Brossman v Weiland
2019 NY Slip Op 30418(U)
February 14, 2019
Supreme Court, New York County
Docket Number: 805213/16
Judge: George J. Silver
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SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NEW YORK: PART 10

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BLAKE BROSSMAN,

Plaintiff,

Index No. 805213/16
Motion Seq. 001

-against-

DECISION & ORDER

ANDREW WEILAND, M.D., ANDY MILLER, M.D. and THE HOSPITAL FOR SPECIAL SURGERY,

Defendants.

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

In this medical malpractice action, defendants ANDREW WEILAND, M.D. ("Dr. Weiland"), ANDY MILLER, M.D. ("Dr. Miller"), and THE HOSPITAL FOR SPECIAL SURGERY ("HSS" collectively "defendants"), move for summary judgment. Dr. Miller also seeks partial summary judgment, in the event that the court denies summary judgment, for allegations subsequent to August 3, 2015, on the ground that he was no longer treating plaintiff. Plaintiff BLAKE BROSSMAN ("plaintiff") only opposes summary judgment as to HSS and Dr. Miller.[1] For the reasons discussed below, the court denies the motion.

On April 14, 2015, plaintiff presented to Dr. Weiland with complaints of pain and swelling in the knuckle area of his left fourth digit. Plaintiff denied fevers, chills, nausea, and vomiting. On physical examination, Dr. Weiland observed localized swelling around the back of plaintiff's hand and a focal soft tissue mass proximal to the metacarpal phalangeal ("MP") joint of his fourth finger. Dr. Weiland noted that the mass was soft, nontender, and did not move with flexion or extension

[1] A stipulation of discontinuance dated October 15, 2018 was filed with respect to Dr. Weiland. The parties also stipulated to amend the caption. Accordingly, the only remaining defendants are HSS and Dr. Miller.

of the finger. Plaintiff did not have surrounding erythema (redness). An x-ray taken that day showed no fracture, dislocation, calcific deposits in the joint, or signs of joint narrowing. Dr. Weiland recommended anti-inflammatory medications to address the pain and swelling.

On April 21, 2015, plaintiff underwent an MRI. Upon review, Dr. Weiland noted that the mass appeared to be a giant cell tumor, and recommended an immediate surgical excision. Dr. Hollis Potter ("Dr. Potter"), a radiologist, also reviewed plaintiff's MRI, and noted that it was "likely synovial chondromatosis."

During plaintiff's surgery on April 27, 2015, Dr. Weiland removed the tissue and submitted a sample to pathology. Dr. Miller, an infectious disease specialist, also sent a sample to the Center for Disease Control ("CDC"), which reported the possible existence of mycobacterium mucogenicum or mycobacerium ilatzerense. Dr. Miller suggested taking an additional specimen. The following day, Dr. Weiland and Dr. Georgio Perino ("Dr. Perino"), a pathologist, discussed the pathology analysis, which stated that the results were suggestive of a mycobacterium infection.

On May 4, 2015, Dr. Perino issued a pathology report. He concluded that the histological findings were consistent with an inflammatory lymphoplasmacytic synovitis with a non-necrotizing granulomatous component, and that these findings were suggestive of infection by atypical mycobacterium species. The pathology report also stated that Dr. Weiland provided a clinical history of plaintiff's recent scuba diving activity in the Atlantic Ocean.

During a post-operative visit at HSS on May 8, 2015, a care provider informed plaintiff that he had an infection in his hand, and advised him to see an infectious disease doctor. Plaintiff also saw Dr. Miller that day. Dr. Miller noted that plaintiff did not have a history of trauma or marine exposure that might comport with a diagnosis of mycobacterium marinum infection, and

that no antibiotics were indicated. Dr. Miller recommended a clinical follow-up, and advised that he would arrange for an additional laboratory review and a potential biopsy.

On May 12, 2015, plaintiff reported to Dr. Weiland that his fingers were stuck together and not moving. Plaintiff was also unable to open or close his hand. Upon examination, Dr. Weiland noted that plaintiff's incisions were clean, dry, and intact with no surrounding redness. Dr. Weiland informed plaintiff that there was no infection present, and recommended physical therapy. On May 20, 2015, plaintiff reported to Dr. Weiland that his hand had increased in swelling. Dr. Weiland observed that plaintiff still lacked range of motion, and instructed plaintiff to continue with physical therapy and follow up with occupational therapy. Antibiotics remained on hold.

On June 17, 2015, Dr. Weiland asked plaintiff to come in immediately. Drs. Weiland and Miller both informed plaintiff that the CDC report showed that he had an infection. Plaintiff was then started on a high dose of antibiotics. Dr. Miller also suggested that Dr. Weiland perform a second surgery to obtain additional tissue to determine if there was an infection present.

On June 22, 2015, Dr. Weiland performed a synovectomy procedure on plaintiff. While waiting for the cultures, Dr. Miller prescribed plaintiff with Ciproflocxacin ("Cipro") and Clarithromycin. The pathology report and cultures from plaintiff's second biopsy showed that the mycobacterium did not grow. Dr. Miller continued to treat plaintiff with antibiotics.

On June 25, 2015, plaintiff complained of dark-colored diarrhea to Dr. Miller. On July 6, 2015, plaintiff reported to Dr. Miller that he was experiencing abdominal pain with the new antibiotics. Plaintiff also reported to Dr. Weiland that he had decreased movement in his finger. The plan was to start plaintiff on physical therapy and scar management. Plaintiff was also taking antibiotics. On July 15, 2015, plaintiff reported to Dr. Miller that the mass in his hand was growing.

On August 3, 2015, plaintiff saw Dr. Howard Rosenberg ("Dr. Rosenberg"), an infectious disease physician, who had taken over plaintiff's care. Dr. Rosenberg noted that plaintiff's hand was swollen and red, and that plaintiff had decreased finger flexion. His impression was synovitis due to mycobacterium infection. Cipro was discontinued, and plaintiff was started on Bactrim.

On September 1, 2015, plaintiff saw Dr. Weiland. He was still on antibiotics, and had no signs of infection. On September 15, 2015, Dr. Rosenberg noted that plaintiff was tolerating the new antibiotics, and that his edema and erythema were improving. On October 14, 2015, plaintiff reported to Dr. Weiland a dyskinesia-type motion (abnormal movement) in his left hand, and an inability to extend his third and fourth fingers. Plaintiff last saw Dr. Weiland on October 14, 2015.

On October 20, 2015, plaintiff saw Dr. Salvatore Lenzo ("Dr. Lenzo"), a hand surgeon, who noted that plaintiff was experiencing a decreased range of motion in his left hand. Dr. Lenzo's impression was that plaintiff was experiencing tenosynovitis and residual adhesions after an atypical mycobacterial infection. The plan was to continue antibiotics. On December 23, 2015, Dr. Rosenberg noted that plaintiff was tolerating Biaxin and Bactrim. He also noted that plaintiff could not fully extend his hand.

On February 24, 2016, Dr. Rosenberg noted that plaintiff was tolerating the antibiotics, but was developing swelling of his left fourth and fifth proximal interphalangeal joints. On March 4, 2016, plaintiff underwent an MRI of his left hand, which revealed "erosive changes" along the palmer margin of the distal fourth metacarpal as well as the proximal extent.

On March 14, 2016, plaintiff saw Dr. Scott Wolfe ("Dr. Wolfe"), who noted that plaintiff had some swelling and loss of extension of the fourth MP joint. Upon review of plaintiff's MRI, Dr. Wolfe observed a 5 mm nodule on the dorsal aspect of plaintiff's ring finger. Dr. Wolfe also

noted that another biopsy should be performed to rule out any potential infection, and that plaintiff should discontinue antibiotic therapy in order to obtain optimal sampling.

On April 13, 2016, Dr. Rosenberg noted that there was no evidence of infection in plaintiff's left hand, and that plaintiff's range of motion was likely maximized. On April 25, 2016, plaintiff reported to Dr. Wolfe that he was still unable to fully extend his ring finger, and that he was experiencing pain and "crunching" within the joint. An MRI performed that week revealed cartilage loss and degenerative arthritis in plaintiff's MP joint. Dr. Wolfe also noted that plaintiff may have been developing Dupuytren's contracture at the site where the infection occurred, and that plaintiff was continuing to experience a flexion contracture. Plaintiff was then scheduled for another biopsy to ensure that no infection was still present in his hand.

On April 25, 2016, plaintiff reported to Dr. Wolfe that his ring finger did not fully extend, and that he had pain and "crunching" within the joint. The following day, Dr. Wolfe performed a biopsy of plaintiff's finger. The pathology and microbiology reports showed no infection. On April 27, 2016, Dr. Rosenberg also noted that there was no evidence of infection.

On June 13, 2016, plaintiff reported to Dr. Michael Hausman ("Dr. Hausman"), a hand surgeon, that he had finger weakness and was unable to move his left ring finger. Dr. Hausman recommended a repeat MRI in three months to ensure that the infection was not returning. On June 8, 2016 and June 27, 2016, Dr. Steven Glickel ("Dr. Glickel"), a hand surgeon, noted that plaintiff had a limited range of motion due to scarring of the tendons and arthritic changes of the MP joint. His assessment included mycobacterial infection and arthritis. On September 1, 2016, November 7, 2016, and March 1, 2017, plaintiff was administered Kenalog injections with lidocaine. On September 11, 2017, Dr. Glickel performed an operation to address plaintiff's finger contracture

and tendon adhesions. On September 25, 2017 and September 14, 2017, Dr. Glickel assessed plaintiff with arthritis due to bacteria and contracture of his left joint finger.

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 proximately caused plaintiff's alleged injuries.

In support of their motion, defendants annex the affirmations of Dr. Louis Catalano ("Dr. Catalano"), a board-certified orthopedic hand surgeon, and Dr. Alan Pollock ("Dr. Pollock"), a board-certified infectious disease specialist (collectively "defendants' experts"). According to defendants' experts, defendants did not misdiagnose plaintiff's condition or cause a delay in his diagnosis and treatment.

Specifically, Drs. Catalano and Pollock opine that defendants' alleged failure to administer antibiotics did not delay plaintiff's treatment or cause plaintiff's alleged injuries. Both experts assert that the pathology and microbiology reports from HSS and CDC reveal that the specimens taken from plaintiff's April 27, 2015 procedure and June 22, 2015 biopsy showed that there was no infection present in plaintiff's hand/finger. Defendants' experts also opine that even if there was an infection, Dr. Weiland surgically removed the infection on April 27, 2015. Defendants' experts explain that contrary to plaintiff's assertion, this procedure was necessary since surgery in a localized space is the primary way to remove a localized infection. Dr. Catalano further elaborates that regardless of whether the mass was a synovial chondromatosis or a giant cell tumor, surgical incision of the mass was necessary in order to obtain a specimen for a pathology evaluation.

Defendants also argue that plaintiff's claim that antibiotics should have been administered prior to his April 27, 2015 surgery is meritless. By contrast, Drs. Catalano and Pollock opine that it was prudent for defendants to wait for the CDC report before starting plaintiff on antibiotics since defendants could not have known whether plaintiff had an infection, what bacteria was involved, and what antibiotics would have been effective if an infection was present.

Additionally, Drs. Catalano and Pollock opine that Dr. Miller appropriately treated plaintiff. Specifically, Dr. Catalano asserts that plaintiff timely saw Dr. Miller on May 8, 2015 for an evaluation, and that Dr. Miller confirmed that plaintiff did not work with fish or fish tanks, and that he did not have any recent marine exposure. Dr. Pollock also asserts that Dr. Miller's decision to withhold antibiotics at that time was reasonable since plaintiff's surgical material showed no stainable organisms that would be visible microscopically, and there was no documented evidence that plaintiff had an infection (no redness, purulent drainage, or obvious signs of tissue necrosis). According to Dr. Pollock, because antibiotics have potential complications and adverse effects, it was prudent not to prescribe them without ample microbiological evidence[2] of active infection that justifies any risk of the treatment.

Dr. Pollack further opines that an immediate second procedure would have been contraindicated because plaintiff may not have had an infection, and that it was prudent to wait for the CDC results to confirm the presence of an infection. According to Dr. Pollack, a premature operation would have resulted in additional anesthesia risk, surgical trauma to the soft tissues, and additional recovery time. Dr. Pollack also avers that it was appropriate for Dr. Miller not to

[2] Dr. Pollack notes that "microbiological evidence" includes identification of a specific organism and its antibiotic susceptibility pattern which guides the selection of specific antibiotics.

prescribe antibiotics until after the second surgery in order to avoid suppressing bacterial growth, thus rendering the second surgery pointless.

Defendants' experts further opine that it was proper for defendants to perform a second biopsy. Both experts assert that because the CDC report stated that there was a suggestion that two types of bacteria might be present, which differed from the type suggested by Dr. Perino's pathology report, it was reasonable for defendants to perform a second biopsy to ascertain whether an infection was present, and if so, the type of infection. Dr. Pollack also highlights that the CDC report was not definitive since it stated that the mycobacterium identified might be simple environmental contaminants, and therefore not the cause of any local infection.

In addition, defendants' experts opine that Dr. Miller prescribed plaintiff with appropriate antibiotics based on his knowledge at the time. Specifically, Dr. Catalano asserts that Dr. Miller properly started plaintiff on prophylactic antibiotics following his second surgery in case there was an infection present since the data that defendants received was confusing and non-specific. Similarly, Dr. Pollock posits that Dr. Miller took the safest route by requesting additional tissue for culture and prescribing empirical antibiotics pending the results of the second pathology report and cultures. Dr. Pollack also asserts that Dr. Miller's decisions to continue plaintiff on Clarithromycin and Cipro while waiting for the results of the cultures comported with good and accepted medical practice since it might require weeks before any mycobacterial growth could be detected in a lab. Dr. Pollack further avers that Dr. Miller's decision to switch plaintiff from Cipro to Bactrim was reasonable after plaintiff complained of a sore Achilles tendon since Cipro can cause inflammation and injury to tendons.

In that regard, Dr. Pollock opines that plaintiff's assertion that Dr. Miller should have immediately treated him with antibiotics to prevent "extensive" damage to the joint is false. Dr.

Pollock explains that the selection of antibiotics is based on reliable data that includes accurate identification of an organism by the microbiology lab as well as antimicrobial susceptibility testing to determine which antibiotics are effective against the organism. Dr. Pollock further elaborates that without this information, "empirical" treatment is inaccurate, speculative, and may be associated with adverse drug reactions. Dr. Pollock also notes that starting antibiotic treatment "immediately" without positive cultures or sensitivity data would obliterate any opportunity to obtain such cultures at a later time. As such, Dr. Pollock concludes that it was proper for Dr. Miller to request additional tissue for culture and sensitivity testing prior to using "empirical" antibiotics.

Lastly, defendants argue that plaintiff does not have a valid informed consent claim, and that plaintiff's claim against HSS based on vicarious liability should be dismissed. According to Dr. Catalano, the records indicate that defendants appropriately explained the procedures to plaintiff and obtained his consent to perform the April 27, 2015 and June 22, 2015 procedures. Dr. Catalano also maintains that contrary to plaintiff's claim, Drs. Weiland and Miller are qualified to examine and treat plaintiff's condition.

In opposition, plaintiff annexes the affirmation of an internal medicine and infectious disease expert.[3] According to plaintiff's expert, Dr. Miller departed from good and accepted medical practice by failing to properly manage, diagnose, and assess plaintiff's signs and symptoms, which were indicative of an atypical mycobacteria infection. Specifically, plaintiff's expert opines that Dr. Miller failed to treat plaintiff for an atypical mycobacterial infection, failed to follow up with plaintiff to further assess his symptoms, and failed to administer proper antibiotics. Plaintiff's expert also asserts that these departures were substantial factors in causing further damage to plaintiff's hand, and worsened plaintiff's condition, outcome, and disability.

[3] As plaintiff has redacted the name of his expert, the court will refer to him/her as "plaintiff's expert."

In plaintiff's expert's opinion, Dr. Miller departed from the standard of care by failing to appropriately manage the abnormal pathology findings from plaintiff's first surgery, and by failing to elicit plaintiff's history of fish tank exposure, which together indicated a M. marinum infection. According to plaintiff's expert, empirical antibiotics for a presumed M. marinum infection should have been prescribed immediately after plaintiff's initial pathology report. Plaintiff's expert notes that the positive PCR test for atypical mycobacteria confirmed the clinical picture of an atypical mycobacterial infection, and that Dr. Miller's decision to begin antibiotics shortly after receiving the test proved that Dr. Miller thought antibiotics were necessary to treat such an infection.

Plaintiff's expert also opines that further damage to plaintiff's hand could have been prevented if plaintiff had started antibiotics when he first saw Dr. Miller on May 8, 2015. Plaintiff's expert asserts that plaintiff suffered damage to his hand due to the atypical mycobacterial infection that went untreated for six weeks, and that plaintiff's treatment was further delayed by receiving antibiotics that he was unresponsive to for an additional six weeks. Plaintiff's expert notes that since plaintiff's swelling and symptoms were not improving following the commencement of antibiotics, Dr. Miller should have changed the antibiotics after a month of observation. According to plaintiff's expert, the standard of care requires a change of antibiotics if a patient's symptoms do not improve within a maximum of four weeks. As such, plaintiff's expert concludes that Dr. Miller's failure to change plaintiff's antibiotics caused an additional two-week delay, which further contributed to plaintiff's joint damage, and worsened plaintiff's functional outcome. Plaintiff's expert further posits that if plaintiff had been treated with antibiotics to which the mycobacterial infection was sensitive within four weeks of his surgery, plaintiff would not have sustained additional injury and damage to his hand, and would have had a significantly improved outcome.

In addition, plaintiff's expert refutes defendants' assertion that "no one could have known" that an infection was present. Rather, plaintiff's expert highlights that Dr. Perino's pathology report following plaintiff's first procedure stated that the findings were suggestive of an infection, plaintiff had a strong exposure to marine environments, and that plaintiff presented with a clinical picture consistent with an atypical mycobacterial infection. Further, plaintiff's expert maintains that defendants' claim that plaintiff's stains and cultures did not show bacteria is unavailing since defendants have testified that cultures are not always positive, especially with mycobacteria.

Plaintiff's expert also contests defendants' assertion that there is no evidence that plaintiff had an infection. Plaintiff's expert highlights that Dr. Miller testified that he thought plaintiff "probably did" have an infection during his first surgery, and that the infection which plaintiff had during the first surgery was not resolved since plaintiff continued to experience damage to his joint and worsening symptoms after the operation. Plaintiff's expert also notes that the initial pathology report following the first surgery showed an atypical mycobacterial infection, which was confirmed by the CDC PCR analysis and pathological examination. Plaintiff's expert further points out that a comparison of plaintiff's October 14, 2015 MRI with his April 14, 2016 MRI (after plaintiff had been on Bactrim and Biaxin for two months) showed an improvement of the infectious mass. Accordingly, plaintiff's expert concludes that defendants' assertion that there was no indication of an infection is contrary to the HSS pathology report, the CDC microbiological analysis, plaintiff's clinical course, and defendants' testimonies and actions.

Plaintiff's expert further opines that Drs. Miller and Weiland did not communicate appropriately and had a different understanding of plaintiff's assessment and plan of care. Plaintiff's expert notes that while Dr. Miller testified that an infection was the highest disease on his differential diagnosis, Dr. Weiland documented that he did not think plaintiff had an infection

following his surgery and until he received the positive CDC results. Plaintiff's expert also highlights that while Dr. Miller testified that another biopsy could have been performed when the mycobacterial findings of the first pathology report were available, there is no indication in Dr. Miller or Dr. Weiland's notes regarding the same, or that they discussed this option with plaintiff. As such, plaintiff's expert opines that had plaintiff been informed of a possible infection, he could have chosen to pursue other treatment following his surgery, and that the failure to provide sufficient information constitutes a lack of informed consent since a reasonable patient could have chosen antibiotic therapy, which could have changed his or her prognosis.

Finally, plaintiff's expert refutes defendants' assertion that plaintiff "falsified" his medical history to Dr. Miller. Rather, plaintiff's expert avers that defendants did not properly elicit plaintiff's medical history, as demonstrated by Dr. Miller's failure to record plaintiff's recent exposure to the ocean six months prior.

Plaintiff also annexes the affirmation of a board-certified expert in orthopedic surgery.[4] In plaintiff's orthopedic expert's opinion, plaintiff did not receive effective antibiotic treatment for over twelve weeks. Specifically, plaintiff's orthopedic expert notes that Dr. Miller believed that plaintiff had an infection on May 8, 2015, but plaintiff was not prescribed with antibiotics for more than six weeks following the pathology results, which were suggestive of a mycobacterial infection. Plaintiff's orthopedic expert also points out that plaintiff was then placed on antibiotics for six weeks, but because he was not responding to the antibiotics, plaintiff's infection worsened.

Plaintiff's orthopedic expert further opines that if plaintiff had been treated with antibiotics to which the mycobacterial infection was sensitive within three to four weeks of his surgery, he would not have sustained additional damage to his hand, and would have had a significantly

[4] As plaintiff's orthopedic expert's name is redacted, the court will refer to him/her as "plaintiff's orthopedic expert."

improved functional outcome. According to plaintiff's orthopedic expert, an untreated mycobacterial infection continues to destroy the joint by creating erosions and damage. Finally, plaintiff's orthopedic expert opines that plaintiff's injury and associated disability are permanent.

In reply, defendants advise that they have filed a stipulation of discontinuance with prejudice as to Dr. Weiland, and because the remaining claims involve the alleged negligence by Dr. Miller, all claims prior to May 8, 2015 are no longer at issue. Defendants specify that plaintiff's remaining claim is that Dr. Miller should have prescribed antibiotics immediately after his first visit on May 8, 2015 to prevent extensive damage to his left fourth finger.

Defendants argue that contrary to plaintiff's assertion that Dr. Miller took an inaccurate and incomplete medical history, plaintiff did not reveal that he had been scuba diving or had exposure to fish tanks. Specifically, defendants highlight Dr. Miller's records stating that plaintiff denied scuba diving, and that plaintiff had minimal exposure to fish or marine environments, Dr. Rosenberg's records stating, "No scuba diving Little ocean exposure," and Dr. Erin Nance's note stating, "The patient denied any recent ocean, scuba diving, lake, pond, or fish tank exposure." Defendants also point out that plaintiff testified that he told an orthopedic resident in Dr. Weiland's office that he had "never been scuba diving in [his] life." Defendants further note that although plaintiff testified that he had a fish tank in his home and office, which he had on occasion cleaned and organized, plaintiff never testified that he told Drs. Miller or Weiland about any fish tank. In that regard, defendants argue that because plaintiff's history was not provided, plaintiff's claim that Dr. Miller should have known to immediately start "empirical antibiotics" is unavailing.

Defendants also reiterate that there is no medical basis for plaintiff's assertions that plaintiff had a mycobacterial infection or that Dr. Miller should have prescribed antibiotics "shortly" after plaintiff's May 8, 2015 visit. According to defendants, Dr. Perino's report and supplemental report

which analyzed plaintiff's tissue from his April 27, 2015 surgery did not diagnose any infection, and it was only in the "comment" section of the report that questioned whether there might be an atypical mycobacterium species present. Defendants also assert that while plaintiff assumes that an infection was present when Dr. Miller received the CDC report on June 17, 2015, the CDC report actually "look[s] backward[s]" at plaintiff's tissue obtained from April 27, 2015, long before Dr. Miller treated plaintiff. Defendants clarify that the CDC report found positive evidence of two microbacterium species which differed from the mycobacterium marinum identified in the HSS pathology report. Defendants also point out that the CDC report did not provide any information about whether there was an infection in plaintiff's hand from April 28, 2015 onward.

In addition, defendants assert that although Dr. Perino's pathology report from plaintiff's June 22, 2015 surgery, stated, "No Evidence of Infection," Dr. Miller went further and ordered cultures of plaintiff's tissue to determine if any bacteria could be found. Defendants maintain that because the cultures from plaintiff's June 22, 2015 tissue were negative, there was no infection present from any time after April 28, 2015. Similarly, defendants submit that plaintiff's April 26, 2016 pathology report following Dr. Wolfe's operation, and follow-up microbiology report demonstrate that no infection was present, and if there was an infection, it was removed during plaintiff's April 27, 2015 surgery.

Defendants further argue that plaintiff's claims that Dr. Miller prescribed the wrong antibiotics and that Dr. Miller should have changed the antibiotics on July 22, 2015 are conclusory. Defendants also point out that contrary to plaintiff's assertion, it was Dr. Miller, not Dr. Rosenberg, who switched plaintiff from Cipro to Bactrim on August 3, 2015 due to plaintiff's sore Achilles tendon.

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 A.D.3d 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 A.D.3d 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 A.D.2d 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, defendants set forth separate *prima facie* showings in favor of dismissal, as evidenced by the submission of defendants' medical records, and defendants' expert affidavits, all of which

attest to the fact that defendants' treatment of plaintiff was in accordance with accepted standards of care and did not proximately cause plaintiff's alleged injuries. To be sure, defendants' expert affirmations are detailed and predicated upon ample evidence within the record. As defendants have made their respective *prima facie* showings, the burden shifts to plaintiffs.

I. Plaintiff's Orthopedic Expert Affidavit Lacks a Certificate of Conformity

As an initial matter, plaintiff's orthopedic expert's affidavit lacks a certificate of conformity. CPLR § 2309(c) requires that an oath taken outside of New York be accompanied by a certificate of conformity. However, although plaintiff's orthopedic expert is not licensed in New York, the absence of a certificate of conformity is not fatal (*Matapos Tech. Ltd. v. Compania Andina de Comercio Ltda*, 68 A.D.3d 672, 673 [1st Dept. 2009]; *see also, Bey v. Neuman*, 100 A.D.3d 581, 582 [2d Dept. 2012]; *Fredette v. Town of Southampton*, 95 A.D.3d 940, 941 [2d Dept. 2012] ["[T]he absence of a certificate of conformity for an out-of-state affidavit is not a fatal defect, a view shared by the . . . First and Third Departments as well."]). Accordingly, the court will consider the affidavit of plaintiff's orthopedic expert, and decide the motion on its merits.

II. Triable Issues of Fact

Substantively, plaintiff has raised triable issues of fact sufficient to preclude summary judgment. For example, the parties disagree as to whether plaintiff had an infection, and whether the infection was present during plaintiff's May 8, 2015 visit at Dr. Miller's office. Specifically, while defendants assert that the HSS and CDC's pathology and microbiology reports of plaintiff's April 27, 2015 and June 22, 2015 specimens showed that there was no infection present in plaintiff's hand/finger, plaintiff argues that Dr. Perino's report following his April 27, 2015 procedure, the CDC PCR analysis, and pathological examination showed an atypical mycobacterial infection. Plaintiff also refutes defendants' assertion that Dr. Weiland surgically

removed the infection on April 27, 2015 since he continued to experience damage to his joint and worsening symptoms following the operation. Moreover, the parties dispute the findings of the CDC report. While plaintiff argues that the CDC report showed an atypical mycobacterial infection, defendants assert that the report was not definitive since it stated that the mycobacterium identified might be simple environmental contaminants, and therefore not the cause of any local infection. Because these issues cannot be resolved by the facts before the court, summary judgment must be denied.

Furthermore, while defendants argue that no M. marinum was ever present, and that the CDC diagnosis did not find M. marinum, plaintiff maintains that the abnormal pathology findings from plaintiff's first procedure coupled with plaintiff's exposure to fish tanks indicated that plaintiff had a M. marinum infection. In that vein, the parties also disagree as to whether plaintiff provided a complete and accurate medical history to defendants. For instance, while defendants argue that Drs. Miller, Rosenberg, and Nance's records illustrate that plaintiff had not been scuba diving or had exposure to fish tanks, plaintiff submits that defendants did not properly elicit his medical history, as demonstrated by Dr. Miller's failure to record plaintiff's exposure to the ocean six months prior. Accordingly, there are triable issues of fact here sufficient to preclude summary judgment.

Additionally, there is an issue of fact as to whether Dr. Miller should have prescribed plaintiff with empirical antibiotics. Specifically, plaintiff argues that he would not have sustained additional damage to his hand if had been treated with antibiotics immediately after the initial pathology report since the positive PCR test for atypical mycobacteria confirmed the clinical picture of an atypical mycobacterial infection. Defendants, however, assert that it was prudent for Dr. Miller not to prescribe antibiotics until there was ample microbiological evidence of an active

infection since antibiotics may cause complications and adverse effects. Moreover, defendants aver that, contrary to plaintiff's view, it was proper for Dr. Miller to request additional tissue for culture and sensitivity testing prior to using empirical antibiotics since empirical treatment without accurate identification of an organism and antimicrobial susceptibility testing is inaccurate and speculative.

Furthermore, while plaintiff asserts that defendants' failure to timely prescribe appropriate antibiotics and failure to change plaintiff's antibiotics contributed to plaintiff's joint damage and worsened plaintiff's functional outcome, defendants argue that Dr. Miller comported with good and accepted medical practice by starting plaintiff on prophylactic antibiotics following his second surgery, continuing plaintiff on Clarithromycin and Cipro while waiting for the results of the cultures, and switching plaintiff from Cipro to Bactrim due to his sore Achilles tendon caused by the Cipro. Because these issues cannot be resolved by the facts before the court, summary judgment must be denied.

Accordingly, based on the foregoing, it is hereby

ORDERED that defendants' motion for summary judgment is DENIED; and it is further

ORDERED that Dr. Miller's request for partial summary judgment for allegations subsequent to August 3, 2015 is DENIED; and it is further

ORDERED that the remaining parties[5] are directed to appear for a pre-trial conference on March 26, 2019 at 9:30 a.m. at 111 Centre Street (Part 10 Room 1227), New York, New York 10013.

This constitutes the decision and order of the court.

Date: February 14, 2019

George J. Silver

GEORGE J. SILVER

[5] *See* Footnote 1, *supra*.