cord stimulator trial. Dr. Slavin further asserted that, "[a]s per Dr. Ahmed's customary practice, he also explained to the patient the limitations of SCS treatment." Specifically, he asserted that Ahmed advised the plaintiff that such a stimulator "has not been shown to cover thoracic pain, but it can cover

lumbar pain and lower or upper extremity pain." Dr. Slavin further asserted that, on October 19, 2016, Ahmed again discussed the risks, benefits, and alternatives with the plaintiff, and he referred to the plaintiff's own deposition testimony, in which the plaintiff averred that Ahmed told him that the stimulator may not resolve 100% of the pain, but may provide some relief. Dr. Slavin also asserted that, on December 8, 2016, immediately prior to undergoing the permanent implantation procedure, the plaintiff signed and dated a second "Consent for Surgical/Invasive Procedure" form, pursuant to which he consented to the spinal cord stimulator implantation. Dr. Slavin concluded that Ahmed obtained the plaintiff's fully informed consent to both the trial and permanent implantation procedures.

In opposition to the defendants' showing in connection with the lack of informed consent cause of action, the plaintiff raised a triable issue of fact as to the qualitative sufficiency of the consent that he gave to Ahmed. In this respect, the plaintiff's expert asserted that, while the plaintiff formally consented to undergoing the spinal cord stimulator procedures, "he was told the permanent procedure would provide him with the same pain relief as the trial period had," but that "this was not possible given Dr. Ahmed's failure to place the permanent leads in the same spot at the trial lead." The expert further expressed skepticism of Ahmed's deposition testimony, in which Ahmed averred that it was his practice to tell his patients that implantation of a stimulator would not cause them to obtain relief from thoracic back pain, particularly because Ahmed admitted that there were no written notes reflecting this alleged conversation. Moreover, in his own affidavit, the plaintiff asserted categorically that,

> "at no time did Dr. Ahmed inform me that the spinal cord stimulator would not relieve pain in my mid-back. In fact, after he placed the permanent spinal cord stimulator and it wasn't working, he told me that he wanted to have the manufacturer of the device, Medtronics, reprogram the device so that it would alleviate pain in my mid-back, as the device had accomplished during the trial."

He further alleged that "Ahmed was aware right from the beginning of my treatment with him that my mid-back was an area of severe pain that I was trying to get alleviated. He represented to me that the implantation of a spinal cord stimulator could help with both the pain in my lower

back and thoracic mid-back area." His expert thus concluded that the consent that he gave to Ahmed was qualitatively insufficient, and the plaintiff himself alleged, in effect, that, had he known that his thoracic pain could not be alleviated with a stimulator, he would not have undergone the procedure.

Inasmuch as the plaintiff raised a triable issue of fact in opposition to the defendants' prima facie showing in connection with the lack of informed consent cause of action, that branch of the defendants' motion seeking summary judgment dismissing that cause of action insofar as asserted against Ahmed must be denied.

The defendants established, prima facie, that no other NYPH employee departed from good and accepted medical care, failed to obtain the plaintiff's fully informed consent, or caused or contributed to the plaintiff's injuries. In opposition to that showing, the plaintiff failed to identify any other NYPH employee or agent who committed any negligent acts or omissions. Nonetheless, "'[i]n 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'" (*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]). Since it is undisputed that Ahmed was NYPH's employee, NYPH may be held vicariously liable to the extent that Ahmed may be held liable for medical malpractice and failure to obtain the plaintiff's fully informed consent. Hence, those branches of the defendants' motion seeking summary judgment dismissing both the medical malpractice and lack of informed consent causes of action insofar as asserted against NYPH must be denied.

There is no merit to the defendants' remaining contentions, including that the plaintiff abandoned certain claims of injury and damage.

Accordingly, it is,

ORDERED that the defendants' motion for summary judgment dismissing the complaint is granted only to the extent that they are awarded summary judgment dismissing so much of the medical malpractice cause of action as alleged a failure to diagnose or identify the etiologies of the plaintiff's condition, that claim is dismissed, and the motion is otherwise denied; and it is further,

ORDERED that that, on the court's own motion, the attorneys for the parties shall appear for an initial pretrial settlement conference before the court, in Room 204 at 71 Thomas Street, New York, New York 10013, on March 13, 2025, at 2:30 p.m., at which time they shall be prepared to discuss resolution of the action and the scheduling of a firm date for the commencement of jury selection.

This constitutes the Decision and Order of the court.

2/24/2025
DATE

JOHN J. KELLEY, J.S.C.

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