Sturchio v Mehling
2012 NY Slip Op 31893(U)
July 5, 2012
Supreme Court, Suffolk County
Docket Number: 07-19842
Judge: Joseph C. Pastoressa
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SHORT FORM ORDER

INDEX No. 07-19842
CAL. No. 11-01480MM

SUPREME COURT - STATE OF NEW YORK
I.A.S. PART 34 - SUFFOLK COUNTY

COPY

PRESENT:

Hon. JOSEPH C. PASTORESSA
Justice of the Supreme Court

Mot. Seq. # 002 - MG; CASEDISP

---X

ROBERT STURCHIO and JOANNE STURCHIO,

Plaintiffs,

- against -

BRIAN MEHLING, M.D.,

Defendant.

---X

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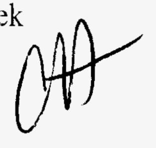
Upon the following papers numbered 1 to 20 read on this motion for summary judgment; Notice of Motion/ Order to Show Cause and supporting papers (002) 1 - 14; Notice of Cross Motion and supporting papers ___; Answering Affidavits and supporting papers 15-18; Replying Affidavits and supporting papers 19-20; Other ____; (~~and after hearing counsel in support and opposed to the motion~~) it is,

ORDERED that motion (002) by the defendant, Brian Mehling, M.D., pursuant to CPLR 3212 for summary judgment dismissing the complaint, is granted and the complaint is dismissed with prejudice.

In this action premised upon the alleged medical malpractice of the defendant, Brian Mehling, M.D., a cause of action has been asserted by the plaintiff, Robert Sturchio, for damages asserted to have been caused by the defendant's alleged departures from the accepted standards of orthopedic care and treatment, with a derivative cause asserted on behalf of the plaintiff's spouse, Joanne Sturchio. It is alleged that the negligent departures from the standard of orthopedic care and treatment occurred on or about September 13, 2005 and during subsequent follow-up office visits with the defendant relative to the surgical repair of a right biceps tendon rupture, tenodesis of the biceps tendon at the elbow causing the biceps to be atrophied and proximally positioned, with weakness of supination, deformity, and loss of motion of the right arm with pain and tenderness. It is asserted by the plaintiff that there are two departures by the defendant, namely that defendant Brian Mehling, M.D. failed to properly immobilize the plaintiff's right arm following the surgical repair of the right biceps tendon, and, secondly, while the plaintiff was wearing a sling, the plaintiff threw a cup and caused a re-rupture of the tendon one week postoperatively, which rerupture Dr. Mehling then failed to diagnose.



The proponent of 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. To grant summary judgment it must clearly appear that no material and triable issue of fact is presented (Friends of Animals v Associated Fur Mfrs., 46 NY2d 1065 [1979]; Sillman v Twentieth Century-Fox Film Corporation, 3 NY2d 395 [1957]). The movant has the initial burden of proving entitlement to summary judgment (Winegrad v N.Y.U. Medical Center, 64 NY2d 851 [1985]). Failure to make such a showing requires denial of the motion, regardless of the sufficiency of the opposing papers (Winegrad v N.Y.U. Medical Center, *supra*). Once such proof has been offered, the burden then shifts to the opposing party, who, in order to defeat the motion for summary judgment, must proffer evidence in admissible form...and must "show facts sufficient to require a trial of any issue of fact" (CPLR 3212[b]; Zuckerman v City of New York, 49 NY2d 557 [1980]). The opposing party must assemble, lay bare and reveal his proof in order to establish that the matters set forth in his pleadings are real and capable of being established (Castro v Liberty Bus Co., 79 AD2d 1014 [2d Dept 1981]).

The requisite elements of proof in a medical malpractice action are (1) a deviation or departure from accepted practice, and (2) evidence that such departure was a proximate cause of injury or damage (Holton v Sprain Brook Manor Nursing Home, 253 AD2d 852 [2d Dept 1998], *app denied* 92 NY2d 818). To prove a prima facie case of medical malpractice, a plaintiff must establish that defendant's negligence was a substantial factor in producing the alleged injury (*see* Derdiarian v Felix Contracting Corp., 51 NY2d 308 [1980]; Prete v Rafla-Demetrious, 221 AD2d 674 [2d Dept 1996]). Except as to matters within the ordinary experience and knowledge of laymen, expert medical opinion is necessary to prove a deviation or departure from accepted standards of medical care and that such departure was a proximate cause of the plaintiff's injury (*see* Fiore v Galang, 64 NY2d 999 [1985]; Lyons v McCauley, 252 AD2d 516 [2d Dept 1998], *app denied* 92 NY2d 814; Bloom v City of New York, 202 AD2d 465 [2d Dept 1994]).

In support of this motion (001), the moving defendant has submitted, inter alia, an attorney's affirmation; the affirmation of his expert physician, Howard Luks, M.D; copies of the summons and complaint, defendant's answer, and plaintiffs' verified bill of particulars; copies of the plaintiff's medical records from Good Samaritan Hospital; and the signed and certified transcripts of the examinations before trial of Robert Sturchio dated March 19, 2009; and the unsigned but certified transcript of Brian Mehling dated April 25, 2011, which is considered adopted as accurate by the moving defendant (*see*, Ashif v Won Ok Lee, 57 AD3d 700 [2d Dept 2008]); and defendant's medical records related to his care and treatment of the plaintiff; the records from Long Island Sports & Rehab Center, East; and the consultation report of Edward D. Wang, M.D. dated January 9, 2007. Although the aforementioned medical records are not certified, they are considered as adopted by reference thereto by plaintiffs' counsel. Counsel for the plaintiff also affirms that the procedural history recited in the defendant's moving papers is essentially accurate.

The defendant's expert, Howard Luks, M.D. affirmed that he is duly licensed to practice medicine in New York State and that he is board certified in orthopedic surgery. He set forth his education and training and affirmed that his opinions are based within a reasonable degree of medical certainty. Dr. Luks set forth that the plaintiff, Robert Sturchio, was first injured when his brother-in-law fell on his right arm during a fall on a boat. He felt a "rubber band... snap in [his] right arm," and knew

immediately that he ruptured a tendon. When he arrived home, he researched on the computer the cause and repair of a ruptured biceps tendon. The plaintiff was evaluated by the defendant, Brian Mehling, M.D. on September 12, 2005 at Good Samaritan Hospital, at which time it was noted that the plaintiff had an obvious deformity in his right upper arm, distal area. X-ray was negative for fracture. Diagnosis of the ruptured biceps tendon was made based upon the plaintiff's history of feeling a snap in his arm, along with the presence of an obvious deformity. It is Dr. Luks' opinion that the diagnosis of a ruptured biceps tendon can be made visually and upon physical examination. At the time of Dr. Mehling's examination, he observed that the plaintiff had a bulge in the proximal right arm. Dr. Mehling repaired the plaintiff's distal biceps tendon in his right arm on September 13, 2005, after having obtained an informed consent. The risks associated with this surgery included re-rupture of the biceps tendon, which would require further surgery.

Dr. Luk described the surgical procedure utilized by the defendant, and stated that upon repair, the plaintiff's arm was stable with full pronation, supination and extension. Mr. Sturchio was discharged from the hospital with instructions to wear a sling on the right arm and to begin physical therapy in one week. On September 19, 2005, the plaintiff presented to Dr. Mehling for his first post-operative visit and offered no complaints. An x-ray revealed that the suture anchor was holding the biceps tendon in place, and that it was in the appropriate position. A prescription was given to the plaintiff for physical therapy, directing the therapist to perform flexibility therapy with gentle range of motion, moist heat, cold, electrostimulation, massage, and ultrasound, with gentle, non-weight bearing exercises.

Dr. Luk stated that on September 21, 2005, Mr. Sturchio presented to Dr. Mehling stating that he tossed a plastic cup with his right arm and felt a click. It is Dr. Luk's opinion that a click would not indicate that there was a re-rupture of the biceps tendon, but, rather, could represent the loosening of scar tissue, an asymptomatic click at the elbow that people may experience on a daily basis, or inflammation. Dr. Luk continued that had the plaintiff re-ruptured his biceps tendon, he would have likely heard a "pop" similar to what he heard at the time of the boating accident. Dr. Luk further stated that the plaintiff was unsure if he actually sustained an injury, as noted in the plaintiff's medical record. When Dr. Mehling examined the plaintiff, he noted that the biceps musculature moved with extension and that he was able to palpate the biceps tendon. Dr. Luk opined that the fact that the biceps musculature moved with extension suggests that the biceps tendon repair was intact. Also, the x-ray taken by Dr. Mehling showed the anchor was still in the appropriate position.

Dr. Luk stated that on September 28, 2005, Mr. Sturchio presented to Long Island Sports and Rehabilitation Center for therapy, and moist heat and electric stimulation were commenced. There is no evidence in the physical therapy records that the patient re-ruptured his biceps tendon repair, and Mr. Sturchio made no complaints to the therapist. When Dr. Mehling saw the plaintiff on October 3, 2005, the plaintiff had minimal complaints. It was noted that he had some moderate atrophy about the biceps and triceps musculature, a normal postoperative finding due to disuse of the muscle. Full range of motion was noted, including supination and pronation. Examination revealed no signs of re-injury. Physical therapy was continued on October 5th, 12th, 17th, 19th and 26th, 2005, with no evidence in the physical therapy records of a re-injury of the biceps tendon muscle. When the plaintiff was seen by Dr. Mehling on October 31, 2005, a small stitch abscess was noted and antibiotics were appropriately

prescribed. The tendon repair was tested with pronation and supination, and was found to be intact. Dr. Luk continued that there is no evidence in the medical record indicating a change in appearance of the muscle from the postoperative period. When the plaintiff returned to physical therapy on November 1, 2005, he advised the therapist that Dr. Mehling was pleased with his progress. The records do not indicate that there was a re-injury to the biceps tendon.

Dr. Luk continued that when Mr. Sturchio returned to Dr. Mehling on December 27, 2005, there was some adhesion of the skin to the repair, possibly representing scar tissue formation. The plaintiff had full range of motion, and the records do not indicate a change in appearance of the muscle from the postoperative period. When he returned to Dr. Mehling's office on March 27, 2006, the plaintiff reported that for several weeks he was having increased pain about the area of repair; however, he denied difficulty with function. Upon physical examination, there was full range of motion with excellent strength. There was an area of scarring following the flexion of the biceps musculature. Upon palpation, the course of the distal biceps tendon and the repair were intact. Upon presentation to the physical therapist on March 28, 2006, the plaintiff advised the therapist that he was unhappy with the scarring of the incision because it pulled when he was trying to use his arm. It is Dr. Luk's opinion that scarring is a known complication of any surgery. Physical therapy was commenced for scar mobilization. Aside from the scar, the therapist did not note any other deformity of the upper extremity. After his April 4, 2006 physical therapy session, the plaintiff reported that he felt better and did not return thereafter to physical therapy for his arm as scheduled on April 22, 2006. As of the last date of treatment with Dr. Mehling on March 27, 2006, the plaintiff was experiencing no difficulty with range of motion. Dr. Luk noted that approximately nine months later, on January 9, 2007, Mr. Sturchio presented to Dr. Edward Wang with complaints of continued pain over the right biceps and a pulling sensation in the arm. He had full range of motion in the bilateral upper extremities, including the right elbow, and full strength of the right upper extremity, including the elbow. An x-ray was negative, however, Dr. Wang did not order an MRI. Dr. Wang opined that the tendon was palpable in the mid-upper arm and was not in the antecubital fossa.

While the plaintiff alleges that the re-injury would not have occurred if Dr. Mehling immobilized the plaintiff's right arm instead of placing it in a sling, it is Dr. Luk's opinion that the decision to place a sling, cast, or splint after a distal biceps tendon repair is a matter of medical or surgical judgment, and the decision to promote early immobilization versus early range of motion is a medical or surgical judgment call to be made by the treating physician in an effort to prevent the formation of scar tissue. Dr. Luk stated that either decision is appropriate and acceptable. Dr. Luk continued that re-rupture of the biceps tendon is a rare complication that may occur in any patient after biceps tendon repair, regardless of whether or not the physician elects to utilize early range of motion or immobilization. Dr. Luk further opined that the judgment to prescribe an early range of motion protocol for Mr. Sturchio did not proximately cause his claimed injuries. Dr. Luk continued that the plaintiff did not suffer an injury tossing a plastic cup as that would not generate enough force to cause a re-rupture of the biceps tendon. He stated that Mr. Sturchio's tendon was intact at the time of his last office visit with Dr. Mehling, as demonstrated by the plaintiff having full range of motion, normal strength, and the course of the biceps tendon was able to be palpated at the time of the visit, indicating the repair was intact. The biceps musculature moved with extension, the neurovascular examination was within normal limits, and the suture anchor was intact in the appropriate position. Thus, concludes Dr. Luk, the re-rupture of the

biceps tendon muscle must have occurred at some point after the plaintiff's last visit with Dr. Mehling, but before the visit with Dr. Wang nine months later. Dr. Luk concludes that there is no support for the plaintiff's allegation that Dr. Mehling failed to diagnose the re-rupture.

Based upon the foregoing, it is determined that Dr. Mehling has established prima facie entitlement to summary judgment dismissing the complaint on the basis that he did not depart from the appropriate orthopedic standard of care, that he did not proximately cause the plaintiff's re-rupture of the biceps tendon, and that he did not fail to diagnose the re-rupture of the biceps tendon. At the time of the plaintiff's last visit with Dr. Mehling, he had full range of motion, normal strength, and the course of the biceps tendon was palpated, indicating the repair was intact. It was also found that the biceps musculature moved with extension, the neurovascular examination was within normal limits, and the suture anchor was intact in the appropriate position, indicating that the re-rupture of the biceps tendon muscle must have occurred at some point after the plaintiff's last visit with Dr. Mehling, but before the visit with Dr. Wang nine months later.

To rebut a prima facie showing of entitlement to an order granting summary judgment by the defendant, the plaintiff must demonstrate the existence of a triable issue of fact by submitting an expert's affidavit of merit attesting to a deviation or departure from accepted practice, and containing an opinion that the defendant's acts or omissions were a competent-producing cause of the injuries of the plaintiff (*see* Lifshitz v Beth Israel Med. Ctr-Kings Highway Div., 7 AD3d 759 [2d Dept 2004]; Domaradzki v Glen Cove OB/GYN Assocs., 242 AD2d 282 [2d Dept 1997]). "Summary judgment is not appropriate in a medical malpractice action where the parties adduce conflicting medical expert opinions. Such credibility issues can only be resolved by a jury" (Bengston v Wang, 41 AD3d 625 [2d Dept 2007]). Here, the plaintiff has opposed the motion with the affidavit of his expert, Dr. Andrew Collier, Jr., M.D.

Dr. Collier averred that he is licensed to practice medicine in New Jersey and Pennsylvania and that he is board certified in orthopedic surgery. He set forth his educational and work experience as an orthopedist. Dr. Collier averred that Dr. Mehling failed to properly immobilize the plaintiff's right arm with a splint or cast following surgery, and then failed to diagnose the re-rupture of the plaintiff's biceps tendon during postoperative follow-up care and treatment.

Dr. Collier stated that the repair of the biceps tendon was performed by Dr. Mehling on September 13, 2005, at which time the plaintiff was discharged with a sling, and was instructed to begin physical therapy within one week. On September 21, 2005, at his second postoperative visit with Dr. Mehling, Mr. Sturchio reported that he felt a click and pain when throwing a plastic cup with his right arm. Dr. Collier stated that the plaintiff thereafter experienced no other singular events in his postoperative course that could explain his development of a re-rupture other than throwing the cup. He was ultimately diagnosed with re-rupture of the right biceps tendon on January 9, 2007 by Dr. Wang.

Dr. Collier stated that if the history is correct, and that Mr. Sturchio had no other events wherein he felt a click and a sudden sharp pain in the elbow in the vicinity of the right biceps tendon from his discharge from the hospital on September 13, 2005 until his diagnosis on January 9, 2007, then it is his opinion to a reasonable degree of medical certainty that Mr. Sturchio re-ruptured his right biceps tendon just prior to his follow up office visit on September 21, 2005, when he threw a cup. Thereafter, stated

Dr. Collier, Dr. Mehling departed from the standard of care by failing to have Mr. Sturchio undergo an MRI, thus causing the window of opportunity to pass to surgically repair the tendon. He continued that had the re-rupture been diagnosed during the period of the postoperative visits with Dr. Mehling, then his condition could have been surgically repaired.

Based upon the foregoing, it is determined that the plaintiff failed to raise a factual issue so as to preclude the granting of summary judgment. Dr. Collier stated that the preservation of the repair is predominant in cases such as this, and that the instruction to the plaintiff to use a sling was a departure from the good and accepted standard of care. Dr. Collier based his opinion on the fact that the plaintiff suffered a re-rupture of the biceps tendon upon throwing a cup. Dr. Collier, however, did not set forth the standard of care as to whether a postoperative sling, cast or splint is to be utilized. He did not take into account the consideration of preserving mobility in an effort to prevent the formation of scar tissue versus preservation of the repair and concluded, without basis, that a splint or cast should have been applied. Dr. Collier opined that the rupture of the tendon occurred when the plaintiff threw the cup. Accordingly, the determination of whether to use a sling versus immobilization with a cast was made prior to the event which Dr. Collier opined was the proximate cause of the injury. Dr. Collier did not opine as to whether the re-rupture would have occurred had the plaintiff not thrown the cup, in disregard of the warnings by Dr. Mehling to avoid strenuous activity.

Dr. Collier did not opine as to whether or not it was poor judgment for Dr. Mehling to elect to use the sling to encourage mobility in an effort to prevent the formation of scar tissue. Mere error in medical judgment does not give rise to a viable claim of medical malpractice because there is risk of error in every medical judgment (Fiederlin v City of New York Health and Hospitals Corporation, 80 AD2d 821 [1st Dept 1981]). The rule requiring a physician to use his best judgment does not hold him liable for mere error or judgment, provided he does what he thinks is best, to bring about a good result after careful examination (Spadaccini v John M. Dolan, 63 AD2d 110 [1st Dept 1978]). If a physician fails to employ his expertise or best judgment, and that omission causes injury, he should not be automatically freed from liability because in fact he adhered to acceptable practice (Toth v Community Hospital at Glen Cove, 22 NY2d 255 [1968]). However, a doctor is not liable in negligence merely because a treatment, which the doctor as a matter of professional judgment elected to pursue, proves ineffective or a diagnosis proves inaccurate, as not every instance of failed treatment or diagnosis may be attributed to a doctor's failure to exercise due care (see, Dumas v Adirondack Medical Center, 89 AD3d 1184 [3rd Dept 2011]; Shahram v Howwitz, M.D., 5 AD3d 1034 [4th Dept 2004]). There has been no basis demonstrated by the plaintiff that Dr. Mehling should have known that the plaintiff would disregard his warnings and instructions by throwing a cup while his arm was in a sling in the early postoperative period. Nor has it been demonstrated that the use of a sling was the proximate cause of the plaintiff's re-rupture. Instead, as opined by Dr. Collier, the re-rupture allegedly occurred when the plaintiff threw the cup, proximately causing the injury. Further, the plaintiff has not raised a factual issue concerning whether or not Dr. Mehling failed to use his best judgment in employing the use of a sling, rather than a cast or splint, in an effort to preserve mobility of the plaintiff's arm.

Thus, in issue is whether Dr. Mehling failed to diagnose a re-rupture of the biceps tendon, whether he departed from the standard of care in failing to order an MRI after September 21, 2005 when the plaintiff threw the cup and felt a click in his arm, and whether he failed to diagnose a rerupture of the

biceps tendon. Dr. Collier concludes that the plaintiff re-ruptured his tendon when he threw the cup while under the care and treatment of Dr. Mehling through March 27, 2006. However, such opinion is conclusory, and unsupported by the record. Dr. Collier does not incorporate the physical findings and clinical presentation demonstrated by Dr. Mehling, or the physical therapist, into his opinion. Dr. Collier fails to take into consideration the findings by Dr. Mehling upon physical examination of the plaintiff after September 21, 2005 and throughout the plaintiff's last visit with Dr. Mehling. While Dr. Mehling found that the plaintiff had full range of motion, normal strength, and the course of the biceps tendon was palpated at the time of the visit, indicating the repair was intact, and that the biceps musculature moved with extension, the neurovascular examination was within normal limits, and the suture anchor was intact in the appropriate position, Dr. Collier failed to correlate his opinion with these objective physical findings by Dr. Mehling and those set forth by the physical therapist, who were both actively treating the plaintiff.

Dr. Collier opined that Dr. Mehling further departed from the standard of care by failing to obtain an MRI of the plaintiff's arm after her threw the cup. He stated an MRI is the only conclusive means of establishing the presence or absence of a re-rupture of the biceps tendon, however, he does not set forth the basis for that opinion or consider the physical findings upon examination by Dr. Mehling or the physical therapist. The plaintiff testified that he had concerns about having an MRI because he thought he might have had a titanium implant placed in his arm with the repair of the ruptured biceps tendon, and was afraid an MRI would cause it to "come flying out." While Dr. Collier opines that it was a departure by Dr. Mehling not to obtain an MRI study of the plaintiff's arm, it is noted that when the plaintiff was examined by Dr. Wang, nine months later, no MRI was taken, and the diagnosis of a ruptured biceps tendon was based upon clinical examination alone wherein provocative testing revealed a right shortened biceps with palpation and on inspection, and that the tendon was palpable in the mid upper arm and not in the antecubital fossa. These were new and different findings which were documented nine months after Dr. Mehling's last examination of the plaintiff on March 27, 2006. At that last visit, the plaintiff reported to Dr. Mehling that he "feels tightening" and that the scar is becoming painful, but he denied any difficulty with function. Upon examination, Dr. Mehling found that "[p]hysical examination today of the patient's right elbow reveals full range of motion. He does have excellent strength including flexion and supination and pronation. Neurovascular examination is within normal limits. The skin is intact. There is an obvious area of scarring that is following the flexion of the biceps musculature and he does indicate that this is the area of the symptom." When the plaintiff presented to Dr. Wang on January 9, 2007, he complained of pain over the right biceps and a pulling sensation in the arm. He also indicated that he was taking Flexeril secondary to a recent neck injury. The plaintiff testified that in December 2006, he suffered a work related injury to his neck when a falling piece of sheetrock, which he was trying to stop from falling, stuck him in the neck.

Dr. Collier does not reconcile the different findings set forth initially by Dr. Mehling on March 27, 2006 when he last saw the plaintiff, and by Dr. Wang on January 9, 2007, when he first saw the plaintiff on consultation. He does not offer an opinion for the change in findings during the nine month period following the plaintiff's last visit with Dr. Mehling. Dr. Collier does not address the fact that Dr. Wang did not perform an MRI to substantiate the re-rupture, although he opines that Dr. Mehling departed from the standard of care by not performing an MRI despite the absence of clinical evidence of a re-ruptured tendon demonstrated upon Dr. Mehling's examination. Dr. Collier does not opine that the

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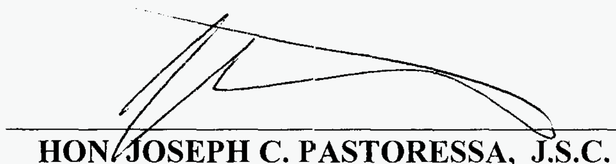
physical findings by Dr. Mehling or the physical therapist in any way indicated a re-rupture of the tendon while under their care and treatment. Additionally, Dr. Collier does not address the issue of spontaneous re-rupture of the biceps tendon in the absence of negligence. Instead, Dr. Collier presents speculative, conclusory opinions based upon conjecture rather than upon the medical documentation and findings set forth by Dr. Mehling, the physical therapist, and Dr. Wang. Accordingly, the plaintiff has failed to raise an issue of fact as to whether the defendant's acts or omissions were the proximate cause of the plaintiffs injuries.

In view of the foregoing, motion (001) by defendant Mehling for summary judgment dismissing the complaint is granted and the complaint is dismissed with prejudice.



Dated: July 5, 2012

HON. JOSEPH C. PASTORESSA, J.S.C.

__X__ FINAL DISPOSITION _____ NON-FINAL DISPOSITION