Lewis v Fufa
2018 NY Slip Op 30902(U)
May 8, 2018
Supreme Court, New York County
Docket Number: 805672/15
Judge: George J. Silver

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NEW YORK: PART 10

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STEVEN LEWIS,

Index 805672/15
Motion Seq. 001

DECISION & ORDER

Plaintiff,

-against-

DURETTI FUFA, M.D., and HOSPITAL FOR SPECIAL SURGERY,

Defendants.

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GEORGE J. SILVER, J.S.C.:

In this medical malpractice action, defendants DURETTI FUFA, M.D., and HOSPITAL FOR SPECIAL SURGERY ("defendants") move for summary judgment. Plaintiff STEVEN LEWIS ("plaintiff") opposes the motion. For the reasons discussed below, the court grants the motion.

While working as an arborist on July 25, 2013, plaintiff fell from a tree and injured his right shoulder as he was reaching for a branch. On July 31, 2013, plaintiff consulted with Dr. Sabrina Strickland at the Hospital for Special Surgery for an evaluation of his right shoulder and right arm. Dr. Strickland diagnosed a tear of the long head of the biceps of plaintiff's right shoulder and recommended surgery. On August 5, 2013, Dr. Strickland performed a right shoulder arthroscopic extensive debridement and biceps tenodesis. Plaintiff then started post-operative physical therapy for his right shoulder, and during a visit with Dr. Strickland on September 18, 2013 reported that his shoulder was injured during a therapy session. On September 23, 2013, Dr. Strickland performed a right shoulder revision biceps tenodesis and a wound exploration on plaintiff's right shoulder.

During a post-operative visit with Dr. Strickland on January 9, 2014, plaintiff complained of numbness and tingling in his right hand and snapping and pain in his left elbow. Dr. Strickland ordered an electrodiagnostic study ("EMG") to evaluate plaintiff for nerve damage. The EMG, performed by Dr. Feinberg on February 25, 2014, revealed that plaintiff had bilateral carpal tunnel syndrome and right side cervical radiculopathy. During a visit with Dr. Strickland the following day, and later on April 9, 2014, plaintiff complained of numbness and tingling in his right hand and pain in his left elbow. Dr. Strickland concluded that the pain in plaintiff's left elbow was a result of a traction injury to his ulnar nerve. On April 29, 2014, Dr. Mazella, a board certified orthopedic surgeon, whom Workers' Compensation designated to evaluate plaintiff, concluded that plaintiff had bilateral carpal tunnel syndrome and left ulnar nerve subluxation. When plaintiff saw Dr. Strickland on May 21, 2014, he complained of bilateral hand numbness, tingling that had worsened over time, and bilateral elbow pain. Dr. Strickland referred plaintiff to Dr. Fufa, a hand and elbow specialist for further evaluation and treatment.

On June 5, 2014, plaintiff saw Dr. Fufa and reported his history of numbness and tingling in both hands, with the right hand worse than the left hand. He also complained of a locking sensation at the left elbow with pain and electricity. Dr. Fufa diagnosed plaintiff with bilateral carpal tunnel syndrome, possible cubital tunnel syndrome, and possible ulnar nerve subluxation. Dr. Fufa also sent plaintiff for another EMG. The EMG, performed by Dr. Feinberg on July 2, 2014, revealed that plaintiff had bilateral carpal tunnel syndrome and bilateral ulnar neuropathy at the elbows.

Plaintiff saw Dr. Fufa again on July 31, 2014 and complained that his right upper extremity had worsened, and that his left upper extremity was unchanged despite conservative management with night braces and various positioning techniques. Dr. Fufa diagnosed plaintiff with bilateral

carpal and cubital tunnel syndrome, and recommended surgery. On August 25, 2014, Dr. Fufa performed a right carpal tunnel release and right ulnar nerve decompression with anterior subcutaneous transposition of the ulnar nerve. During a post-operative visit on September 4, 2014, plaintiff reported that he had no numbness or tingling on the right side, but complained that he had developed severe cubital tunnel syndrome on the left side, and requested that Dr. Fufa perform the same surgery on his left arm.

On September 18, 2014, plaintiff reported to Dr. Fufa that his right arm continued to improve, but complained of increased feelings of electricity on his left side. On November 5, 2014, Dr. Fufa performed a left carpal tunnel release and a left ulnar nerve decompression and anterior subcutaneous transposition of the ulnar nerve on the plaintiff's left arm. During a post-operative visit on November 13, 2014, plaintiff had swelling, numbness, and tingling in the ulnar distribution from the left elbow to the fingertips of his left hand. Plaintiff's surgical wounds were healing, and eight days after the surgery, he had no signs or symptoms of an infection.

On November 19, 2014 plaintiff visited Nyack Hospital Emergency Room ("ER") with complaints of pain and swelling in his left hand since the previous day. His white blood cell count was within a normal range of 9.1. The ER physician contacted Dr. Fufa, who directed him to administer Vancomycin antibiotic intravenously and discharge plaintiff on Clindamycin oral antibiotic. Plaintiff was also instructed to see Dr. Fufa the following morning on November 20, 2014. During that visit, Dr. Fufa noted that plaintiff appeared to have an infection and ordered an ultrasound to evaluate the extent of his condition. The ultrasound was performed the same day, and revealed a fluid collection under the incision in plaintiff's left hand. That evening, Dr. Fufa performed a left wrist irrigation, debridement, tenosynovectomy, and neurolysis of the ulnar and median nerves to address plaintiff's infection. During the surgery, plaintiff experienced atrial

fibrillation and required a subsequent surgery. Plaintiff remained in the hospital on intravenous antibiotics until November 25, 2014 when he was discharged and instructed to continue intravenous antibiotics for the following weeks at home.

Dr. Fufa saw plaintiff on December 2, 2014, and noted that his pain had improved and the swelling of his left hand had decreased. Dr. Fufa saw plaintiff again on December 11, 2014, and noted that he had no signs or symptoms of infection, but plaintiff continued to complain of hypersensitivity and numbness in his left hand. On December 30, 2014, Dr. Fufa observed that plaintiff's motion had improved, but noted that he continued to experience neuropathic problems including numbness along the ulnar nerve. Dr. Fufa prescribed plaintiff with gabapentin (also known as Neurontin), and considered ordering another EMG and/or revision surgery with a submuscular transposition of the left ulnar nerve.

When plaintiff saw Dr. Fufa on January 29, 2015, plaintiff had stopped taking the Neurontin, and reported that his pain had improved. Dr. Fufa also found decreased sensation in the ulnar aspect of plaintiff's left hand. On March 18, 2015, plaintiff complained to Dr. Fufa about neuropathic pain and numbness and tingling in his left hand. An ultrasound performed that day revealed inflammation of the ulnar nerve at plaintiff's left elbow. Dr. Fufa ordered an EMG to determine if the nerve irritation was coming from the elbow alone or from both the elbow and the wrist. On March 24, 2015, an EMG performed by Dr. Feinberg revealed that plaintiff had left ulnar neuropathy at the elbow. Plaintiff did not see Dr. Fufa again.

Plaintiff thereafter consulted with Dr. Richard McGill, who diagnosed him with failed ulnar transposition. On June 26, 2015, Dr. McGill performed a left ulnar nerve neurolysis and submuscular transposition and a tenotomy of the flexor pronator origin on plaintiff's left arm.

According to plaintiff, Dr. McGill's surgery did not relieve his symptoms and complaints, and he continues to experience numbness and tingling in his left hand.

ARGUMENTS

Based on the record before the court, defendants argue that summary judgment must be granted, because plaintiff cannot establish that defendants' medical treatment deviated from accepted standards of care or that this treatment proximately caused plaintiff's alleged injuries.

Defendants argue that plaintiff injured his left ulnar nerve long before Dr. Fufa operated on his right arm on August 25, 2014, and that plaintiff's assertion that he did not have problems or complaints with his left upper extremity until after Dr. Fufa operated on his right arm is false. Specifically, defendants claim that the records of Dr. Strickland, Dr. Feinberg, and Dr. Mazella reveal that from as early as January 2014, plaintiff had signs and symptoms of nerve damage in his left arm. Defendants also contend that Dr. Fufa did not worsen plaintiff's pre-existing ulnar nerve injury and that Dr. Fufa did not cause plaintiff to develop a post-operative wound infection. Rather, defendants assert that Dr. Fufa correctly diagnosed plaintiff's condition, performed appropriate surgeries, and did so using proper surgical techniques.

In support of their motion, defendants annex the affirmation of Dr. Nader Paksima ("Dr. Paksima"), a board certified orthopedic surgeon. In his affirmation, Dr. Paksima asserts that plaintiff's left arm was fully and appropriately placed on a well-cushioned arm board during plaintiff's right arm surgery on August 25, 2014. Dr. Paksima explains that the aim of surgical positioning is to allow surgical access while minimizing the risk of harm to the patient, and that the primary goal of positioning is to avoid nerve compression by providing appropriate padding to all pressure points. According to Dr. Paksima, this is all the standard of care requires, but

defendants went a step further and afforded plaintiff greater protection by placing a pillow under his left arm. In Dr. Paksima's opinion, no other precautions were necessary or required. He further explains that in a patient like plaintiff, with a pre-existing ulnar nerve injury, the neuropathy can worsen spontaneously and inexplicably even where all appropriate measures are taken to protect the nerves. Accordingly, defendants argue that plaintiff's claim that Dr. Fufa negligently positioned his left arm during the August 25, 2014 surgery should be dismissed.

Additionally, defendants argue that plaintiff had significant damage to his left ulnar nerve before his left arm surgery on November 5, 2014, and that the surgery did not and could not have caused the nerve injury. According to Dr. Paksima, Dr. Fufa appropriately protected the nerves in plaintiff's left (surgical) arm by placing his arm on a well-cushioned arm board and padding all of plaintiff's pressure points. Dr. Paksima explains that it would have been inappropriate to place plaintiff's surgical arm on a pillow because a pillow is not a sufficiently stable surface for a surgical procedure. Dr. Paksima notes that the only time plaintiff's left ulnar nerve could have been exposed to any pressure during surgery was while Dr. Fufa performed the carpal tunnel release procedure, which takes about 10-15 minutes. In Dr. Paksima's opinion, that is not enough time to cause an irreversible nerve injury, and at worst, 10-15 minutes of pressure on the nerve could cause a transient neuropraxia, akin to when a limb "falls asleep." Dr. Paksima further elaborates that when the position of the "sleeping" limb changes, the nerves "wake up" without any injury.

Dr. Paksima also opines that Dr. Fufa's use of a tourniquet[1] on plaintiff's left upper extremity during his left arm surgery on November 5, 2014 did not cause any injury to his ulnar nerve. According to Dr. Paksima, the type of tourniquet used during plaintiff's surgery was inflated to 250 mmHg (millimeters of mercury), which is standard and appropriate for this kind of surgery.

[1] A tourniquet is a compressive device that provides a bloodless surgical field.

Dr. Paksima also notes that the tourniquet was used for only 59 minutes, which is not enough time to cause any harm to plaintiff's left ulnar nerve. In Dr. Paksima's opinion, plaintiff's left ulnar nerve injury pre-dated the surgery, and nothing in the surgical positioning and/or the use of a tourniquet caused plaintiff's nerve injury or made it worse. Accordingly, defendants argue that plaintiff's claim that Dr. Fufa improperly positioned his left arm and/or improperly used a tourniquet on his left arm during his surgery on November 5, 2014 should be dismissed.

Dr. Paksima further opines that plaintiff received appropriate preventative treatment for his surgery on November 5, 2014, and that plaintiff's infection was not the result of any departure from good and accepted medical or surgical practice. Specifically, Dr. Paksima notes that plaintiff's left arm was cleaned with a topical antiseptic prior to any incision, plaintiff received an antibiotic known to be effective against staphylococcus and streptococcus organisms, and Dr. Fufa and the operating room personnel followed all sterile protocols. According to Dr. Paksima, it is not the standard of care to order or administer post-operative antibiotics following a carpal tunnel and/or subcutaneous ulnar nerve transposition surgery. In that regard, Dr. Paksima concludes that had plaintiff contracted an infection due to inadequate sterile techniques or insufficient antibiotic therapy, he would have exhibited signs and symptoms long before November 18, 2014, and that his surgical wounds would not have been healing well. Indeed, Dr. Paksima notes that during plaintiff's first post-operative visit with Dr. Fufa on November 13, 2014, 8 days after the surgery, he had decreased pain, no fever, and no redness, streaking, or drainage from the incisions. Dr. Paksima also notes that the swelling on plaintiff's hand was a normal and expected post-operative condition, and that without any other indicators, swelling by itself is not indicative or suggestive of an infection. Accordingly, defendants argue that plaintiff's claim that Dr. Fufa and the Hospital for Special Surgery caused him to contract a post-operative infection should be dismissed.

In opposition, plaintiff asserts that questions of fact exist as to the issues of liability and damages. Plaintiff alleges that each party's expert differs in opinion, and that disregarding plaintiff's expert's opinion would amount to "choosing a side in this battle of the experts." Plaintiff also argues that contrary to defendants' assertion, Dr. Fufa did not tell plaintiff to seek medical intervention regarding his infection, but in fact affirmatively advised against it and caused plaintiff's premature discharge from Nyack Hospital. Plaintiff further contends that defendants' expert affirmation is conclusory, and does not address plaintiff's claims that Dr. Fufa failed to properly follow up with him, that Dr. Fufa discouraged him from seeking further medical attention despite knowing his symptoms, and that Dr. Fufa advised against medical intervention despite knowing that his condition was worsening.

In support of his opposition, plaintiff annexes the affirmation of his expert, a physician licensed in New Jersey, and board certified in infectious disease and internal medicine. Plaintiff argues that his expert is qualified to make assessments concerning the standard of care for the diagnosis and treatment of an infection and defendants' departures from the standard of care because these assessments are not particular to the field of orthopedic surgery. According to plaintiff's expert, defendants deviated from accepted standards of care by failing to recognize the signs and symptoms of an infection, and at the very least, timely perform the debridement surgery. Plaintiff's expert also opines that plaintiff's symptoms on November 19, 2014 required immediate intervention, and that in the days that led up to November 20, 2014, Dr. Fufa missed opportunities to refer plaintiff to get medical treatment for a suspected infection. According to plaintiff's expert, these deviations allowed plaintiff's infection to cause resultant scaring of the left wrist and caused the toxicity of the post-operation infection to "precipitate atrial fibrillation" which required an ablation procedure. Plaintiff's expert concludes that had defendants followed the appropriate

standard of care, plaintiff's condition could have been properly managed, his infection would not have reached a severe level, and his resulting pain, suffering and subsequent surgery would have been avoided.

In reply, defendants argue that Dr. Fufa comported with the applicable standard of care when she operated on plaintiff on August 25, 2014 and November 5, 2014, and since plaintiff's expert failed to offer an opinion to support a contrary conclusion, all of plaintiff's claims must be dismissed as a matter of law. Defendants further argue that plaintiff has abandoned his entire theory of liability and replaced it with a new claim that Dr. Fufa negligently failed to timely diagnose and treat his infection.

DISCUSSION

To prevail on summary judgment in a medical malpractice case, a physician must demonstrate that he did not depart from accepted standards of practice or that, even if he did, he did not proximately cause the patient's injury (*Roques v. Noble*, 73 AD3d 204, 206 [1st Dept. 2010]). In claiming treatment did not depart from accepted standards, the movant must provide an expert opinion that is detailed, specific and factual in nature (*see e.g.*, *Joyner-Pack v. Sykes*, 54 AD3d 727, 729 [2d Dept. 2008]). The opinion must be based on facts in the record or personally known to the expert (*Roques*, 73 AD3d at 207). The expert cannot make conclusions by assuming material facts which lack evidentiary support (*id.*). The defense expert's opinion should state "in what way" a patient's treatment was proper and explain the standard of care (*Ocasio-Gary v. Lawrence Hosp.*, 69 AD3d 403, 404 [1st Dept. 2010]). Further, it must "explain 'what defendant did and why'" (*id. quoting Wasserman v. Carella*, 307 AD2d 225, 226 [1st Dept. 2003]).

Once defendant makes a *prima facie* showing, the burden shifts to plaintiff "to produce evidentiary proof in admissible form sufficient to establish the existence of material issues of fact which require a trial of the action" (*Alvarez v. Prospect Hosp.*, 68 NY2d 320, 324 [1986]). To meet that burden, plaintiff must submit an expert affidavit attesting that defendant departed from accepted medical practice and that the departure proximately caused the injuries (*see Roques*, 73 AD3d at 207). "Summary judgment is not appropriate in a medical malpractice action where the parties adduce conflicting medical expert opinions" (*Elmes v. Yelon*, 140 A.D.3d 1009 [2nd Dept 2016] [citations and internal quotation marks omitted]). Instead, the conflicts must be resolved by the factfinder (*id.*).

Here, as an initial matter, plaintiff's expert affidavit is inadmissible. CPLR § 2309(c) requires that an oath taken outside of New York be accompanied by a certificate of conformity. Because plaintiff's infectious disease expert is not licensed in New York, his affidavit fails since it was not accompanied by a certificate of conformity. Accordingly, defendants are entitled to summary judgment, as plaintiff has proffered inadmissible evidence to rebut defendants' *prima facie* showing.

Even if plaintiff had provided a certificate of conformity, defendants are nonetheless entitled to summary judgment because plaintiff's infectious disease expert has no education, training, knowledge, or expertise in surgical procedure or orthopedic surgery (*Schechter v. 3320 Holding LLC*, 64 A.D.3d 446, 450 [1st Dept. 2009]; *Behar v. Coren*, 21 A.D.3d 1045, 1047 [2d Dept. 2005]). Plaintiff's expert also failed to establish that he is familiar with the applicable standards of care regarding surgical procedure or orthopedic surgery (*id.*).

Additionally, plaintiff's expert affirmation fails to raise triable issues of fact. Defendants' reply affirmation correctly points out that plaintiff failed to address or rebut their expert's assertion

that defendants properly treated plaintiff on August 25, 2014 and November 5, 2014. Specifically, plaintiff's expert does not indicate what the appropriate standard of care should have been, and fails to address or dispute whether Dr. Fufa departed from that standard of care in the manner that she operated on plaintiff. Moreover, plaintiff's expert does not address whether Dr. Fufa's alleged departure proximately caused plaintiff's injuries. Rather, plaintiff's opposition wholly relies on the claims that defendants failed to consider the possibility of infection and did not advise plaintiff to seek immediate medical treatment. Since plaintiff does not challenge defendants' assertions that Dr. Fufa properly performed the surgeries on August 25, 2014 and November 5, 2014, and that defendants did not proximately cause plaintiff's injuries, there are no triable issues of fact here sufficient to defeat summary judgment.

Moreover, defendants properly contend that plaintiff cannot now assert a new claim based on Dr. Fufa's alleged failure to timely diagnose and treat his infection. A plaintiff cannot defeat a motion for summary judgment by asserting a new theory of liability (*Sutin v. Manhattan & Bronx Surface Transit Operating Auth.*, 54 A.D.3d 616, 616 [1st Dept. 2008]; *Abalola v. Flower Hosp.* 44 A.D.3d 522, 522 [1st Dept. 2007]). In his opposition papers, plaintiff alleges for the first time that Dr. Fufa negligently failed to diagnose and treat his infection. However, plaintiff made no allegations of that nature in his initial pleadings. In plaintiff's verified bill of particulars, for instance, his only reference to an infection was that defendants failed to use sterile equipment and maintain a sterile environment during plaintiff's November 5, 2014 surgery. Because this failure to timely diagnose claim was not previously alleged, and because it constitutes a substantive change in plaintiff's theory of liability, it is insufficient to raise a triable issue of fact as a matter of law (*id.*). Therefore, defendants are entitled to summary judgment.

Accordingly, based on the foregoing, it is hereby ORDERED that defendants' motion for summary judgment is GRANTED; and it is further

ORDERED that the clerk is directed to enter judgment in defendants' favor.

This constitutes the decision and order of the court.

May 8, 2018

HON. GEORGE J. SILVER