Atick v Auerbach
2020 NY Slip Op 32263(U)
June 12, 2020
Supreme Court, New York County
Docket Number: 805124/2017
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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JOSEPH ATICK,

Plaintiff,

Index No. 805124/2017
Motion Seq. 001

-v-

DECISION & ORDER

LISA AUERBACH, M.D., BURTON SURICK, M.D., BETH ISRAEL MEDICAL GROUP, and BETH ISRAEL MOUNT SINAI,

Defendants.

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

In this medical malpractice action, defendants LISA AUERBACH, M.D. ("Dr. Auerbach"), BURTON SURICK, M.D. ("Dr. Surick"), BETH ISRAEL MEDICAL GROUP, and BETH ISRAEL MEDICAL CENTER ("BIMC") s/h/a BETH ISRAEL MOUNT SINAI ("BIMS" collectively "defendants") move for summary judgment. Plaintiff JOSEPH ATICK ("plaintiff") only opposes the motion with respect to Dr. Surick and BIMC.[1] For the reasons discussed below, the court denies the motion.

On July 29, 2014, plaintiff, then 50-years-old, presented to Dr. Auerbach at BIMC with complaints of chest tightness and shortness of breath for the past six months. Plaintiff reported that he had a normal echocardiogram ("EKG") in 2013, and that he was taking antacids for Helicobacter pylori ("H. pylori").[2] Plaintiff's physical examination that day was "non-localizing," and plaintiff's EKG was normal. Dr. Auerbach recommended that plaintiff take sublingual nitroglycerin PRN ("NTG"), aspirin daily, and nitrous oxide as needed. Dr. Auerbach also referred

[1] As plaintiff does not oppose defendants' motion with respect to Dr. Auerbach, summary judgment is granted in Dr. Auerbach's favor. Similarly, any claims of vicarious liability against BIMC for the acts/omissions of Dr. Auerbach are dismissed. Accordingly, this decision will only pertain to the remaining defendants.

[2] H. pylori is an infection that occurs when H. pylori bacteria infects the stomach.

plaintiff to a cardiologist to rule out cardiac etiology and a gastroenterologist for a routine colonoscopy screening.

On July 23, 2015, plaintiff presented to Dr. Auerbach with complaints of shortness of breath and dyspnea[3] upon exertion. Plaintiff's cardiac work-up was negative, and plaintiff's chest x-ray was normal. Dr. Auerbach noted that plaintiff was no longer taking aspirin or NTG. Dr. Auerbach also documented that plaintiff had a history of gastroesophageal reflux disease ("GERD"), but had stopped taking his medication. Upon examination, Dr. Auerbach observed that plaintiff's supraclavicular region was swollen, and ordered a CT scan of plaintiff's neck and chest. Dr. Auerbach recommended that plaintiff restart Zantac, and referred plaintiff to a pulmonologist.

On July 30, 2015, plaintiff underwent a CT scan of his neck and chest. The CT scan did not show any issues with plaintiff's neck, but revealed a large hiatal hernia.[4] Dr. Auerbach was unsure whether the hiatal hernia caused plaintiff's symptoms, and referred plaintiff to Dr. David Carr-Locke ("Dr. Carr-Locke"), a gastroenterologist, and Dr. Burton Surick ("Dr. Surick"), a bariatric surgeon.

On August 11, 2015, plaintiff saw Dr. Surick at BIMC. Dr. Surick noted that plaintiff felt pressure on his chest after eating, but there was no associated vomiting. Plaintiff reported that he was taking Zantac to control his GERD, and that he did not need a proton pump inhibitor ("PPI").[5] A physical examination was "non-localizing," and a chest CT scan showed a large hiatal hernia. Dr. Surick diagnosed plaintiff with a diaphragmatic hernia, and instructed plaintiff to undergo an esophagogastroduodenoscopy ("EGD") and an upper gastrointestinal ("UGI") endoscopy.

[3] Dyspnea is breathing difficulty or discomfort.
[4] A hiatal hernia is a condition in which the upper part of the stomach bulges through an opening in the diaphragm.
[5] PPIs are medicine that reduce the amount of acid made by glands in the lining of the stomach.

On August 14, 2015, plaintiff underwent a UGI series, which showed evidence of a large hiatal hernia and reflux up to the level of the thoracic inlet. On August 28, 2015, plaintiff underwent an UGI endoscopy. On September 8, 2015, Dr. Surick informed plaintiff that the tests revealed a large hiatal hernia with spontaneous GERD up to the level of the thoracic inlet and negative results for H. pylori. There was also localized mild erythema of the mucosa without bleeding in the cardia, localized moderate inflammation and erythema in the gastric antrum, and mild chronic inactive gastritis. A physical examination was "non-localizing," and Dr. Surick ordered pre-operative tests. Dr. Surick also discussed the possibility of a lengthening procedure and/or a partial fundoplication surgery,[6] and plaintiff agreed to undergo a partial fundoplication procedure. On September 10, 2015, Dr. Auerbach cleared plaintiff for surgery.

On September 21, 2015, plaintiff underwent a laparoscopic fundoplication, hiatal hernia repair, and excision of an epigastric fat pad at BIMC. The surgery was uncomplicated with a pathology consistent with an epiphrenic fat pad. Plaintiff was transferred to the post-anesthesia care unit in stable condition, and was subsequently discharged on September 23, 2015.

During a post-operative visit with Dr. Surick on October 1, 2015, plaintiff reported persistent dizziness, which was present before the surgery, and left shoulder pain, which Dr. Surick attributed to diaphragmatic irritation. Plaintiff also advised that his GERD had improved. Dr. Surick reassured plaintiff that his shoulder pain would likely resolve, and recommended that plaintiff follow up in six weeks.

On October 6, 2015, plaintiff saw Dr. Gary Palatucci ("Dr. Palatucci") at BIMC, who noted that plaintiff had a high blood pressure, dizziness, dyspnea on exertion, and shortness of breath. Dr. Palatucci saw plaintiff again on October 29, 2015, and noted that plaintiff's dizziness was

[6] Fundoplication is a surgery used to treat heartburn caused by GERD.

improving, although not fully resolved, and that plaintiff was experiencing diarrhea and loose stools associated with extreme gas, flatus, and burping. Plaintiff underwent blood and stool studies.

On November 10, 2015, plaintiff saw Dr. Surick, and reported excessive diarrhea and belching since his surgery, and that he felt better after taking Imodium. Dr. Surick noted that plaintiff's hernia symptoms had resolved, and attributed plaintiff's diarrhea and belching to vagus nerve[7] irritation. Dr. Surick believed that plaintiff's symptoms would resolve with time, and recommended that plaintiff continue taking Imodium for diarrhea and Simethicone for belching. Dr. Surick also instructed plaintiff to follow up in four weeks.

On February 5, 2016, plaintiff saw Dr. Gustav Seliger ("Dr. Seliger"), a radiologist, at BIMC. Dr. Seliger conducted a UGI air contrast, and observed partial disruption of the fundoplication wrap, supradiaphragmatic herniation of the partially disrupted fundoplication wrap, 2-3 centimeters sliding hiatal hernia, a small amount of gastroesophageal reflux, and residual food in the stomach, suggestive of delayed gastric emptying.

On February 9, 2016, plaintiff presented to Dr. Surick with complaints of gas pain, bloating, an elevated heart rate, a sharp pain in the chest, and loose bowel movements three times a day. Upon review of plaintiff's abdomen x-ray and plaintiff's previous UGI air contrast, Dr. Surick diagnosed plaintiff with a partial disruption of the fundoplication wrap, supradiaphragmatic herniation of the partially disrupted fundoplication wrap, and vagus nerve disorder. Dr. Surick also noted that plaintiff had tachycardia,[8] which Dr. Surick did not believe was related to distension. Dr. Surick further noted that plaintiff could be suffering from partial gastric outlet obstruction, and ordered plaintiff to follow a liquid diet, and prescribed plaintiff with Reglan and simethicone. Dr.

[7] The vagus nerve is the longest nerve of the autonomic nervous system, and helps to regulate critical aspects of human physiology, including heartrate, blood pressure, sweating, digestion, and speaking.
[8] Tachycardia is a fast heartrate.

Surick also planned for a UGI endoscopy to assess plaintiff's stomach, and noted that a pyloromyotomy might be necessary if medication did not alleviate plaintiff's symptoms.

On February 12, 2016, plaintiff underwent a UGI endoscopy. Dr. Surick observed a large amount of phytobezoar in the cardia, and suspected gastroparesis due to retained gastric contents. Plaintiff's esophagus appeared normal, his anti-reflux surgery site was devoid of sutures, and his pylorus appeared slightly narrowed. Plaintiff tolerated the procedure well, and was discharged with instructions to follow up with Dr. Surick.

On February 13, 2016, plaintiff was hospitalized at BIMC for acute chest pain. Plaintiff's blood test, EKG, abdominal x-ray, and Troponin I level tests were normal. Plaintiff was discharged the following day.

On February 19, 2016, plaintiff saw Dr. Palatucci for abdominal bloating. Plaintiff remained intolerant of solid foods.

On March 14, 2016, plaintiff saw Dr. Daniel MacGowan ("Dr. MacGowan") at BIMC for left upper-quadrant pain that began three-to-four hours after eating. Plaintiff informed Dr. MacGowan that his symptoms increased as his abdomen filled with air, and that his reflux symptoms were present for ten years prior to the surgery. Upon examination, Dr. MacGowan believed that plaintiff was suffering from vagotomy-induced gastroparesis[9] with unraveling of his wrap. Dr. MacGowan ordered domperidone and a gastric emptying study, and considered mirtazapine. Plaintiff also saw Dr. Palatucci that day, who noted plaintiff that plaintiff had continued abdominal bloating and distension.

On March 16, 2016, plaintiff presented to Dr. Carr-Locke for delayed gastric emptying. Plaintiff reported bloating, pain, and paresthesia in his left arm and hand. Plaintiff also indicated

[9] Gastroparesis is a disorder that occurs when the stomach takes too long to empty food.

that his chronic diarrhea had resolved, but that Gas-X, calcium channel blockers, and Reglan provided no relief. Dr. Carr-Locke documented that plaintiff's hiatal hernia repair had been complicated by chronic diarrhea for the past three months, and diagnosed plaintiff with gastroparesis due to vagal nerve injury during his hiatal hernia repair. Dr. Carr-Locke ordered a gastric emptying study, which confirmed delayed gastric emptying consistent with gastroparesis.

During a follow-up visit on March 24, 2016, Dr. Surick documented that plaintiff had severe symptoms of bloating, tachycardia, and hypertension, and diagnosed plaintiff with gastroparesis and a vagal nerve disorder. Dr. Surick also noted that plaintiff was about to start domperidone, and blood pressure and anti-anxiety medication. Dr. Surick indicated that if the medication did not alleviate plaintiff's symptoms, then plaintiff would need either a laparoscopic pyloromyotomy or endoscopic myotomy. Dr. Surick also advised plaintiff to follow up in four weeks. However, this was plaintiff's last visit with Dr. Surick.

On April 11, 2016, plaintiff saw Dr. Palatucci for abdominal distension, which had improved with the use of an abdominal binder. The domperidone had caused plaintiff tremors, and was discontinued. On May 16, 2016, plaintiff visited Dr. Palatucci, who noted that plaintiff had seen a motility specialist, and that a full gastric emptying study showed full paralysis of the antrum.

Plaintiff alleges that Dr. Surick failed to properly treat his hiatal hernia, and improperly and unnecessarily performed a surgery, resulting in a vagus nerve injury, gastroparesis, subsequent surgical procedures, and other gastrointestinal issues.

ARGUMENT

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

In support of defendant's motion on behalf of Dr. Surick, defendants annex the affirmation of Ashutosh Kaul, M.D. ("Dr. Kaul"), a physician board-certified in general and bariatric surgery. Dr. Kaul opines that Dr. Surick's treatment of plaintiff from August 11, 2015 to March 24, 2016 conformed to accepted standards of bariatric surgery. Specifically, Dr. Kaul asserts that Dr. Surick properly examined and diagnosed plaintiff with a hiatal hernia, and that based on the presence of a hernia and plaintiff's symptoms, Dr. Surick appropriately recommended a partial fundoplication procedure rather than a conservative course of treatment. Dr. Kaul notes that plaintiff's hiatal hernia was symptomatic since it caused shortness of breath and chest pain, and that medication did not alleviate plaintiff's symptoms. Dr. Kaul also highlights that plaintiff's symptoms likely led to plaintiff's development of anxiety, which worsened his pre-operative symptoms. Dr. Kaul further points out that if left untreated, large hiatal hernias can cause gastro necrosis and death. As such, Dr. Kaul concludes that Dr. Surick's recommendation of a partial fundoplication procedure was not only indicated based on plaintiff's complaints and prior treatment, but one of medical necessity.

Dr. Kaul also opines that Dr. Surick properly obtained plaintiff's informed consent prior to performing the partial fundoplication procedure. Dr. Kaul notes that Dr. Surick discussed the risks, benefits, and alternatives of the surgery with plaintiff on September 8, 2015 as well as on the morning of the procedure, at which time plaintiff signed a consent form. Dr. Kaul further avers that based on plaintiff's background, education, and "habit of researching" his medical conditions and procedures, it is unlikely that plaintiff underwent the surgery without giving informed consent.

Additionally, Dr. Kaul opines that Dr. Surick properly performed plaintiff's fundoplication procedure. Dr. Kaul contends that contrary to plaintiff's assertion that Dr. Surick lacerated or injured plaintiff's vagus nerve during the procedure, Dr. Surick took necessary steps to avoid

damaging plaintiff's vagal nerves.[10] According to Dr. Kaul, it is not the standard care to isolate or clip the vagal nerves since visual confirmation of the vagal nerves' location is sufficient. In that regard, Dr. Kaul notes that by excluding the nerves from the operative field, Dr. Surick sufficiently safeguarded the nerves from harm. Dr. Kaul also points out that there is no radiographic evidence to demonstrate that plaintiff's vagus nerve was "lacerated," or diagnostic tests to determine whether plaintiff's vagus nerve was irritated or injured.

Dr. Kaul also opines that Dr. Surick appropriately managed plaintiff's post-operative care from November of 2015 to March of 2016. Dr. Kaul highlights that Dr. Surick managed plaintiff conservatively to ascertain whether plaintiff's symptoms were due to irritation, and to attempt to resolve plaintiff's gastrointestinal issues with medication. Dr. Kaul also notes that Dr. Surick properly ordered a UGI series, a UGI endoscopy, x-rays, and a liquid diet when plaintiff's symptoms did not improve after approximately five months.

In Dr. Kaul's opinion, while plaintiff's post-operative complaints can be seen as consistent with a vagus nerve injury, plaintiff's complaints are not diagnostic of a vagus nerve injury since a multitude of other factors and conditions could have caused plaintiff's complaints. Similarly, Dr. Kaul maintains that plaintiff's subsequent gastric emptying study is of "no value" in assessing a vagus nerve injury because a patient can develop gastroparesis without a vagus nerve injury. In that regard, Dr. Kaul reiterates that there is no diagnostic test that can definitely identify the existence or etiology of a vagus nerve injury. Dr. Kaul further notes that plaintiff's claims of gastroparesis, abdominal distention, cramping, nausea, belching, flatulence, constipation, chest pain, and shortness of breath are general symptoms that can be caused by problems unrelated to the vagus nerve. To highlight, Dr. Kaul underscores that plaintiff suffered from a deficiency in

[10] According to Dr. Kaul, there are very small branches of the vagal nerves that cannot be visualized.

vitamin D, used Ambien, and had previously been diagnosed with cervical spine disease, all of which are known causes of vagus nerve injury.

Finally, Dr. Kaul opines that even if plaintiff's vagus nerve was irritated, compressed, or otherwise compromised during the partial fundoplication procedure, it does not mean that Dr. Surick improperly performed the procedure. According to Dr. Kaul, vagus nerve injury is a known and accepted risk of a hiatal hernia repair surgery and Nissen fundoplication procedure, and is known to occur even when there are no deviations from standard surgical practice. As such, Dr. Kaul concludes that because the vagus nerve is not a single tract, but consists of smaller branches that cannot be visualized, there is no indication that Dr. Surick was negligent even if there was trauma to plaintiff's vagus nerve.

In opposition, plaintiff asserts that although Dr. Surick is a general surgeon, Dr. Kaul's opinions relate to bariatric surgery. Plaintiff argues that there is no indication that the procedures and medical treatment at issue relate to the field of bariatric surgery.[11]

In support of his opposition, plaintiff annexes the affirmation of a physician board-certified in general surgery.[12] Plaintiff's expert opines that Dr. Surick inappropriately recommended and performed a partial fundoplication procedure rather than pursue a conservative course of treatment since plaintiff was not a candidate for a partial fundoplication procedure. Specifically, plaintiff's expert asserts that Dr. Surick "jumped to the conclusion" that plaintiff's hiatal hernia was symptomatic without performing a full and necessary evaluation to determine if the hiatal hernia caused plaintiff's shortness of breath and chest pressure. Rather, plaintiff's expert submits that it

[11] While plaintiff's argument is unclear, it appears that plaintiff argues that Dr. Kaul is not qualified to render an opinion because he is bariatric surgeon, not a general surgeon. However, the court does not take any issue with respect to Dr. Kaul's expertise or qualifications to render an opinion in this matter.
[12] As plaintiff has redacted the name of his expert, the court will refer to the expert as "plaintiff's expert."

was incumbent upon Dr. Surick to investigate whether conservative treatment would be effective and warranted before recommending this "aggressive and risky type of surgery."

According to plaintiff's expert, plaintiff's UGI endoscopy showed a hiatal hernia, however, the absence of acute inflammation on the esophageal biopsies showed that there was no relation between the hiatal hernia and plaintiff's symptoms. Plaintiff's expert explains that when acid reflux is associated with a hernia, the biopsies usually show inflammation or ulcers, and that in their absence, esophageal manometry and pH studies should have been performed. As such, plaintiff's expert concludes that Dr. Surick's failure to perform these studies or try a month-long trial of H-2 blockers or PPIs[13] means that the partial fundoplication procedure was not indicated.

Additionally, plaintiff's expert asserts that while a CT scan of plaintiff's chest showed a large hiatal hernia, the mere presence of a hiatal hernia is not sufficient to ensure that plaintiff's symptoms can be attributed to a hiatal hernia. Plaintiff's expert notes that about half of the population has a hiatal hernia, which is often not symptomatic. According to plaintiff's expert, the presence of both "typical" reflux symptoms (heartburn, regurgitation, or dysphagia), as well as "atypical" symptoms that might be attributable to GERD (cough, wheezing, hoarseness, shortness of breath, or sore throat) must be noted. Plaintiff's expert explains that because "there are fewer potential mechanisms for their generation," typical symptoms are more likely to be secondary to pathologic gastroesophageal reflux than are atypical symptoms. As such, plaintiff's expert concludes that a patient "must be made aware" of the relatively diminished probability of success

[13]Plaintiff's expert notes that plaintiff reported that PPIs, which minimize the acid in the stomach and help with traditional symptoms of GERD, provided him relief. However, plaintiff's expert highlights that Dr. Surick did not recommend a trial of PPIs to determine whether GERD was the main source of plaintiff's complaints when it clearly was. Instead, plaintiff's expert notes that Dr. Surick recommended surgery despite evidence that the hiatal hernia was not the source of plaintiff's complaints. As such, plaintiff's expert opines that a detailed objective evaluation was required to assess the presence of pathologic gastroesophageal reflux and to determine whether plaintiff's main complaints were reflux-related.

of an anti-reflux surgery when atypical symptoms are the primary factors driving intervention. Moreover, plaintiff's expert avers that while GERD and a hiatal hernia can cause dyspnea on exertion and shortness of breath, these are not typical symptoms, and therefore, adequate studies should be conducted before performing surgery to correct a hiatal hernia.

Plaintiff's expert also opines that Dr. Surick's performance of the partial fundoplication procedure departed from accepted medical practice based on Dr. Surick's documentation in the operative report that plaintiff's vagal nerves were "visualized" and "essentially moved out of harm's way."[14] According to plaintiff's expert, if the vagal nerves were visualized and cleared from the area, the severity of plaintiff's vagal nerve damage and gastroparesis should not have been the result of the surgery. Rather, plaintiff's expert notes that Dr. Palatucci confirmed that plaintiff sustained full paralysis of the antrum, a type of injury that would not have occurred had plaintiff's vagal nerves been identified and moved out of harm's way. In that regard, plaintiff's expert emphasizes that Dr. Surick departed from accepted medical practice by failing to fully visualize plaintiff's vagal nerves and safely segregate them from the operative field.

Plaintiff's expert further opines that Dr. Surick departed from the standard of care by failing to obtain plaintiff's informed consent prior to performing the partial fundoplication procedure. Specifically, plaintiff's expert notes that Dr. Surick did not discuss vagal nerve injury, paralysis, or digestive and stomach problems with plaintiff as these are known risks of the procedure that should have been discussed prior to the surgery. Plaintiff's expert also points out that plaintiff testified that he was told that the procedure was a minor situation, and that he was not aware of the risk of digestive and stomach problems.

[14] The quotations are based on plaintiff's expert's statements.

Finally, plaintiff argues that summary judgment should be denied as to BIMC and BIMS as they are vicariously liable for the acts/omissions of Dr. Surick. Plaintiff highlights that it is undisputed that plaintiff was seen at BIMC, and that Dr. Surick conceded that he was an employee of BIMC at the time he treated plaintiff.

In reply, defendants argue that plaintiff's expert fails to establish his/her qualifications since he/she does not indicate when he/she graduated from medical school or when he/she performed his/her internship, residency, and/or fellowship. Defendants also note that plaintiff's expert does not indicate when he/she was board-certified, or when he/she began practicing general surgery. Defendants further highlight that plaintiff's expert fails to explain his/her knowledge of fundoplication procedures. As such, defendants argue that the court should disregard plaintiff's expert's opinion.

Defendants also assert that contrary to plaintiff's argument, plaintiff was conservatively worked-up to determine the etiology of his chest pain and shortness of breath, and that his fundoplication procedure was indicated. Defendants contend that Dr. Surick decided to perform a partial fundoplication procedure based on plaintiff's prior conservative treatment and the continuation of his symptoms. Specifically, defendants note that at the time of plaintiff's first presentation to Dr. Surick on August 11, 2015, plaintiff had already received a negative cardiology and pulmonology work-up for his symptomology, which included shortness of breath and chest pain. Defendants also posit that contrary to plaintiff's expert opinion that Dr. Surick should have prescribed plaintiff with an H-2 Blocker or a PPI to rule out GERD as an etiology, plaintiff had used an H-2 blocker (Zantac) and refused Dr. Surick's alternative of a PPI.

Additionally, defendants argue that plaintiff's expert does not address Dr. Kaul's opinion that the partial fundoplication procedure was indicated and necessary. Similarly, defendants posit

that plaintiff's expert ignores the fact that the medical records demonstrate that Dr. Surick discussed the risks, benefits, and alternatives of the fundoplication procedure with plaintiff on September 8, 2015 and September 21, 2015, and that plaintiff signed a consent form.

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 A.D.3d 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 A.D.3d 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 affidavit, 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 affirmation is detailed and predicated upon ample evidence within the record. As defendants have made a *prima facie* showing, the burden shifts to plaintiff.

As a preliminary matter, plaintiff's expert is sufficiently qualified to render an opinion in this matter (*see, Frye v. Montefiore Med. Ctr.*, 70 A.D.3d 15, 24 [1st Dept. 2009] ["The determination that a witness is qualified to give expert testimony rests . . . within the sound discretion of the court . . ."]). Notably, plaintiff's expert is licensed to practice medicine in the State of New York, and is board-certified in general surgery (*see, id.* [plaintiff's experts were qualified to give expert testimony where the medical experts' affirmations revealed that the experts were board-certified in their respective disciplines]). Moreover, plaintiff's expert currently practices in the field of general surgery at a hospital in New York. Accordingly, the court will consider plaintiff's expert's affirmation in deciding the motion herein.

In response to defendants' *prima facie* showing, plaintiff has raised triable issues of fact sufficient to preclude summary judgment. For example, the parties disagree as to whether Dr. Surick's treatment of plaintiff departed from accepted standards of care. Notably, while defendants assert that Dr. Surick appropriately recommended a partial fundoplication procedure based on the presence of a hiatal hernia and plaintiff's symptoms, plaintiff argues that Dr. Surick inappropriately recommended a partial fundoplication procedure rather than pursue a conservative

course of treatment. Specifically, while plaintiff maintains that Dr. Surick failed to perform a full and necessary evaluation to determine if plaintiff's hiatal hernia caused his shortness of breath and chest pressure, defendants submit that a partial fundoplication procedure was indicated and necessary because plaintiff's hiatal hernia was symptomatic as it had caused shortness of breath and chest pain, and because medication did not alleviate plaintiff's symptoms. By contrast, plaintiff underscores that esophageal biopsies showed no relation between the hiatal hernia and his symptoms, and that in the absence of inflammation or ulcers, esophageal manometry and pH studies should have been performed. Because these issues cannot be resolved by the facts before the court, summary judgment must be denied.

In further rebutting plaintiff's argument that Dr. Surick failed to pursue a conservative course of treatment, defendants assert that Dr. Surick performed a conservative work-up to determine the etiology of plaintiff's chest pain and shortness of breath. Indeed, defendants emphasize that Dr. Surick decided to perform a partial fundoplication procedure based on plaintiff's August 11, 2015 presentation in which plaintiff had already received a negative cardiology and pulmonology work-up for his symptomology, including shortness of breath and chest pain, and based on the continuation of plaintiff's symptoms. Plaintiff, however, posits that a partial fundoplication procedure was not indicated as Dr. Surick had failed to perform esophageal manometry and pH studies, or try a month-long trial of H-2 blockers or PPIs, which had helped to relieve plaintiff's symptoms. In challenging the veracity of plaintiff's argument, defendants highlight that plaintiff had previously used Zantac, an H-2 blocker, and refused to use a PPI. Accordingly, there are triable issues of fact here sufficient to preclude summary judgment.

The parties also disagree as to whether Dr. Surick properly obtained plaintiff's informed consent prior to performing the partial fundoplication procedure. While defendants aver that Dr.

Surick properly obtained plaintiff's informed consent based on his discussion with plaintiff about the risks, benefits, and alternatives of the surgery on September 8, 2015 and September 21, 2015, plaintiff contends that Dr. Surick did not discuss vagal nerve injury, paralysis, or digestive and stomach problems prior to the surgery. Moreover, in light of plaintiff signing a consent form for the procedure, and plaintiff's argument that he was not aware of the risk of digestive and stomach problems associated with the procedure, there are triable issues of fact here sufficient to preclude summary judgment.

Significantly, plaintiff also raises an issue of fact as to whether Dr. Surick properly performed the partial fundoplication procedure, and whether Dr. Surick's performance of the partial fundoplication procedure caused plaintiff's alleged injuries. Specifically, while plaintiff avers that Dr. Surick failed to fully visualize plaintiff's vagal nerves and safely segregate the nerves from the operative field, defendants argue that it is not the standard of care to isolate or clip the vagal nerves, and that Dr. Surick sufficiently safeguarded the nerves from harm by excluding the nerves from the operative field. By contrast, plaintiff maintains that he sustained full paralysis of the antrum, a type of injury that would not have occurred had plaintiff's vagal nerves been identified and moved out of harm's way. Defendants, on the other hand, underscore that there is no radiographic evidence to demonstrate that plaintiff's vagus nerve was "lacerated," or diagnostic tests to determine whether plaintiff's vagus nerve was irritated or injured.

Moreover, defendants further challenge plaintiff's theory of causation by arguing that plaintiff's complaints are not diagnostic of a vagus nerve injury since other factors and conditions, including plaintiff's vitamin D deficiency, cervical spine disease, and use of Ambien, could have caused plaintiff's complaints. Plaintiff, however, maintains that the severity of his vagal nerve damage and gastroparesis would not have resulted had Dr. Surick visualized and cleared the vagal

nerves from the area during surgery. Still, defendants argue that even if plaintiff's vagus nerve was irritated, compressed, or otherwise compromised during the procedure, vagus nerve injury is a known and accepted risk of a hiatal hernia repair surgery and Nissen fundoplication procedure, and is known to occur even when there are no deviations from standard surgical practice. Because there are issues of fact as to whether defendants departed from the standard of care by improperly and unnecessarily performing a partial fundoplication procedure, and as to whether such departures proximately caused plaintiff's vagus nerve injury, gastroparesis, and subsequent surgical procedures, summary judgment must be denied.

Based on the foregoing, it is hereby

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

ORDERED that the clerk is directed to amend the caption as follows:[15]

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JOSEPH ATICK,

Plaintiff,

-v-

Index No. 805124/2017

BURTON SURICK, M.D., BETH ISRAEL MEDICAL GROUP, and BETH ISRAEL MOUNT SINAI.

Defendants.

----------X

ORDERED that the remaining parties are directed to appear for a pre-trial conference on July 15, 2020 by Skype or virtually at 9:30 a.m. ~~at 111 Centre Street~~ (Part 10, Room 1227), New York, NY 10013.

This constitutes the decision and order of the court.

The parties are directed to forward their e mail addresses to Hasa Kinge, Esq at HKinge@nycourts.gov.

Dated: June 11, 2020

George J. Silver

HON. GEORGE J. SILVER

GEORGE J. SILVER

[15] The amended caption reflects the fact that Dr. Auerbach is no longer a defendant in this action.