SUPREME COURT OF THE STATE OF NEW YORK
NEW YORK COUNTY

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

Justice

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CRAIG KEELS,

Plaintiff,

- v -

DARWIN CHEN, M.D., and THE MOUNT SINAI HOSPITAL,

Defendants.

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INDEX NO. 805132/2019

MOTION DATE 10/14/2025

MOTION SEQ. NO. 002

DECISION + ORDER ON MOTION

The following e-filed documents, listed by NYSCEF document number (Motion 002) 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93

were read on this motion to/for SUMMARY JUDGMENT.

In this action to recover damages for medical malpractice based on alleged departures from good and accepted practice, negligent hiring, training, supervision, and retention of healthcare personnel, and common-law negligence unrelated to medical malpractice, the defendants move pursuant to CPLR 3212 for summary judgment dismissing the complaint. The plaintiff opposes the motion. The motion is granted to the extent that the defendants are awarded summary judgment dismissing the negligent hiring, training, supervision, and retention of healthcare personnel cause of action, the common-law negligence cause of action, and so much of the medical malpractice cause of action as was premised upon the defendants' alleged failure to take a proper medical history of the plaintiff or refer him to other specialists, their alleged performance of a non-indicated or unnecessary procedure, and allegations that they left the plaintiff unattended and failed to satisfy their administrative obligations. The motion is otherwise denied.

The crux of the plaintiff's claim is that, on November 13, 2017, the defendant orthopedic surgeon Darwin Chen, M.D., while in the course of his employment for the defendant The Mount

Sinai Hospital (Mount Sinai), negligently performed a hip replacement surgery upon him. In his complaint, the plaintiff alleged that Chen departed from good and accepted medical practice in failing to take a proper medical history from him, in failing properly to examine him, and in failing timely to refer him refer for appropriate diagnostic tests and studies, including a computed tomography (CT) scan, thus failing timely or adequately to formulate a proper differential diagnosis, to diagnose his actual condition, or to appreciate his symptoms. He also contended that Chen failed to appreciate the results of the diagnostic testing that had been ordered. The plaintiff further faulted Chen for failing to refer him for appropriate consultations with other medical specialists. He further asserted that Chen failed timely or adequately to treat his condition, which included a failure to prescribe proper medications and the negligent performance of "unnecessary procedures." In addition, the complaint asserted that both of the defendants failed to provide the plaintiff with proper and adequate supervision and monitoring, which included leaving him unattended. With respect to Mount Sinai, the plaintiff asserted in his complaint that it failed properly to perform and exercise its administrative functions.

The plaintiff further alleged, both in the medical malpractice cause of action, and in a separate cause of action, that Mount Sinai negligently hired, trained, supervised, and retained its healthcare personnel.[1] He also set forth an additional cause of action sounding in common-law negligence, presumably unrelated to medical malpractice, although he did not specify any conduct that constituted negligence separate and apart from medical malpractice or negligent hiring, training, supervision, and retention of healthcare employees.

[1] The court notes that allegations of negligent hiring, training, supervision, and retention constitute a cause of action independent of a medical malpractice cause of action, and instead constitute a claim sounding in common-law negligence that subject to a three-year limitations period (*see Calamari v Panos,* 131 AD3d 1088, 1090 [2d Dept 2015]; *Burgos v Lau*, 2025 NY Slip Op 33250[U], *2 n 2, 2025 NY Misc LEXIS 7290, *2 n 2 [Sup Ct, N.Y. County, Aug. 28, 2025] [Kelley, J.]; *Estate of Gebert v Huntington Hills Ctr. for Health*, 2024 NY Misc LEXIS 51911, *16 [Sup Ct, Suffolk County, Sep. 5, 2024]; *see also Taylor v Methodist Hosp*., 6 Misc 3d 1008[A], 2004 NY Slip Op 51750[U], *4, 2004 NY Misc LEXIS 2898, *9 [Sup Ct, Kings County, Nov. 1, 2004] [deeming allegation of "negligent credentialing" to constitute an independent cause of action]).

In his bills of particulars, the plaintiff essentially reiterated the allegations in his complaint, adding that the defendants negligently performed the hip replacement surgery and ignored the signs and symptoms that he was at risk for developing severe injuries, all of which began with his admission to Mount Sinai on November 13, 2017 and continued until May 14, 2019, during which time he developed severe injuries arising from the surgery. He further alleged that, as a consequence of the defendants' tortious conduct, he sustained injuries to his right hip, leading to severe limping and drop foot. Specifically, he asserted that, as a result of the defendants' malpractice, he experienced large fiber, length-dependent peripheral neuropathy, the absence of a peroneal nerve response, chronic denervation, greater trochanteric bursitis, arthritis, including osteoarthritis, myelopathic and antalgic gait, erythema of the occipito-posterior position and around the distal portion of the surgical incision, right iliac crest pain radiating from the lower back, postoperative anemia due to acute blood loss, hematomas, and abductor muscle strain, as well as hip pain, swelling, stiffness, weakness limited range of motion, catching, popping, clicking, numbness, and tingling. The plaintiff asserted that these conditions caused him to experience difficulty in walking, standing, and performing other activities of daily life, required him to undergo revision surgery, and now requires him to employ a cane for ambulation.

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 Flanders v Goodfellow,* 44 NY3d 57, 62-63 [2025]; *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]; *see Haymon v Pettit*, 9 NY3d 324, 327 n [2007]). Once the movant meets that 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 the burden of affirmatively establishing entitlement to judgment as a matter of law merely by pointing to gaps in the plaintiff's case, but 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]). The law does not require a health-care provider to guarantee a good result (*see Saliaris v D'Amelia*, 143 AD2d 996, 996 [2d Dept 1988]), and, although an outcome or result may truly be unfortunate, "'a bad result does not, ipso facto, support a claim for medical malpractice'" (*Saliaris v D'Amelia*, 143 AD2d at 996-997; quoting *Schoch v Dougherty*, 122 AD2d 467, 468 [3d Dept 1988]; *see*

Nestorowich v Ricotta, 281 AD2d 870, 871 [4th Dept 2001], *affd* 97 NY2d 393 [2002]; *Bobek v Crystal*, 291 AD2d 521, 523 [2d Dept 2002]; *Nabozny v Cappelletti*, 267 AD2d 623, 628 [3d Dept 1999]; *Zito v Friedman*, 77 AD2d 514, 515 [1st Dept 1980] [jury must be instructed that a bad result by itself is not proof of malpractice]). Even where an adverse outcome is a known risk of a surgical procedure, a plaintiff may raise a triable issue of fact as to whether a physician committed malpractice by showing that the outcome was caused by improper surgical or medical technique, rather than by an unexplained or incidental event (*see Matney v Boyle,* 237 AD3d 1382, 1384-1385 [3d Dept 2025]; *Bengston v Wang*, 41 AD3d 625, 626 [2d Dept 2007]; *see also Hoffman v Taubel*, 2021 NY Slip Op 31523[U], *4-5, 2021 NY Misc LEXIS 2379, *8-9 [Sup Ct, N.Y. County, Apr. 30, 2021] [Kelley, J.], *affd* 208 AD3d 1099 [1st Dept 2022] [merely because the transection of a ureter is a known risk of a hysterectomy, it does not follow that a surgeon or a surgeon's assistant is excused from properly performing the procedure]; *Mathias v Capuano*, 2015 NY Slip Op 32160[U], *5-6, 2015 NY Misc LEXIS 4141, *12-14 [Sup Ct, Suffolk County, Nov. 5, 2015]; *cf. Henry v Duncan*, 169 AD3d 421, 421 [1st Dept 2019] [plaintiff failed to raise triable issue of fact in opposition to physician's showing that injury was a "known risk that may occur despite competent surgical care having been provided"]).

Moreover, 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]; *see generally Kristie M. v. Mercy Hosp. of Buffalo,* 240 AD3d 1228 [4th Dept 2025]; *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]; *Jones v Ricciardelli*, 40 AD3d 935, 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 the burden on a summary judgment motion, 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, 1045 [2d Dept 2010]; *Grant v Hudson Val. Hosp. Ctr.*, 55 AD3d 874, 874 [2d Dept 2008]; *Terranova v Finklea*, 45 AD3d 572, 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; *Luu v Paskowski*, 57 AD3d 856, 857 [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 also Pancila v Romanzi,* 140 AD3d 516, 516 [1st Dept 2016]; *Callistro ex rel. Rivera v Bebbington*, 94 AD3d 408, 410 [1st Dept 2012], *affd sub nom. Callistro v Bebbington*, 20 NY3d 945 [2012]; *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 bills of particulars, relevant medical and hospital records, the transcripts of the parties' deposition testimony, the note of issue, prior court orders, a statement of allegedly undisputed material facts, a memorandum of law, an attorney's affirmation, and the expert affirmations of board-certified orthopedic surgeon Daniel S. Rich, M.D., and board-certified neurologist and electro-diagnostician Caroline Miranda, M.D., who has a specialty in clinical neurophysiology, both of whom opined that the defendants did not depart from good and accepted practice, and that nothing that they did or did not do caused or contributed to the injuries claimed by the plaintiff.

Dr. Rich first recounted the plaintiff's medical history that is relevant to his claim herein, noting that the plaintiff presented to the Mount Sinai emergency department on September 6, 2017, complaining of right hip pain over the two prior weeks, and reporting that he had fallen one month prior to this visit. According to Dr. Rich, the plaintiff also reported a significant lengthy medical and surgery history, including a *left* total hip replacement, a partial left knee replacement, two lumbar and two cervical spine surgeries, decompression of the spinal cord, and an appendectomy and bunionectomy. In addition, Dr. Rich asserted that the plaintiff

reported having suffered from diabetes, chronic lower back pain, hip pain, knee pain, and osteoarthritis of the hip, secondary to a workplace injury. He claimed that, as early as 2010, the plaintiff had consistently reported experiencing bilateral lower extremity weakness, with decreased balance, as well as frequent falls secondary to "feet dragging," along with a chronic right foot drop and an antalgic gait since 2011, allegedly arising from an old spinal injury. Mount Sinai personnel diagnosed the plaintiff with a hip strain on that initial visit, and instructed him to follow up with its orthopedics department.

As Dr. Rich read the Mount Sinai chart, a right hip x-ray taken there of the plaintiff on October 10, 2017 depicted a narrowing right hip, with degenerative changes and osteoarthritis. He explained that the plaintiff first saw Chen on October 24, 2017, and complained at that time of sharp right hip pain that had radiated to his legs for several months, had worsened over the previous one to two months, and had limited his walking and activities of daily living. As set forth in the chart, the plaintiff was taking the nerve-pain analgesic Lyrica and long-acting morphine, which previously had been prescribed to him by a physical medicine and rehabilitation physician for back pain. Dr. Rich asserted that Chen fully appreciated the plaintiff's medical and surgical history, including his longstanding history of osteoarthritis of the right hip, with right hip pain recalcitrant to conservative, nonoperative treatment, chronic low back pain, essential hypertension, and knee pain. Upon examining the plaintiff on that date, Chen reported that the plaintiff walked with an antalgic gait, and that x-rays of the right hip taken that date revealed moderate joint space narrowing of the right hip joint, also known as the femoro-acetabular joint, predominantly superolateral, with associated subchondral sclerosis, which Dr. Rich described as a thickening of the bone under the cartilage in a joint constituting a sign of osteoarthritis. Chen further reported osteophyte formation. Dr. Rich explained that all of these findings were "compatible" with moderate degenerative changes. According to Dr. Rich, Chen diagnosed the plaintiff with right hip degenerative joint disease. In light of the x-ray scan results, the severe arthritis and associated pain that the plaintiff then was experiencing, the

progression of the plaintiff's symptoms, and the ineffectiveness of more conservative treatment, Dr. Rich concluded that Chen properly determined that a right hip replacement was indicated and warranted. As Dr. Rich described it, on November 10, 2017, Mount Sinai medical staff performed a preoperative medical risk assessment, in which they noted that the plaintiff presented with severe right hip pain that was worse with movement, that he was able to walk a maximum of one block, and that he was able to climb two flights of stairs very slowly using a railing, further documenting that the plaintiff had reported that his right hip pain would wake him up at times. After the completion of this assessment, the plaintiff was cleared for surgery.

Dr. Rich went on to explain that, on November 13, 2017, Mount Sinai staff administered two intravenous dosages of the antibiotic Ancef to the plaintiff for prophylactic purposes, after which Chen performed a right total hip arthroplasty upon the plaintiff, with assistance from orthopedic surgeon Douglas Nowacki, M.D., and physician's assistant Maureen Phillips. According to Dr. Rich's reading of the operative report, Chen was present for, and performed all critical portions of, that procedure, including the placement of all components, which included a Biomet G7 OsseoTi, 54-millimeter (mm) cluster holed-shell acetabular component, a Biomet Taperloc, 16 extended offset, type 1 taper femoral component, a Biolox Delta Ceramic, 36+0-mm, type 1 taper head component, a Biomet ArComXL, 54/36-mm neutral liner component, and two acetabular screws. Dr. Rich asserted that, to perform the procedure, Chen purposefully dislocated the plaintiff's right hip posteriorly and, following what he described as a "careful femoral neck osteotomy," removed the femoral head, exposed the acetabulum, and obtained a healthy bony bed for a press fit socket. At that juncture, Chen "impacted" a 54-mm cup into the acetabulum, and affixed it with screws to the superior acetabular dome for adjunctive fixation. Dr. Rich explained that Chen then placed the final polyethylene liner in the shell, impacted it into place, and fully engaged the locking mechanism. Dr. Rich asserted that Chen then exposed the femur, placed an extended neck, and reduced the hip, after which the right hip was brought through its range of motion, and was checked for stability. He stated that the plaintiff's right hip

was stable in the "sleep" position, evinced good soft tissue tension, and was stable up to 90 degrees of flexion combined with 70 degrees of internal rotation, concluding that these components gave the plaintiff optimal fit, stability, offset restoration, and leg-length equalization.

The operative report recited that the plaintiff had been experiencing severe, end-stage degenerative joint disease of the acetabulum and femoral head. It further reported that there were no complications, and that the plaintiff was awakened and transferred to the recovery room in stable condition, while a postoperative right hip x-ray showed "excellent" component position. Dr. Rich asserted that the plaintiff had an uneventful postoperative course, with good pain control, ambulation, and weightbearing as tolerated, while he was provided with physical and occupational therapy as well as an abduction pillow while he was in bed, and that the plaintiff was discharged home in stable condition on November 15, 2017, with home physical therapy, assistance from Visiting Nurses Services, a rolling walker, a commode, and a hip kit, consisting of items designed to help patients after hip replacement. The chart reflected that the plaintiff was discharged with prescriptions for Lyrica, Avinza, and Percocet.

As Dr. Rich described the plaintiff's postoperative course, on November 28, 2017, he returned to see Chen, and reported that his pain was tolerable with the use of Avinza, Lyrica, and Percocet, but that he still walked with an antalgic gait while employing a cane. According to Chen's notes, the plaintiff's incision was healing "nicely" without drainage, and the plaintiff presented with a "normal degree" of postoperative edema surrounding the incision and adjacent thigh. Chen reported that the plaintiff's passive range of motion of the hip was smooth and well-tolerated, while an x-ray revealed right and left hip arthroplasties in "satisfactory" alignment. Chen reportedly advised the plaintiff to continue taking Avinza and Lyrica for pain management but to stop taking Percocet, continue taking aspirin, and begin a regimen of physical therapy. On December 5, 2017, the plaintiff again presented to Chen with complaints of pain, and the plaintiff continued to walk with a cane with an antalgic gait. Chen reported that the plaintiff's passive range of motion was smooth and well-tolerated, and told the plaintiff to continue taking

his pain medications and aspirin. On December 12, 2017, the plaintiff reported to Chen that he was experiencing persistent pain and difficulty walking normally, and that he was still using a cane, while his gait remained antalgic. As Dr. Rich summarized Chen's chart, the "incision had healed nicely, and edema was much improved," while there was "no tenderness to palpation and range of motion was well-tolerated." Chen reportedly advised the plaintiff to continue to take pain medications, and encouraged the plaintiff to engage in home exercises until he started a course of outpatient physical therapy.

Between December 12, 2017 and January 9, 2018, the plaintiff began a regimen of physical therapy and, on the latter date, returned to Chen for a postoperative evaluation. At that time, the plaintiff continued to use a cane, and reported generalized stiffness and intermittent groin pain when walking, but allegedly no longer had an antalgic gait. According to Dr. Rich's interpretation of Chen's chart, the plaintiff's passive range of motion was smooth and well-tolerated overall, while x-rays revealed right and left total hip arthroplasties in stable alignment. Chen reportedly encouraged the plaintiff to continue physical therapy, with weightbearing as tolerated, but to discontinue posterior hip precautions, and wean off the cane entirely when he felt ready. On January 24, 2018, the plaintiff reported to Chen that his hip pain had noticeably improved and, by February 15, 2018, he reported that his hip "hardly bothered him anymore." The plaintiff next saw Chen on April 10, 2018, at which time he was still using a cane, had continued going to physical therapy, and still took Avinza and Lyrica for pain. According to Dr. Rich, the plaintiff had made progress due to the physical therapy, but reported some pain in the hip near the incision site when sitting down and leaning to his right, although the plaintiff was able to ambulate one block without stopping. Chen wrote in the plaintiff's chart that the plaintiff appeared well, his incision had healed well, and the right hip was nontender with normal range of motion. On June 12, 2018, however, the plaintiff complained of pain on the right side of his hip, at which point Chen wrote in the relevant chart that the plaintiff had experienced known, persistent, severe lumbar spine stenosis preoperatively, with chronic pain issues. Chen's

examination reflected tenderness to palpation to the greater trochanter, but no pain upon range-of-motion exercises, while an x-ray purportedly revealed the total hip arthroplasty to be in satisfactory alignment, without evidence of hardware complication. Chen concluded that the total hip arthroplasty manifested no issues of concern, and determined that any weakness likely was driven by problems with the plaintiff's spine. On July 24, 2018, Chen administered a right hip greater trochanter bursa injection that allegedly provided the plaintiff with some relief.

The plaintiff presented to spinal surgeon Arthur Jenkins, M.D., on August 20, 2018, after which Dr. Jenkins noted progressively worse upper and lower spinal complaints, with progressive gait problems. Specifically, Dr. Jenkins reported that a CT cervical spine scan revealed a solid fusion at the C3-through-C7 levels of the plaintiff's spine, with residual congenital stenosis at the C2 and C3 levels, along with good decompression and severe kyphotic degenerative changes at the C7/T1 and T1/T2 levels, degenerative changes at the C2/C3 level, and loss of cervical lordosis from the C2 through the T2 levels. A magnetic resonance imaging (MRI) scan of the plaintiff's cervical spine reportedly showed central stenosis at the C2/C3 and C7/T2 levels, and a CT scan of his lumbar spine reportedly demonstrated mild congenital stenosis throughout the lumbar spine, along with L4/L5 spondylolisthesis, left-sided spondylolysis, and advanced Modic-type endplate changes at the L5/S1 level, with lumbosacral transitional vertebra.

On September 18, 2018, the plaintiff returned to the Mount Sinai orthopedics department with complaints of persistent right hip pain radiating from his lower back and swelling that had commenced one week prior to the visit. The plaintiff reported difficulty walking, but apparently asserted that he was able to ride a bicycle. Mount Sinai orthopedics personnel examined the plaintiff, and concluded that there was mild tenderness to palpation over his iliac crest and greater trochanter, but no edema, erythema, or ecchymosis. According to the Mount Sinai chart, the plaintiff's passive range of motion was 90 degrees on flexion, and "past neutral" on extension, while the plaintiff evinced passive range of motion of 30 degrees on external rotation

and 45 degrees on internal rotation. The chart further reported that the plaintiff's motor strength was 5 out of 5 on hip extension and flexion, and his sensation was intact to light touch, although he continued to walk with a myelopathic gait. Mount Sinai orthopedists concluded that there was evidence of lumbar radiculopathy, and that the pain was "unlikely related to the hip." As Dr. Rich noted, the plaintiff himself testified at his deposition that his own treating providers informed him that his right hip complaints were unrelated to the November 13, 2017 right hip replacement surgery, but were instead "directly attributable to his spinal issues," which became an impetus for the plaintiff's commencement of treatment with a neurosurgery team for back pain that radiated to his lower extremities. According to Dr. Rich, the plaintiff was instructed to obtain an MRI scan of the lumbar region of his spine, and to follow up with his spinal surgeon and pain management specialists.

Dr. Rich asserted that a lumbar spine x-ray and MRI scan performed in September 2018 revealed spondylolisthesis at the L4/L5 level of his spine, and degenerative narrowing of the L3/L4-through-L5/S1 disc space, with associated moderate-to-severe facet arthrosis and significant degenerative stenosis at the L3/S1 level, with mild congenital stenosis and minimal degenerative stenosis.

As Dr. Rich recounted it, on April 19, 2019, the plaintiff presented to the Mount Sinai emergency department, complaining of worsening right hip pain and discomfort and a newly developed clicking sensation that he had experienced over the previous five days. An examination reflected the presence of pain upon passive internal and external rotation of the right hip, but no overlying skin changes or point bony tenderness. Mount Sinai physicians formulated a plan to x-ray the plaintiff's hip to evaluate the condition of his hardware. On May 14, 2019, the plaintiff returned to the Mount Sinai St. Luke's orthopedics clinic, reporting to the physicians there that he was experiencing back pain that radiated to his right lower extremity, hip pain, grinding in his right hip, and numbness upon ambulation. According to Dr. Rich, an examination reflected the absence of midline spinal or paraspinal tenderness, while the

plaintiff's bilateral lower extremity strength was 4 on a scale of 5 on the right, and 5 on a scale of 5 on the left. He nonetheless noted that the plaintiff was able to perform straight leg raising only to 20 degrees, remarking that the plaintiff's ability to perform this task limited by weakness, but not by pain. Dr. Rich further averred that an examination of the plaintiff's right hip revealed no tenderness to palpation, no pain upon internal or external rotation, and "sensation intact to light touch in L4-S1, 2+ dorsalis pedis pulse, soft, nontender, and compressible components, and no calf tenderness." Mount Sinai physicians concluded that the plaintiff's right hip pain likely was related to his spine.

On July 8, 2019, the plaintiff began treatment with orthopedic surgeon Richard Seldes, M.D., and reported pain in his right hip, along with a clicking and popping sensation. As set forth in Dr. Seldes's chart, the plaintiff reported that his hip felt stable, but that he experienced difficulty walking, sitting, and bending, and difficulty standing, the latter due to chronic back pain, to which he also attributed difficulty in sitting for extended periods of time, dressing, bending, lifting objects, and performing daily activities around his home. According to Dr. Rich, Dr. Seldes diagnosed the plaintiff with "subjective instability." Dr. Rich further explained that, on August 7, 2019, neurologist Shanna Patterson, M.D., performed an electromyogram (EMG) upon the plaintiff to assess the cause of his right leg weakness. As Dr. Rich interpreted the plaintiff's records, this study showed a variety of abnormalities related to the plaintiff's peripheral neuropathy and lumbosacral radiculopathy, specifically reflecting diagnostic electrophysiologic evidence of large-fiber, length-dependent peripheral neuropathy, and revealed that the degree of abnormality of motor nerve conduction in the plaintiff's right lower extremity was slightly greater than the left lower extremity. He stated that the EMG also showed evidence of chronic denervation in several muscles, including the gluteus medius. Dr. Rich opined that it was very challenging to determine whether the plaintiff's right leg weakness was due to sciatic peripheral nerve injury, primary peripheral neuropathy, or possibly superimposed chronic right lumbosacral

radiculopathy. He noted that, on November 11, 2019, the plaintiff returned to see Dr. Seldes, who reportedly reviewed the EMG, and recommended that the plaintiff see a neurologist.

Dr. Rich further explained that, on April 20, 2020, Dr. Seldes reiterated his prior impression that the August 2019 EMG was consistent with possible sciatic nerve injury/ peripheral neuropathy or possible chronic lumbar radiculopathy and, thus, suggested that the plaintiff undergo a repeat EMG study. On May 18, 2020, the plaintiff presented to neurologist Joel Delfiner, M.D., for an EMG evaluation of his leg weakness. Dr. Delfiner's records recited that the patient had experienced hip weakness that predated Chen's 2017 procedure. According to Dr. Rich, Dr. Delfiner performed an EMG which resulted in a "highly abnormal study indicative of widespread neuropathic processes," findings that Dr. Rich opined were compatible with multiple independent coexistent pathologies, such as underlying generalized neuropathy with superimposed multiple radiculopathies in the lumbar region. Dr. Rich further asserted that diabetes may also have been a contributing cause of the neuropathic component, and that the residual spondylotic and stenotic lesions in the plaintiff's lumbar and cervical spine were "certainly contributing" to his condition. He stated that there was no cord deformation or signal change in the cervical cord, but that there may have been some cord atrophy.

According to Dr. Rich, Dr. Delfiner's impression was that the plaintiff presented clinical evidence of a neuromyelopathy, based upon his spasticity, a condition in which muscles stiffen or tighten, thus preventing normal fluid movement, as well as upon the plaintiff's suggestive Babinski responses, the results of a physical examination, the plaintiff's gait, and the results of the EMG. Dr. Delfiner's primary diagnosis was multifocal neuropathy.

On December 7, 2020, the patient returned to see Dr. Seldes, who documented an alleged leg length discrepancy of approximately 1 cm, and also reported that the plaintiff's prosthesis was stable. At that time, Dr. Seldes discussed the possibility of a revision surgery to increase leg length and possibly to decrease any offset. On February 4, 2021, Dr. Jenkins performed a C2-T4 level posterior cervical instrumented decompression and fusion, with a C6-

T3 level laminectomy, which Dr. Rich described as "without complication." Dr. Rich stated that both the preoperative and postoperative diagnoses with respect to that procedure were cervical stenosis, cervical spondylitic myelopathy, and kyphotic deformity. Nonetheless, the plaintiff continued to report postoperative constant low back pain that radiated to his right leg and down into his foot, and complained that he had difficulty walking and needed a cane to ambulate.

On February 19, 2024, the plaintiff returned to see Dr. Seldes, complaining of right hip instability and pain. According to Dr. Rich, Dr. Seldes's neurologic workup revealed general neuropathy. On April 9, 2024, Dr. Seldes performed a revision of Chen's 2017 right total hip replacement surgery. As Dr. Rich described it, the revision surgery involved the replacement of the acetabular polyethylene component and femoral head component, excision of 5.6 cm of soft tissue mass, excision of bony mass, sciatic nerve neuroplasty, local soft-tissue advancement, and excision of hypertrophic skin scar tissue in the hip. According to the operative report, there was wear observed in the previously placed polyethylene component and in the acetabulum, although the metal shell of that component was "found to be in good position and stable," while Dr. Seldes purportedly documented that there was no significant damage to the femoral stem. As Dr. Rich interpreted the operative report, Dr. Seldes dissected and removed scar and soft tissue from the proximal femur and found a bony mass, measuring approximately 4 cm to 4.5 cm, that extended off the proximal femoral neck posteriorly, and was a source of impingement that had been observed in the iliotibial band, as well as posteriorly in the region of the sciatic nerve. Dr. Rich asserted that Dr. Seldes excised the bony mass without difficulty. He further stated that the previously placed femoral component was well fixed and in good position, with good rotation, and that, consequently, Dr. Seldes retained the femoral component, while changing only the femoral head component, placing a "0 size 40 trial." The operative report recited that Dr. Seldes checked the plaintiff's leg lengths, and found them to be equal and within normal limits, while intraoperative x-rays showed the right hip in stable position. As Dr. Rich explained it, Dr. Seldes did not revise the actual acetabular shell or femoral stem, nor did he

change the location of the components. The plaintiff, however, made postoperative complaints of persistent pain in both of his hips, and of weakness and decreased sensation bilaterally in his upper and lower extremities, which Dr. Rich concluded was unchanged from his baseline.

Dr. Rich stated that, as of September 16, 2024, the plaintiff ambulated with an antalgic gait, and continued to complain of clicking and a deep persistent aching pain in the lateral aspect of his right hip, as well as of difficulty ambulating well because of the stiffness and clicking. Dr. Seldes's impression, as set forth in the relevant chart, was of heterotopic ossification in the right hip status post right hip revision, with weakness, stiffness, and crepitus.

Dr. Rich opined that the November 13, 2017 surgery that Chen performed upon the plaintiff was an indicated procedure, that it was properly and appropriately performed, and that Chen properly and appropriately effectuated the placement and employment of all bone ingrowth components. He additionally concluded that both the preoperative and postoperative care that Chen rendered to the plaintiff was proper, and further asserted that the plaintiff's alleged injuries were not causally connected to the defendants' actions or inactions.

With respect to the preoperative care, Dr. Rich asserted that Chen properly evaluated the plaintiff for right hip osteoarthritis, and that he appropriately appreciated the plaintiff's medical and surgical history and history of complaints at the initial October 24, 2017 consultation. As he framed it,

> "[c]onsistent with good and accepted medical practice, Dr. Chen performed a thorough physical examination during which he manually manipulated Plaintiff's right hip and performed a forward flexion test and flexion internal rotation test, which involves bending the hip joint forward and rotating it inwards to properly assess range of motion and evaluate potential issues in the hip."

Dr. Rich further stated that Chen properly performed a flexion and abduction external rotation test, pursuant to which he brought the plaintiff's leg into an outward pose, with the knee pointed away from the body, to evaluate the condition of the plaintiff's hip. In addition, he averred that Chen satisfied the appropriate standard of care by obtaining a right hip x-ray as part of the

preoperative assessment, correctly recognized the presence of progressive moderate-to-severe degenerative arthritis, appropriately diagnosed the plaintiff with right hip degenerative joint disease, and properly recommended a right total hip arthroplasty, which Dr. Rich described as an exercise of appropriate medical judgment in light of the plaintiff's history, the results of the examination and x-ray scans, and the plaintiff's complaints of pain and difficulty in walking. In this respect, Dr. Rich asserted that diagnostic testing revealed a bone-on-bone hip, and that surgery was both necessary and the best option to provide the plaintiff with long-lasting relief, particularly in light of the plaintiff's failed course of physical therapy. He further noted that the plaintiff appropriately obtained preoperative medical clearance for surgery.

In connection with the November 13, 2017 procedure itself, Dr. Rich concluded that Chen utilized appropriate surgical technique and exercised proper medical and surgical judgment. He stated that Chen placed appropriate bone ingrowth components, including the acetabular component, femoral component, femoral head component, liner component, and two acetabular screws, specifically, that Chen correctly selected a 36-mm femoral head and acetabular shell to increase joint stability and range of motion, as well as to reduce the risk of component impingement. In this respect, Dr. Rich stated that this size was the preferred and most commonly used size, and provided the plaintiff with the best fit, stability, appropriate offset, and leg lengths. Dr. Rich opined that Chen's operative report detailed good surgical technique and proper performance of the total right hip arthroplasty, since Chen appropriately dislocated the right hip posteriorly and carefully performed femoral neck osteotomy, which involved cutting the femur to remove the arthritic femoral head, and then properly removed the femoral head, exposed the acetabulum, obtained a healthy bony bed for a press fit socket, and impacted a 54-mm cup into the acetabulum that was affixed with screws in the superior acetabular dome for adjunctive fixation, "all of which was appropriate and consistent with the standard of care." He concluded that Chen then properly placed the final polyethylene liner in the shell to replace the

hip socket cartilage and restore the hip's length, alignment, and rotation, then appropriately impacted it into place, and correctly fully engaged the locking mechanism.

Dr. Rich further averred that, consistent with good and accepted orthopedic surgical care, Chen thereafter properly brought the plaintiff's right hip through a range-of-motion test and checked for stability, concluding that the plaintiff's right hip was stable in the position of sleep, had good soft tissue tension, and was stable up to 90 degrees of flexion combined with 70 degrees of internal rotation, which he characterized as appropriate and consistent with a proper and successful hip replacement. As Dr. Rich explained it, to restore and duplicate a patient's baseline anatomy and soft-tissue tension, a surgeon must obtain appropriate hip offset, which he described as the perpendicular distance from the "teardrop" through the femoral-head cuff center of rotation, and then to the axis of the femur. He opined that Chen properly considered and obtained appropriate hip offset to provide the plaintiff with the best stability.

Dr. Rich concluded that the postoperative films confirmed that the plaintiff was provided with an "excellent ingrown hip," with no evidence of infection or implant subluxation and that, consequently, the right hip total arthroplasty was appropriately and properly performed, with the components correctly and properly placed. He further opined that, postoperatively, Mount Sinai Hospital medical providers and Chen properly and appropriately monitored the plaintiff's vital signs, pain levels, and condition of the right-hip surgical wound. Specifically, he stated that Chen evaluated the plaintiff on post-operative day one, and appreciated that the plaintiff was afebrile, with controlled pain, and was provided with or instructed with respect to posterior hip precautions, including no hip adduction, no internal rotation or flexion greater than 90 degrees, while the plaintiff was permitted to be weightbearing as tolerated. Additionally, Dr. Rich asserted that the defendants timely and properly ordered and administered medications and implemented the proper plan and course of treatment, which conclusion was supported by the facts that there was no evidence of any postoperative complications, and that the plaintiff was discharged on November 15, 2017 in good condition to be followed postoperatively at Chen's

office. According to Dr. Rich, there also was no evidence that the plaintiff was abandoned or left unattended, as he noted that Chen saw the plaintiff on November 28, 2017, at which time the plaintiff reported "tolerable pain," while Chen performed a physical examination that reflected a "normal degree" of postoperative edema, along with "smooth" and "well-tolerated" passive range of motion and an x-ray revealed the right hip arthroplasty to be in satisfactory alignment. Dr. Rich further asserted that, subsequent to that visit, Chen continued properly to evaluate and work up the plaintiff at routinely scheduled postoperative visits, all of which revealed no evidence of any surgical complication, inasmuch as the plaintiff complained of "expected" postoperative pain, while physical examinations continued to show that his range-of-motion testing was well tolerated, with no tenderness to palpation, and x-rays continued to demonstrate the right hip arthroplasty in stable alignment. He characterized these findings as reflective of signs of continuing improvement in ambulation, effectiveness of physical therapy, and range of motion of the right hip. In this respect, Dr. Rich noted that, by early 2018, the plaintiff himself reported "noticeable improvement" in his right hip pain and that the hip hardly bothered him.

Dr. Rich thus concluded that the plaintiff did not evince any signs or symptoms consistent with a surgical complication, including hardware complication, and that there was no evidence of improper offset or subluxation. He explained that it was not until April 2019 that the plaintiff first reported worsening right hip pain and a clicking sensation. According to Dr. Rich, his review of the operative report of Dr. Seldes's April 9, 2024 revision procedure confirmed that there was no revision of the actual acetabular cup or femoral stem, that the components were all in good position during the revision surgery, and that, consequently, there was no evidence that Chen improperly placed any of the components or left the plaintiff with instability in his hip. As Dr. Rich described it, Dr. Seldes merely removed hypertrophic scar tissue from around the femoral head, simply changed the cup liner, and provided the plaintiff with a new femoral head. He explicitly opined that Dr. Seldes's determination to increase the size of the femoral component to size 40 provides no evidence of any impropriety during Chen's initial surgery,

since the increase was effectuated solely to decrease the risk of dislocation from the revision surgery. Moreover, Dr. Rich concluded that, since Dr. Seldes did not change the location of the components and did not increase the neck length of the femoral-head component, any allegation that there was excessive offset or improper placement is baseless. As he phrased it,

> "[s]pecifically, Dr. Chen originally placed a 0 size 36 femoral head and during the revision procedure, Dr. Seldes placed a 0 size 40 femoral head confirming there was no change in the femoral head component neck length. A change in the length of the neck of the femoral head component would be necessary to increase offset and length. It is my opinion that Dr. Seldes operative report confirms there was no underlying issue with the offset and is further evidence that Dr. Chen properly performed the November 13, 2017 right hip arthroplasty."

In any event, Dr. Rich agreed with Dr. Seldes's assessment that the plaintiff had developed heterotopic ossification, that is, "bone broth" in soft tissue, manifesting as the 4 cm-to-4.5 cm bony mass found during the revision procedure that extended off the proximal femoral neck. He asserted that such a development was not uncommon in patients who had undergone a hip replacement surgery and had underlying neurologic issues. Dr. Rich opined that heterotopic ossification is a consequence that develops in the absence of negligence, and occurs even with the proper performance of a hip arthroplasty; he concluded that the heterotopic ossification that the plaintiff experienced was unrelated to Chen's performance the right hip replacement surgery, which he averred was confirmed by the fact that the plaintiff developed heterotopic ossification even after Dr. Seldes performed the revision procedure. Moreover, Dr. Rich asserted that the heterotopic ossification was the source of the plaintiff's symptoms, including the clicking and popping, "as evidenced by Dr. Seldes['s] operative report which documents the bony mass was located in the proximal femoral neck posteriorly causing impingement in the iliotibial band and irritation on the sciatic nerve," and particularly in light of the length of time over which those symptoms developed. In connection with that opinion, Dr. Rich explained that Chen had no reason during 2017 and 2018 to suspect that the plaintiff was experiencing heterotopic ossification, as that condition takes time to develop, and the plaintiff had discontinued his care with Chen when his symptoms of pain and clicking had started.

Dr. Rich further rejected, as "unfounded and not supported by the relevant medical records," Dr. Seldes's suggestion that there was a leg-length discrepancy. In fact, according to Dr. Rich, even though Dr. Seldes recorded an approximately 1-cm leg-length discrepancy in his December 7, 2020 note, in the 2024 operative report, the latter specifically noted that the patient's leg lengths were checked and found to be equal, although Dr. Rich did not specify whether this measurement was taken preoperatively or postoperatively. In any event, he asserted that Dr. Seldes did not perform the appropriate workup, as the latter failed to obtain the appropriate diagnostic testing to prove a length discrepancy, which would have required a CT scanogram that would actually have measured leg length in an accurate fashion. Nor, as Dr. Rich explained it, did Dr. Seldes take any steps to correct such an alleged discrepancy.

Dr. Miranda's opinion primarily was addressed to the issue of proximate cause. She concluded that the defendants' treatment was unrelated to the plaintiff's injuries, including hia right hip pain, weakness, limping, right foot drop, and gait problems, which she asserted were "directly related to his many neurologic deficits including his longstanding cervical myelopathy, lumbar radiculopathy and generalized peripheral neuropathy, which were preexisting and had been progressively worsening."

More specifically, Dr. Miranda alleged that the plaintiff's subjective right hip complaints were directly attributable to his extensive neurologic deficits that had resulted from his numerous spinal issues and diabetes. In this respect, she stated that her review of the results of the plaintiff's EMGs and nerve conduction studies (NCSs), performed on August 17, 2019, and May 18, 2020, led her to the conclusion that the plaintiff suffered from a generalized peripheral neuropathy, cervical myelopathy, and lumbar radiculopathy, which she concluded were the causes of his right hip pain, weakness, and impaired balance. Dr. Miranda opined that the plaintiff was appropriately referred to a neurologist for evaluation and EMG/NCS testing in light of his "well-documented progressively worsening upper and lower spinal complaints [and] progressive gait problems," as well as the opinions of his various treating medical providers,

who attributed his right hip complaints to his spine. As she explained it, EMGs and NCSs are procedures that help diagnose muscle and nerve disorders. She asserted that an EMG measures the electrical activity of muscles when they are at rest and when they contract, thus helping to determine if muscles are responding properly to nerve signals and to identify diseases that damage muscles, while an NCS measures how quickly and well electrical signals travel along nerves, thus detecting nerve damage or disease. She further stated that an NCS also can assess the flow of electricity through sensory nerves, which she identified as the nerves that receive and transport sensory and pain information to the central nervous system.

In connection with the plaintiff's August 17, 2019 EMG/NCS, Dr. Miranda concluded that the EMG revealed a variety of abnormalities caused by peripheral neuropathy and lumbosacral radiculopathy, as the plaintiff's sensory nerves were not reactive on either side, which she described as consistent with a generalized peripheral neuropathy. She explained that peripheral neuropathy causes pain, numbness, tingling, and sometimes weakness, which affects both sides of the body. Dr. Miranda further opined that the plaintiff's generalized peripheral neuropathy likely was caused by his diabetes, which she described as one of the most common causes of neuropathy. She also asserted that the NCS performed that same day reflected that the plaintiff's motor nerves, which are the nerves that control muscle movement, had no response in the right ankle and almost completely no response in the left ankle. Dr. Miranda stated that, inasmuch as the amplitudes actually improved when the examination probes moved closer to the center of the plaintiff's body, there was further support for her conclusion that the plaintiff suffered from a peripheral neuropathy, since the longest nerves, which go to the furthest part of an extremity, are the first to show the absence of a response.

Additionally, Dr. Miranda concluded that, based upon the results of the EMG, there was clear evidence of lumbar radiculopathy, primarily at the plaintiff's L4 and L5 levels, which she explained occurs when the nerve roots in the lower back are compressed, thus causing pain,

weakness, and/or difficulty walking. She thus averred that any alleged right hip weakness or pain originated in the spine from a chronic right lumbar radiculopathy.

With respect to the May 18, 2020 EMG/NCS, Dr. Miranda concluded that the results therefrom further confirmed that the plaintiff suffered from peripheral neuropathy originating from his spine, which was consistent with the earlier EMG study. She asserted that Dr. Delfiner, who performed these studies, correctly documented that the plaintiff had experienced pain and weakness in his hips that predated the subject procedure, thus further demonstrating that these symptoms were not caused by, and were unrelated to, the November 2017 right total hip replacement surgery. She thus agreed with Dr. Delfiner that the May 18, 2020 EMG study was consistent with underlying generalized neuropathy, with superimposed multiple radiculopathies in the lumbar and cervical regions, and that a contributing neuropathic component was caused by the plaintiff's diabetes. Additionally, Dr. Miranda opined that the plaintiff's numerous lumbar and cervical diagnostic studies further confirmed that he suffered from many neuropathic diseases, such as lumbar radiculopathy, spondylolisthesis, stenosis, and degenerative changes, all of which directly contributed to and caused the pain and weakness in his right hip. She added that the plaintiff also suffered from cervical myelopathy, which, together with his "progressively worsening" lumbar radiculopathy, contributed to his condition.

In opposition to the defendants' motion, the plaintiff relied on many of the same documents that they had submitted, and also submitted additional medical records, a counterstatement of material facts, an attorney's affirmation, and the expert affirmation of board-certified general surgeon David A. Mayer, M.D., who asserted that he had significant experience in performing hip replacement surgeries and providing postoperative care to patients who had undergone that procedure.

Dr. Mayer opined that Chen departed from good and accepted medical practice by failing to prevent limb-length discrepancy during the surgery. In this respect, he asserted that Chen did not properly document any preoperative templating and intraoperative measurement

techniques, and that, as a result, the plaintiff's right leg was shortened by 12.7 mm, which was greater than the 10-mm shortening that he characterized as the upper limit of acceptability in connection with a total hip arthroplasty. He explained that a shortening of more than 10 mm creates biomechanical dysfunction, hip instability, gait abnormalities, and postural misalignment, and that Chen's failure to ensure equal limb length intraoperatively resulted in the plaintiff's chronic postsurgical pain, difficulty ambulating, and long-term disability. In addition, Dr. Mayer concluded that Chen failed properly to position and secure the several prosthetic components that were employed in the subject surgery. According to Dr. Mayer, postoperative radiological imaging revealed malalignment of the femoral and acetabular components, which he concluded led to joint instability, abnormal hip mechanics, and excessive wear on the surrounding soft tissues. He also asserted that loose bodies were later identified within the joint space, which further confirmed mechanical failure of the prosthesis due to improper surgical technique. As he explained it, had the prosthetic components been appropriately aligned intraoperatively, the plaintiff would not have suffered ongoing joint instability, clicking, and pain.

Dr. Mayer additionally concluded that, despite the plaintiff's presentation of persistent postoperative pain, weakness, and an abnormal gait, Chen failed timely to diagnose and correct these complications. Specifically, Dr. Mayer adverted to the plaintiff's December 12, 2017 visit with Chen, at which the plaintiff complained of pain, instability, and difficulty walking, while Chen's physical examination revealed weakness in the right hip and an antalgic gait. As Dr. Mayer framed the issue, despite these findings, Chen did not order further x-ray or CT, imaging or initiate corrective interventions. He also referred to the plaintiff's April 19, 2019 presentation to Mount Sinai St. Luke's, at which the plaintiff complained of worsening pain and persistent clicking in the right hip. Dr. Mayer asserted that radiological imaging from that visit confirmed multiple loose bodies within the right hip joint, evidence of postoperative instability, and altered biomechanics, which he concluded were consistent with improper prosthetic positioning and

indicative of early mechanical failure of the implants, which he characterized as a preventable complication of a total hip arthroplasty procedure.

With respect to the plaintiff's August 16, 2019 EMG/NCS, Dr. Mayer concluded that these studies confirmed sciatic nerve dysfunction, which he concluded was more likely than not secondary to biomechanical dysfunction caused by leg-length discrepancy and hip instability, and caused, as of January 9, 2020, the plaintiff's progressive weakness, neuropathic pain, increased difficulty in walking, and foot drop. He noted that, despite these worsening symptoms, no surgical correction was recommended, and physical therapy provided minimal relief. Thus, Dr. Mayer opined that, as a direct result of Chen's surgical errors and failure properly to manage the plaintiff's postoperative complications, the plaintiff was caused to suffer from chronic right hip pain, limb-length discrepancy of 12.7 mm, right-hip instability, sciatic nerve damage resulting in foot drop, gait disturbances requiring a cane, and clicking and popping in the hip joint, all of which he concluded were indicative of prosthetic instability and mechanical failure. In this respect, Dr. Mayer concluded that, had Chen adhered to proper surgical protocols, including accurate intraoperative limb-length assessment, correct prosthetic placement, and early recognition of postoperative complications, the leg-length discrepancy, hip instability, and sciatic nerve complications that the plaintiff experienced could have been avoided. He further stated that it is highly likely that the plaintiff will require further painful and invasive attempts at reconstructive hip surgery in the future, with no assurance of a good functional outcome.

In reply, the defendants submitted an attorney's affirmation, in which counsel argued that the court should reject the plaintiff's opposition papers because they were served three days late, that Dr. Mayer was not qualified to render an opinion as to whether Chen's alleged departures caused or contributed to the plaintiff's injuries and the need for revision surgery, and that Dr. Mayer's opinions were speculative, conclusory, and not supported by the medical records in any event.

Initially, the court exercises its discretion, and determines that it will not reject the plaintiff's opposition papers due to lateness (*see Mo v Zhou*, 235 AD3d 556, 557 [1st Dept 2025]), based on law office failure (*see* CPLR 2004, 2005), in light of the fact that the plaintiff's opposition papers were served on a Monday, only three days after the Friday deadline by which he stipulated to serve them, and the defendants were not prejudiced in timely serving a reply.

The court, in the further exercise of its discretion (*see Guzman v 4030 Bronx Blvd. Assoc., LLC*, 54 AD3d 42, 49 [1st Dept 2008]), concludes that Dr. Mayer was, in fact, qualified by training, education, and experience to render all of the opinions set forth in his affirmation (*see Fuller v Preis*, 35 NY2d 425, 431 [1974]; *Bartolacci-Meir v Sassoon*, 149 AD3d 567, 572 [1st Dept 2017]; *Bickom v Bierwagen*, 48 AD3d 1247,1248 [4th Dept 2008]; *Julien v Physician's Hosp*., 231 AD2d 678, 680 [2d Dept 1996]; *Matter of Enu v Sobol*, 171 AD2d 302, 304 [3d Dept 1991]; *Joswick v Lenox Hill Hosp*., 161 AD2d 352, 355 [1st Dept 1990]). The courts of this State repeatedly have rejected the concept that only a specialist practicing in a defendant's particular specialty is competent to testify that another specialist departed from accepted practice in the specialty (*see Fuller v Preis*, 35 NY2d at 431; *Bartolacci-Meir v Sassoon*, 149 AD3d at 572; *Bickom v Bierwagen*, 48 AD3d at 1248; *Julien v Physician's Hosp*., 231 AD2d at 680; *Matter of Enu v Sobol*, 171 AD2d at 304; *Joswick v Lenox Hill Hosp*., 161 AD2d at 355). Nonetheless, a practitioner who is put forward by a party as an expert qualified to support or oppose a summary judgment motion must assert that he or she possesses the necessary knowledge and training in the relevant specialty, or explain how he or she came to it, and also must articulate the standard of care that allegedly was applicable (*see Colwin v Katz*, 122 AD3d 523, 524 [1st Dept 2014]).

> "To qualify as an expert, the witness should be possessed of the requisite skill, training, education, knowledge or experience from which it can be assumed that the opinion rendered is reliable. Thus, if a physician possesses the requisite knowledge and expertise to make a determination on the issue presented, he need not be a specialist in the field. The question of whether a physician may testify regarding the standard of accepted medical practice outside the scope of his specialty can be a troublesome one, but appellate courts have rejected claims

> of error directed at a physician's qualifications to offer an opinion outside the scope of his specialty when the witness's specialty is closely related to the specialty at issue"

(*Matter of Enu v Sobol*, 171 AD2d at 304 [citations omitted]). Thus,

> *"the affidavit must be by a qualified expert who 'profess[es] personal knowledge of the standard of care in the field of . . . medicine [or dentistry at issue], whether acquired through his practice or studies or in some other way'* (*Nguyen v Dorce*, 125 AD3d 571, 572 [1st Dept 2015] [pathologist not qualified to render opinion as to whether defendant deviated from the standard of care in the field of emergency medicine]; *see also Atkins v Beth Abraham Health Servs.*, 133 AD3d 491 [1st Dept 2015] [osteopath not qualified to render opinion on treatment of a geriatric patient with diabetes and other conditions]; *Udoye v Westchester-Bronx OB/GYN, P.C.,* 126 AD3d 653 [1st Dept 2015] [pathologist not qualified to render an opinion as to the standard of care in obstetrics or cardiology]; *Mustello v Berg,* 44 AD3d 1018 [2d Dept 2007] [general surgeon not qualified to render opinion as to gastroenterological treatment])"

(*Bartolacci-Meir v Sassoon*, 149 AD3d at 572-573 [emphasis added]).

Dr. Mayer asserted that he obtained extensive training in orthopedic surgery, including hip arthroplasty procedure. In this regard, he stated as follows:

> "I have performed and/or participated in hundreds of total hip arthroplasty (THA) procedures, including complex cases involving limb length discrepancy (LLD), hip instability, and prosthetic implant failures. I have experience in diagnosing, managing, and treating patients with post-surgical hip complications, including LLD, sciatic nerve damage, and prosthetic joint instability. I have taught and continue to teach the principles of hip arthroplasty, proper implant positioning, and post-operative care to medical students and surgical residents at three (3) New York area accredited medical colleges I am therefore fully familiar with the standards of care required in performing total hip arthroplasty, as well as the surgical techniques and intraoperative protocols necessary to prevent complications such as limb length discrepancy, instability, and nerve damage"

Where, as here, a general surgeon proffering an allegedly expert affirmation demonstrates familiarity with, training in, and experience with certain aspects of the defendant's surgical specialty, specifically, orthopedic hip replacement surgery, and the standards applicable to proper postoperative care, he or she will be deemed to have the requisite experience, training, and knowledge necessary to render an opinion as to whether that defendant departed from standards of good practice that proximately caused injury to the plaintiff (*see Fuller v Preis*, 35 NY2d at 431 [neurologist was permitted to give an opinion in the

closely related specialty of psychiatry on the issue of whether an accident was the proximate cause of a subsequent suicide]; *Humphrey v Jewish Hosp. & Med. Ctr*., 172 AD2d 494 [2d Dept 1991] [general surgeon was deemed to be qualified to render an opinion in the specialty of obstetrics and gynecology]; *Matter of Sang Moon Kim v Ambach*, 68 AD2d 986, 987 [3d Dept 1979] [opinion testimony of qualified neurosurgeon at a professional misconduct hearing was sufficient to permit a finding of gross negligence or gross incompetence of an orthopedic surgeon committed during spinal surgery]; *Matter of Lincoln v New York City Health & Hosps. Corp*., 2018 NY Slip Op 34085[U], *5, 2018 NY Misc LEXIS 14236, *8 [Sup Ct, Bronx County, May 3, 2018] [internist is qualified to render opinion as to the standard of care governing medical care and treatment of patients who undergo breast examinations and breast imaging studies, despite not being a radiologist, oncologist, or breast surgeon]; *cf. Vargas v Bhalodkar,* 204 AD3d 556, 557 [1st Dept 2022] ["(p)laintiff's expert, an internist and gastroenterologist with no apparent training or knowledge in cardiology, did not set forth sufficient qualifications to opine on whether [defendant] deviated from the relevant standard of care when she gave cardiac clearance for decedent to temporarily cease taking blood thinners and undergo a colonoscopy"]; *Newell v City of New York*., 204 AD3d 574, 574 [1st Dept 2022] ["an internist who demonstrated no familiarity with surgery in general or abdominal surgery in particular, was not qualified to render an opinion that [defendant] departed from accepted standards of medical care in performing plaintiff's appendectomy"]; *Samer v Desai*, 179 AD3d 860 [2d Dept 2020] [general and vascular surgeon not qualified to render opinion as to orthopedics or family medicine where he failed to describe his familiarity with the latter specialties]; *Bartolacci-Meir v Sassoon*, 149 AD3d at 572 [1st Dept 2017] [general surgeon lacked any experience in gastroenterology sufficient to qualify him as an expert]; *Steinberg v Lenox Hill Hosp*., 148 AD3d 612, 613 [1st Dept 2017] [plaintiffs' expert was "not qualified to offer an opinion as to causation[,as h]e specializes in cardiovascular surgery, not neurology or ophthalmology [and]

failed to 'profess the requisite personal knowledge' necessary to make a determination on the issue of whether [an arterial] perforation was responsible for plaintiff's visual impairment"]).

To the extent that the defendants suggest that, because Dr. Mayer is not a neurologist, he is not qualified to render an opinion as to whether leg shortening, improper surgical technique, and/or improper placement of various components of the artificial hip caused or contributed to the plaintiff's various physical deficits, including neurological deficits, as well as the need for revision surgery, the court rejects it. Surgeons who perform hip replacements, of necessity, need to know how the placement of artificial components affects not only the hip, but the spine, the back, and adjacent nerves that could cause pain, antalgic gait, and foot drop.

With respect to the merits of the motion, the court concludes that the defendants established their prima facie entitlement to judgment as a matter of law with respect to the medical malpractice cause of action insofar as asserted against Chen with their submissions, including the expert affirmations of Drs. Rich and Miranda. Since Dr. Mayer did not address the defendants' prima facie showing in connection with their alleged failure to take a proper medical history of the plaintiff or refer him to other specialists, their alleged performance of a non-indicated or unnecessary procedure, and allegations that they left the plaintiff unattended, summary judgment must be awarded dismissing so much of the medical malpractice cause of action against Chen as was premised upon these allegations. The court nonetheless concludes that the plaintiff raised triable issues of fact as to whether Chen departed from good and accepted practice in the manner in which he performed the subject procedure, the manner in which he diagnosed the plaintiff's conditions postoperatively, and the manner in which he rendered postoperative treatment and care, and whether those departures cause or contributed to the plaintiff's injuries, conditions, and symptoms. Contrary to the defendants' contention, Dr. Mayer's opinions were "neither conclusory nor speculative, as [they] established the elements of a medical malpractice claim by specific factual references to the care and treatment" of the plaintiff's decedent (*Wiands v Albany Med. Ctr.*, 29 AD3d 982, 984 [2d Dept 2006]), particularly

with respect to whether the radiological studies reflected that Chen's surgery shortened his right leg by more than 10 mm, and whether it was Chen's inappropriate placement of several of the artificial hip components, rather than preexisting neuropathies, that led to the plaintiff's continuing hip and leg pain and weakness, and the need for revision surgery. It is well settled that a battle of experts, such as presented here, raises credibility issues which must be resolved by a fact finder and which preclude summary judgment (*see Frye v Montefiore Med. Ctr.*, 70 AD3d at 25). Hence, summary judgment must be denied in connection with so much of the medical malpractice cause of action against Chen as was premised upon these contentions.

"'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]). Since it is not disputed that Chen was employed by Mount Sinai and working for it in the course of performing the subject procedure, to the extent that there are triable issues of fact as to whether Chen may be held liable for malpractice, there are triable issues of fact as to whether Mount Sinai may be held vicariously liable therefor.

To establish a cause of action to recover for negligent hiring, supervision, training, and retention of healthcare personnel, a plaintiff must demonstrate that the defendants either "knew, or should have known," of their employees' "propensity for the sort of conduct which caused the [patient's] injury" (*Sheila C. v Povich*, 11 AD3d 120, 129-130 [1st Dept 2004]; *see Kuhfeldt v New York Presbyt./Weill Cornell Med. Ctr*., 205 AD3d 480, 481-482 [1st Dept 2022]), or that "any of the persons involved in plaintiff's care was unqualified" (*Shewbaran v Laufer,* 177 AD3d 510, 511 [1st Dept 2019]). Dr. Rich opined that Chen was appropriately credentialed and qualified to perform a total right-hip arthroplasty at Mount Sinai in November 2017. In this

respect, he noted that Chen graduated from Columbia University College of Physicians and Surgeons in 2006, completed an orthopedic surgery residency at Mount Sinai in 2011, and completed a fellowship in adult reconstruction/joint replacement at Rush University Medical Center in 2012. He explained that Chen has been licensed to practice medicine in New York since 2008 and has been board certified in orthopedic surgery since 2014 and that, in his years of practice, has performed many hip replacement surgeries. In opposition to that showing, Dr. Mayer did not address that issue and, hence, the plaintiff failed to raise a triable issue of fact. Consequently, summary judgment must be awarded to the defendants dismissing the negligent hiring, training, supervision, retention, and credentialing cause of action.

To establish common-law negligence, the plaintiff must prove that the defendants owed him a duty of care and breached that duty, and that the breach proximately caused his injuries (*see Solomon v City of New York*, 66 NY2d 1026, 1027 [1985]; *Wayburn v Madison Land Ltd. Partnership*, 282 AD2d 301, 302 [1st Dept 2001]). "Conduct may be deemed malpractice, rather than negligence, when it 'constitutes medical treatment or bears a substantial relationship to the rendition of medical treatment by a licensed physician'" (*Scott v Uljanov*, 74 NY2d 673, 674, 675 [1989], quoting *Bleiler v Bodnar*, 65 NY2d 65, 72 [1985]). "When the duty arises from the physician-patient relationship or is substantially related to medical treatment, the breach gives rise to an action sounding in medical malpractice, not simple negligence" (*Mendelson v Clarkstown Med. Assoc.*, 271 AD2d 584, 584, [2d Dept 2000]; *see Bleiler v Bodnar*, 65 NY2d at 72; *Morales v Carcione*, 48 AD3d 648, 649 [2d Dept 2008]; *Levinson v Health S. Manhattan*, 17 AD3d 247, 247 [1st Dept 2005]). Here, the plaintiff alleged no facts giving rise to an independent claim sounding in common-law negligence, other than as set forth in the separate cause of action alleging negligent hiring, training, supervision, and retention of healthcare personnel (*see Calamari v Panos*, 131 AD3d at 1090), which, as noted above, the court is summarily dismissing. Nor did Dr. Mayer render an opinion as to whether Mount Sinai was negligent in performing its administrative functions. Hence, that branch of the defendants'

ORDERED that the defendants' motion for summary judgment dismissing the complaint is granted only to the extent that they are awarded summary judgment dismissing the negligent hiring, training, supervision, and retention of healthcare personnel cause of action and the common-law negligence cause of action, and so much of the medical malpractice cause of action as was premised upon the defendants' alleged failure to take a proper medical history of the plaintiff or refer him to other specialists, their alleged performance of a non-indicated or unnecessary procedure, and allegations that they left the plaintiff unattended, those causes of action and claims are dismissed, and the motion is otherwise denied; and it is further,

ORDERED that, on the court's own motion, the attorneys for all of 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 January 9, 2026, at 11:00 a.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.

12/5/2025
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