Cooke v Drucker
2020 NY Slip Op 32278(U)
July 1, 2020
Supreme Court, New York County
Docket Number: 805434/2013
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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JOHN COOKE,

Plaintiff,

Index No. 805434/2013
Motion Seq. 002

-v-

DECISION & ORDER

DAVID A. DRUCKER, M.D., NEW YORK HIP & KNEE, GEORGE VISVIKIS, M.D., KUMUD GUGLIADA, M.D., REGIONAL IMAGING & THERAPEUTIC RADIOLOGY SERVICES, P.C., d/b/a REGIONAL RADIOLOGY, and BETH ISRAEL MEDICAL CENTER,

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

Defendants DAVID A. DRUCKER, M.D. ("Dr. Drucker"), NEW YORK HIP & KNEE ("NYHK"), and BETH ISRAEL MEDICAL CENTER ("Beth Israel" collectively "defendants") move for summary judgment. Plaintiff JOHN COOKE ("plaintiff") opposes the motion. For the reasons discussed below, the court grants the motion in part.

On June 7, 2011, plaintiff, then 46-years-old, presented to Dr. Drucker at his practice at NYHK. Plaintiff stated that he had sustained a fracture of his right tibia in four places after being hit by a car when he was 15-years-old, and that the pain had been getting worse. Plaintiff also reported that a "bone popped out of [his] knee" when he fell two years earlier. Dr. Drucker's impression was that plaintiff had severe post-traumatic arthritis with "severe incapacitating pain in his right knee." Dr. Drucker also noted that plaintiff had failed conservative treatment.

Upon examination, plaintiff walked with an antalgic gait, and his right knee demonstrated a significant varus deformity,[1] with full extension and flexion at about 90 degrees. Plaintiff's x-

[1] A varus deformity is a deformity of a bone or joint in which the distal end bends inward.

rays showed severe varus deformity of the right knee with some subluxation of the joint of the tibial fracture. After discussing surgical and non-surgical options, plaintiff chose to undergo an elective right total knee replacement ("TKR") surgery in January of 2012.

Between plaintiff's visit with Dr. Drucker and his TKR surgery, plaintiff saw Dr. Christopher Perez ("Dr. Perez"), a pain management specialist from June of 2011 to January 3, 2012 for right knee pain and "low back and bilateral leg pain." Plaintiff's pain level was 7/10 at his June visit, and 6/10 at his July, August, and September visits.

On December 9, 2011 and January 3, 2012, plaintiff's right knee x-rays taken at co-defendant REGIONAL RADIOLOGY showed a severe narrowing of the medial compartment of the tibiofemoral joint. However, no fracture was seen.

On January 18, 2012, plaintiff was admitted to Beth Israel where he signed a consent form for the TKR surgery. Plaintiff's pre-operative diagnosis was post-traumatic arthritis of the right knee. During the surgery, the anterior cortex of the distal femur was perforated,[2] which required Dr. Drucker to place a stem on the femoral component to bypass the defect.

On January 19, 2012, plaintiff underwent an orthopedic physical therapy initial evaluation at Beth Israel. Plaintiff had a knee immobilizer, and reported that his pain was not controlled. Plaintiff was able to maintain toe touch weightbearing throughout his treatment, but demonstrated decreased mobility and strength. It was noted that plaintiff "would benefit from continued" physical therapy to increase his functional mobility.

On January 20, 2012, a physical therapy progress note indicated that plaintiff's pain was better controlled. The following day, plaintiff was discharged to Clove Lakes Health Care and

[2] Plaintiff contends that there was a fracture of the anterior cortex of the femur.

Rehabilitation Center ("Clove Lakes") for upper and lower extremity muscle strengthening, gait and balance training, and therapeutic exercise. Plaintiff tolerated the physical therapy well.

On February 6, 2012, an x-ray of plaintiff right knee showed that the anatomic alignment was well-maintained with no acute fracture. An x-ray of plaintiff's tibia and fibula showed the knee prosthesis, and an old deformity of the proximal tibia with some periosteal thickening that appeared post-traumatic.

On February 9, 2012, plaintiff was discharged from Clove Lakes with a recommendation to use a rolling walker. It was noted that plaintiff did not consistently follow instructions regarding weightbearing and immobilizers, and assists were recommended for his safety. Plaintiff was also encouraged to continue physical therapy and a home exercise program.

At plaintiff's first post-operative visit with Dr. Drucker on February 24, 2012, Dr. Drucker noted that plaintiff's "complex primary knee replacement" was "complicated by a fracture of the anterior cortex," which was treated with a stemmed femoral component and protected weightbearing. Dr. Drucker also observed that plaintiff was doing reasonably well, and that his February 24, 2012 x-rays looked "excellent." Dr. Drucker instructed plaintiff to continue with in-home physical therapy followed by outpatient therapy.

On April 19, 2012, plaintiff returned to Dr. Drucker with complaints of numbness along the lateral aspect of his knee with some pain in the distal part of the quad tendon. Plaintiff also reported weakness and some warmth in the leg. Upon examination, Dr. Drucker noted that plaintiff's knee looked "quite good," and that the warmth was of normal temperature. Dr. Drucker also noted that plaintiff's range of motion and stability were "excellent" for three months post-operation, and that his April 19, 2012 x-rays looked "great." The plan was to increase plaintiff's physical therapy, and have plaintiff progress from a walker to a cane.

On May 31, 2012, plaintiff presented to Dr. Drucker. Plaintiff's range of motion was 10 to 100, and plaintiff's x-rays looked "excellent." The perforation in the anterior cortex of the distal femur had healed,[3] and plaintiff had no signs of infection. The plan was for plaintiff to progress to weightbearing as tolerated with a cane, and to start muscle strengthening.

During plaintiff's last visit with Dr. Drucker on September 13, 2012, Dr. Drucker noted that plaintiff was doing well with "good" pain relief, range of motion, and stability. Dr. Drucker documented that plaintiff's x-rays "look[ed] excellent," but that plaintiff had "significant quad atrophy and he really needs to increase his muscle strength in his right lower limb." Plaintiff was instructed to continue physical therapy, and to follow up in six months. However, plaintiff never followed up.

Plaintiff subsequently moved to Florida, and began treatment at Cleveland Clinic. An x-ray report from Cleveland Clinic dated June 16, 2015 noted that, "There is irregularity to the cortical contour of the right femoral head/neck at its superior aspect seen on AP view. This is of uncertain significance the possibility of right femoral neck fracture considered."

As of March 4, 2016, Cleveland Clinic noted that plaintiff was narcotic dependent, and that plaintiff's heavy doses of narcotics "would preclude any surgical intervention at this time."

Plaintiff alleges that Dr. Drucker failed to appreciate his x-rays in preparation for his TKR surgery on January 18, 2012, which caused an intraoperative perforation of the anterior cortex. As a result, plaintiff claims that Dr. Drucker "compromised" or "fractured" the cortex of the femur, leading to permanent disability, and chronic pain in the hips, lower back, and knees.

[3] Plaintiff, however, notes that he complained to Dr. Drucker that his right knee felt "loose," and that there was a noise like knuckles cracking. Plaintiff also highlights that Dr. Drucker prepared a "Medical Report for Determination of Disability" dated June 1, 2012, which indicated, *inter alia*, that plaintiff had an unhealed fracture of the right femur.

ARGUMENTS

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 their motion, defendants annex the affirmation of Joseph Bosco, M.D. ("Dr. Bosco"), a physician board-certified in orthopedic surgery. Dr. Bosco opines that defendants properly obtained plaintiff's medical history, including plaintiff's prior accident, injuries, current condition, and current medication, and created an appropriate treatment plan based on plaintiff's symptoms and complaints. Dr. Bosco also avers that Dr. Drucker correctly interpreted plaintiff's pre-operative x-rays, which did not depict any right femur deformity or abnormality. In that regard, Dr. Bosco points out that Dr. Drucker testified that plaintiff's pre-operative films provided him with enough information to prepare for plaintiff's TKR surgery.

Dr. Bosco also opines that plaintiff was a proper candidate for a right TKR surgery based on plaintiff's complaints of disabling pain and severe arthritis in his right knee despite undergoing conservative treatment. Dr. Bosco contends that surgical intervention was appropriate since plaintiff's pre-operative x-rays confirmed that there was joint space narrowing. As such, Dr. Bosco posits that plaintiff's history of post-traumatic arthritis and healed tibial fractures did not contraindicate a TKR surgery. Rather, Dr. Bosco reiterates that Dr. Drucker was aware of plaintiff's medical and surgical history, and considered the same before recommending and performing the right TKR surgery.

Dr. Bosco further opines that Dr. Drucker properly obtained plaintiff's informed consent prior to performing the TKR surgery on January 18, 2012. Dr. Bosco highlights that Dr. Drucker discussed surgical and non-surgical options with plaintiff, and that plaintiff chose to undergo an

elective knee replacement surgery since conservative treatment had been unsuccessful. Dr. Bosco also notes that Dr. Drucker properly discussed the risks,[4] benefits,[5] and complications[6] of the surgery with plaintiff, and documented that plaintiff understood the risks. Dr. Bosco further points out that the risk of an intra-operative perforation is rare, and that the vast majority of perforations, as was the case for plaintiff, are treated with a stem on the femoral component, which result in no harm to the patient. As such, Dr. Bosco asserts that plaintiff's alleged injuries of knee buckling, decreased mobility, and continuing pain post-surgery are known risks of the procedure, and are not indicative of medical malpractice. Additionally, Dr. Bosco notes that plaintiff signed an informed consent document for the TKR surgery on January 18, 2012.

In Dr. Bosco's opinion, plaintiff's right TKR surgery was indicated, and Dr. Drucker properly performed the surgery on January 18, 2012. Dr. Bosco asserts that Dr. Drucker appreciated plaintiff's medical history of post-traumatic arthritis with healed tibial fractures and tibial deformity, and anticipated potential complications during the surgery. Dr. Bosco also contends that while Dr. Drucker was drilling to place intramedullary rods, there was a perforation[7] of plaintiff's anterior cortex. In that regard, Dr. Bosco highlights that Dr. Drucker's impression was that the problems he encountered during the surgery were most likely secondary to an old fracture that had healed. Dr. Bosco also points out that Dr. Drucker properly switched to the use of a legion revision knee replacement during the surgery since it allowed him to "tackle these

[4] The risks include blood loss, scarring, damage to tissue, post-operative pain and tenderness, infections, knee buckling, knee stiffness, continued pain post-operatively, loss of range of motion, and the possibility of a revision surgery.
[5] The benefits include increased mobility in the knee joint and decreased pain in the arthritic knee joint.
[6] Dr. Bosco underscores that a "great result" is not guaranteed for any patient.
[7] Dr. Bosco notes that although Dr. Drucker refers to this as a "fracture" in his notes, it was a perforation or puncture of the anterior cortex of the distal femur. In that regard, Dr. Bosco agrees with Dr. Drucker's statement that his use of the word "fracture" in his operative report did not accurately reflect what occurred. Rather, Dr. Drucker contends that plaintiff's bone was weakened due to "at worst a hole that is about the diameter of my little finger."

problems or anatomical relationships that [he] encountered." As such, Dr. Bosco concludes that Dr. Drucker appreciated plaintiff's anatomy pre-operatively such that he was able to anticipate and prepare the operating room with appropriate hardware for potential complications such as the perforation that occurred.

Additionally, Dr Bosco opines that Dr. Drucker properly treated the perforation by placing a stem on the femoral component as a precautionary measure to prevent a post-operative fracture in light of plaintiff's compromised anterior cortex and known tibial deformity. In that regard, Dr. Bosco reiterates that Dr. Drucker did not cause a fracture to plaintiff's right femur during the surgery, but was instead able to prevent this post-operative complication. To be sure, Dr. Bosco notes that plaintiff's post-operative imaging did not reveal a fracture of the femur or mechanical issues with his right knee. Similarly, Dr. Bosco highlights that none of plaintiff's post-operative x-rays taken at Dr. Drucker's office or Patient Care Associates, Inc. showed the need for additional surgery. Rather, Dr. Bosco points out that plaintiff's post-operative x-rays consistently showed proper anatomic alignment, a well-healed femur with no deformities, no evidence of loosening of the prosthesis, and no acute fracture.

Dr. Bosco also opines that defendants' post-operative care and treatment comported with the standard of care. According to Dr. Bosco, defendants ordered appropriate post-operative studies and consultations, including physical therapy, and timely examined and treated plaintiff during his follow up visits. Dr. Bosco also highlights that Beth Israel properly discharged plaintiff to Clove Lakes on January 21, 2012 for upper and lower extremity muscle strengthening, gait and balance training, and therapeutic exercise, which was the proper course of post-operative treatment. However, Dr. Bosco points out that plaintiff's Clove Lakes' discharge summary noted that plaintiff was inconsistent in following instructions regarding weightbearing, immobilizers,

and physical therapy, particularly in the immediate post-operative period. According to Dr. Bosco, this caused plaintiff's knee to become stiff, which in turn caused pain in the knee joint.

Dr. Bosco further posits that during plaintiff's February 24, 2012 post-operative visit with Dr. Drucker, plaintiff was doing reasonably well, plaintiff's x-rays looked "excellent," and Dr. Drucker properly instructed plaintiff to continue with in-home physical therapy followed by outpatient therapy. Likewise, Dr. Bosco submits that at each of plaintiff's subsequent visits, Dr. Drucker properly obtained x-rays, and correctly interpreted the same. Dr. Bosco also maintains that Dr. Drucker properly examined plaintiff's knee at each visit, which showed no signs of infection or hardware failure, and properly instructed plaintiff to increase his physical therapy, and to try to progress from a walker to a cane to increase his strength. In that regard, Dr. Bosco highlights that plaintiff's range of motion had continued to improve, and that there was no indication for a revision surgery during plaintiff's post-operative treatment with Dr. Drucker.

Similarly, Dr. Bosco underscores that by May 31, 2012, plaintiff's perforation appeared to have healed, and Dr. Drucker appropriately planned for plaintiff to progress to weightbearing as tolerated with a cane, and to begin muscle strengthening. Dr. Bosco also notes that Dr. Drucker properly prescribed plaintiff with physical therapy, including inpatient and outpatient therapy, and in-home exercises.

In Dr. Bosco's opinion, defendants did not cause or contribute to plaintiff's alleged injuries. Dr. Bosco posits that the perforation had no bearing on the outcome of plaintiff's TKR surgery, and that the placement of the stem did not change plaintiff's prognosis. Rather, Dr. Bosco reiterates that plaintiff required a stem on the femoral component to prevent a post-operative fracture. Dr. Bosco also emphasizes that plaintiff's allegation that he had a "fractured right femur" is erroneous since the perforation was recognized and addressed intra-operatively. In that regard, Dr. Bosco

asserts that plaintiff's recovery would have been the same even if the intra-operative perforation had not occurred based on plaintiff's pre-existing conditions. According to Dr. Bosco, patients with post-traumatic arthritis have a higher rate of complication from this type of surgery, however, post-traumatic arthritis is not a contraindication to a TKR procedure.

Moreover, Dr. Bosco opines that plaintiff's claims of continuing pain, mild instability in the right knee, and a long recovery process are not the result of any negligence by Dr. Drucker. Rather, Dr. Bosco proffers that plaintiff's complaints are due to his post-traumatic arthritis,[8] his heavy use of narcotics prior to the surgery,[9] and his non-compliance with post-operative physical therapy.[10] Dr. Bosco also notes that the perforation did not cause mild instability in plaintiff's right knee as plaintiff's medical records and x-rays show that plaintiff's hardware remained intact and well-aligned.

Finally, Dr. Bosco opines that there is no causal link between plaintiff's TKR surgery and plaintiff's complaints of hip and back pain, or plaintiff's need for a left hip replacement surgery as plaintiff experienced these issues prior to his treatment with Dr. Drucker. Likewise, Dr. Bosco maintains that Dr. Drucker did not "disable" plaintiff such that plaintiff was permanently unable to work. Rather, Dr. Bosco notes that plaintiff had stopped working full-time in 2004, and applied for disability benefits in 2011 due to "a knee problem." Similarly, Dr. Bosco contends that none of plaintiff's medical records show that plaintiff has "excess metal in the right femur and right leg," or any "loose metal in the right femur" requiring the removal of hardware or a knee revision

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[8] Dr. Bosco notes that there is a higher complication rate for TKR patients with post-traumatic arthritis.
[9] Dr. Bosco notes that patients, such as plaintiff, who have a documented history of heavy narcotic use, have a lower threshold for pain, and are more prone to post-surgical pain. Dr. Bosco also highlights that patients who use narcotics for pain relief prior to a knee replacement surgery have worse outcomes post-surgery than patients who did not use narcotics prior to surgery.
[10] Dr. Bosco notes that when a TKR patient is not aggressive with physical therapy immediately after the surgery, the knee becomes stiff and loses range of motion, which cannot thereafter be remedied with physical therapy alone.

surgery. According to Dr. Bosco, plaintiff's subsequent treating providers have not documented any "inadequate fixation of fracture," or a failed knee replacement requiring revision.

In opposition, plaintiff annexes the affirmation of a physician board-certified in orthopedic surgery and sports/medicine/arthroscopic surgery.[11] Plaintiff's expert opines that Dr. Drucker departed from the standard of care by failing to appreciate plaintiff's x-rays pre-operatively, which was a substantial factor in causing a fracture of the anterior of the right femur when Dr. Drucker attempted to insert the intermedullary rod during plaintiff's TKR surgery. Plaintiff's expert notes that plaintiff had fractured his tibia in an accident in 1980, and despite treating with Dr. Drucker since June of 2011, Dr. Drucker was unsure if plaintiff had fractured his femur in the accident. Plaintiff's expert also points out that Dr. Drucker did not order a pre-operative CT scan of plaintiff's femur.

In plaintiff's expert's opinion, Dr. Drucker's performance of plaintiff's TKR surgery departed from the standard of care. Plaintiff's expert highlights that Dr. Drucker stated that he "compromised" the femoral shaft during the procedure, and that he was unsure whether he created a "through and through" puncture, or if he "thinned the cortex." According to plaintiff's expert, this event prompted Dr. Drucker to document in his operative report that "there may have been some deformity on the femoral side as well, which is not totally appreciated on [plaintiff's] films from the office or in preparation for the surgery. As a result, when we drilled the femur to put in the intermedullary rod, the anterior cortex of the femur was compromised."

Plaintiff's expert also points out that Dr. Kumud Gugliada ("Dr. Gugliada"), a radiologist at Regional Radiology who was involved in reading plaintiff's films, testified that there was a bony overgrowth of the superior aspect of the medial femoral condyle, which Dr. Gugliada characterized

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[11] As plaintiff has redacted the name of his expert, the expert will be referred to as "plaintiff's expert" herein.

as a deformity in the femoral area. Similarly, plaintiff's expert notes that Dr. George Visvikis ("Dr. Visvikis"), another radiologist at Regional Radiology, testified that osteoarthritis changes caused a deformity about the distal femur of plaintiff's right knee. Likewise, plaintiff's expert highlights that Dr. Drucker's "Musculoskeletal Medical Report" stated that plaintiff fractured his distal femur during the TKR surgery on January 18, 2012, and that an x-ray from Cleveland Clinic on June 16, 2015 demonstrated an irregularity which could "possibly" be a fracture of the cortical neck of the right femur. Upon reviewing the June 16, 2015 film, plaintiff's expert agrees that the film showed a fracture of the cortical neck of the right femur, which was the fracture that was sustained during plaintiff's TKR surgery on January 18, 2012.

Additionally, plaintiff's expert opines that the implantation of a stem into the femur "was not the intended course for plaintiff's knee replacement." Rather, plaintiff's expert posits that Dr. Drucker inserted a stem into the femur to address the fracture that he had caused by drilling into an area of deformity in the femur which he had failed to appreciate pre-operatively. Plaintiff's expert highlights that Dr. Drucker testified that

> "When you compromise the cortex or thin the cortex, that is an area where the bone potentially breaks. You weakened it. It will heal. But in the time between when it occurs and it heals, you need to protect it in some way. So I used a type of implant that I could attach a stem to go well beyond the weakened cortex that would protect the bone from fracturing."

In that regard, plaintiff's expert disagrees with Dr. Bosco's opinion that the "intraoperative perforation" is a known risk of the procedure, and not indicative of malpractice. According to plaintiff's expert, plaintiff's cortical fracture was avoidable as an orthopedic surgeon is required to appreciate the deformities when determining where to begin drilling. Instead, plaintiff's expert proffers that Dr. Drucker inappropriately and incorrectly determined the point where to begin drilling (i.e. where he "normally" begins the drilling for the intramedullary rod), which resulted in the "compromised" or "fractured" femoral cortex. As such, plaintiff's expert concludes that Dr.

Drucker's implantation of the stem into the femur, which was already compromised by arthritic deformities, "made a bad situation worse."

Plaintiff's expert further opines that plaintiff's fractured femur was a substantial factor in causing plaintiff's increased pain and disability. According to plaintiff's expert, after plaintiff's TKR surgery, plaintiff experienced the same or increased pain from his initial complaints in June of 2011 and from his first presentation at Dr. Drucker's office. Plaintiff's expert also notes that plaintiff experienced an altered gait, leading to hip and back problems.

Plaintiff's expert further avers that the implantation of a long stem into the femur during a TKR surgery increases surgical complexities, raises the concern of reduction in bone density, and complicates further revision and secondary replacement surgeries. Plaintiff's expert claims that because plaintiff was 48-years-old at the time of his TKR surgery, he is "certain to be required" to undergo not only a potential revision surgery, but also a replacement of the current implant since there is a 15-to-20-year life span for this particular hardware. Plaintiff's expert also asserts that any attempt to replace the hardware in his knee will be "severely complicated" by the stem implant, which will be a source of "severe medical difficulties" in the future, especially at an advanced age.

Finally, plaintiff argues that he is entitled to loss of future earnings. Plaintiff highlights that he was "told" that there was an opening for him as a "trading assistant and assistant head clerk," a position he held in the past, and that he had advised his former employers that he would return after his knee surgery. Plaintiff also notes that he previously earned $50,000 annually in that capacity, but was unable to return to that position after his TKR surgery.

In reply, defendants challenge the sufficiency of plaintiff's expert's affirmation. Defendants also argues that plaintiff mischaracterizes the testimony of Drs. Gugliada and Visvikis,

as both physicians confirm that the "deformities" seen about plaintiff's knee were caused by arthritis.[12]

Defendants further argue that while plaintiff claims that his June 16, 2015 Cleveland Clinic radiology report show that he sustained a femur fracture, plaintiff never previously claimed that the TKR surgery caused a cortical neck fracture. Defendants also note that while this report from more than three years post-surgery mentions a "possible" fracture of the cortical neck of the femur, the cortical neck of the femur concerns the hip joint, and is nowhere near the distal femur where the perforation or puncture at issue occurred. Defendants further highlight that plaintiff's expert ignores that the June 16, 2015 radiology demonstrated that there was "no hardware failure or loosening seen. No occult fracture to the osseous structures of the right knee."

Additionally, defendants argue that there is no basis for plaintiff's claim that plaintiff will require revision surgery, or that the revision surgery will be complicated because of the implanted stem. Rather, defendants contend that none of plaintiff's treatment or radiology records show that a removal of hardware or knee revision is required. Defendants also point out that plaintiff has not undergone a further right knee surgery in the last eight years, and that none of plaintiff's subsequent treatment providers have documented a recommendation for such surgery.

Similarly, defendants argue that contrary to plaintiff's assertion that plaintiff's TKR surgery caused "an altered gait, leading to hip and back problems," Dr. Drucker documented plaintiff's antalgic gait during plaintiff's first visit on June 7, 2011, and that Dr. Perez documented

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[12] Dr. Bosco avers that contrary to plaintiff's assertion, Dr. Gugliada specified that the deformity was secondary to degeneration of the knee joint, which was from plaintiff's arthritis, and that there was no separate extra-articular deformity or defect in plaintiff's femur apart from the arthritic knee. Similarly, Dr. Bosco asserts that Dr. Visvikis confirmed that plaintiff's "deformities" were caused by arthritis. As such, Dr. Bosco emphasizes that Drs. Gugliada and Visvikis' testimony reaffirms that plaintiff's pre-operative radiology shows arthritic changes about plaintiff's right knee, and that such findings do not suggest the existence of an extra-articular femur defect that would lead to a fracture.

that the "date of onset" for plaintiff's low back and bilateral leg pain was 30 years ago when plaintiff fractured his right tibia.

In further support of their motion, defendants submit a supplemental affirmation of Dr. Bosco. Dr. Bosco reiterates that defendants ordered appropriate pre-operative radiology, which did not depict any right femur deformity, except for one typically seen in arthritic knees. In that regard, Dr. Bosco notes that plaintiff had an arthritic right knee due to severe post-traumatic arthritis, which Dr. Drucker visualized pre-operatively. Dr. Bosco also points out that Dr. Drucker noted that plaintiff's x-rays demonstrated "severe varus deformity of the right knee," and planned a surgical technique that accounted for plaintiff's severely arthritic knee.

Dr. Bosco further avers that plaintiff's use of the term "deformity" is misleading as plaintiff conflates two different types of deformities—the typical deformity of the knee joint caused by arthritis, and a deformity of the femur apart from the knee joint (extra-articular deformity) caused by something else, such as an old fracture. Dr. Bosco also highlights that plaintiff's healed tibial fracture in the proximal tibial shaft was visible on the pre-operative radiology, and that Dr. Drucker noted the same prior to plaintiff's surgery. Dr. Bosco further elaborates that if an extra-articular femoral defect had been present, the standard of care would have required Dr. Drucker to modify his surgical technique, however, plaintiff had no extra-articular defect of the femur away from the knee joint, and therefore, Dr. Drucker's surgical technique was appropriate.

Dr. Bosco further opines that while plaintiff claims that Dr. Drucker "incorrectly determined the point to begin drilling [which] resulted in the 'compromised' or 'fractured' femoral cortex," the location where Dr. Drucker began drilling had nothing to do with a purported deformity in the femur, and that drilling a hole in the femoral cortex was not a "fracture." Dr.

Bosco explains that a fracture is an uncontrolled occurrence, but here, the bone weakened while Dr. Drucker was drilling, which resulted in a puncture.

Similarly, Dr. Bosco opines that while plaintiff's expert states that, "[I]t is well-settled that implantation of a long stem into the femur during total knee replacement increases surgical complexities, raises concern of reduction in bone density and complicates further revision and secondary replacement surgery," there are no clinical issues with the implantation of a stem. Rather, Dr. Bosco posits that a long stem is implanted to provide additional stability in the knee joint post-operatively, and that when a perforation occurs during the initial procedure, such as the one here, it is proper to implant a stem to protect the femur from fracturing post-operatively. Dr. Bosco further emphasizes that the implantation of a stem does not result in harm to a patient.

Additionally, defendants reiterate that while plaintiff states a cause of action for loss of future earnings, awarding plaintiff loss of future earnings based on a job that plaintiff held nine years prior to his TKR surgery is speculative. According to defendants, plaintiff cannot establish any causal connection between his alleged loss of earnings and his TKR surgery.

Finally, defendants argue that the only remaining claims against NYHK and Beth Israel are vicarious in nature, and because Dr. Drucker, NYKH, and Beth Israel did not depart from the standard of care, plaintiff's claims against NYHK and Beth Israel must be dismissed.

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 a *prima facie* showings in favor of dismissal, as evidenced by the submission of defendants' medical records, and defendant's 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.

I. Deficiencies of Plaintiff's Expert's Affirmation

As a preliminary matter, plaintiff has submitted an unredacted copy of his expert's affirmation to the court, which includes the expert's identity, signature, and qualifications. Following an *in camera* inspection, the court is satisfied with plaintiff's expert's affirmation (*see, Turi v. Birk*, 118 A.D.3d 979, 980 [2d Dept. 2014]; *Marano v. Mercy Hosp.*, 241 A.D.2d 48, 50 [2d Dept. 1998]; *Carrasquillo v. Rosencrans*, 208 A.D.2d 488, 488 [2d Dept. 1994]). Accordingly, defendants' request to disregard plaintiff's expert's affirmation is denied

Moreover, contrary to defendants' argument, plaintiff's expert's board-certification in orthopedic surgery and sports/medicine/arthroscopic surgery, residency in orthopedic surgery, fellowship in sports medicine, and treatment of patients with the same condition as plaintiff are sufficient to qualify plaintiff's expert to render an opinion in this matter (*see, Lopez v. Gem Gravure Co.*, 50 A.D.3d 1102, 1103 [2d Dept. 2008]; *Enu v. Sobol*, 208 A.D.2d 1123, 1125 [3d Dept. 1994]). Accordingly, the court will consider plaintiff's expert's affirmation.

II. New Theory of Liability

"It is axiomatic that a plaintiff cannot defeat a summary judgment motion that made out a prima facie case by merely asserting, without more, a new theory of liability for the first time in the opposition papers" (*Biondi v. Behrman*, 149 A.D.3d 562, 563–64 [1st Dept. 2017]; *Abalola v. Flower Hosp.*, 44 A.D.3d 522, 522, 843 N.Y.S.2d 615, 616 [1st Dept. 2007]).

Here, plaintiff has impermissibly raised a new theory of liability in opposition to defendants' motions for summary judgment. Notably, plaintiff's allegation that defendants caused a cortical neck fracture was not pleaded in plaintiff's complaint or bills of particulars (*see, Marti v. Rana*, 173 A.D.3d 576, 577 [1st Dept. 2019]). Accordingly, this claim is dismissed.

III. Triable Issues of Fact

In response to defendants' *prima facie* showing, plaintiff has raised triable issues of fact sufficient to preclude summary judgment. For instance, the parties disagree as to whether defendants failed to appreciate plaintiff's radiology films pre-operatively. Notably, while plaintiff asserts that Dr. Drucker failed to appreciate plaintiff's x-rays pre-operatively, which was a substantial factor in causing a fracture of the anterior of the right femur when Dr. Drucker attempted to insert the intermedullary rod during plaintiff's surgery, defendants argue that Dr. Drucker correctly interpreted plaintiff's pre-operative x-rays, which did not depict any right femur deformity or abnormality. In that regard, while plaintiff claims that Dr. Drucker was unsure whether plaintiff had fractured his femur in his 1980 accident despite treating with Dr. Drucker since June of 2011, defendants contend that Dr. Drucker was aware of, and considered plaintiff's medical and surgical history before recommending and performing plaintiff's TKR surgery, and that plaintiff's pre-operative films provided Dr. Drucker with enough information to prepare for the surgery. Accordingly, there are triable issues of fact here sufficient to preclude summary judgment.[13]

The parties also disagree as to whether Dr. Drucker properly performed plaintiff's right TKR surgery on January 18, 2012. While plaintiff avers that Dr. Drucker "compromised" his femoral shaft during the TKR procedure by drilling the femur to place the intermedullary rod, defendants submit that there was a perforation of the anterior cortex while Dr. Drucker was drilling to place the intramedullary rods.[14] To that point, while plaintiff attributes his fracture to Dr.

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[13] Plaintiff and defendants' disagreement as to Drs. Gugliada and Visvikis' testimony with respect to the "deformities" seen about plaintiff's knee raises a triable issue of fact sufficient to preclude summary judgment.

[14] Plaintiff and defendants' conflicting position as to whether Dr. Drucker "fractured" or "perforated" the anterior cortex of the distal femur further supports denial of summary judgment.

Drucker's drilling into "an area of deformity in the femur" that he failed to appreciate pre-operatively, defendants posit that Dr. Drucker appreciated plaintiff's anatomy pre-operatively such that he was able to anticipate and prepare the operating room with appropriate hardware for potential complications such as the perforation that occurred. In that regard, defendants emphasize that Dr. Drucker did not cause a fracture to plaintiff's right femur during the surgery, but rather, Dr. Drucker was able to prevent this post-operative complication by placing a stem on the femoral component. Because there are triable issues of fact as to whether Dr. Drucker's performance of plaintiff's TKR surgery departed from the standard of care, summary judgment is denied.

Additionally, plaintiff raises a triable issue of fact as to whether Dr. Drucker's treatment of plaintiff's perforation departed from the standard of care, and whether such departures proximately caused plaintiff's alleged injuries. Notably, defendants maintain that Dr. Drucker properly treated the perforation by placing a stem on the femoral component as a precautionary measure to prevent a post-operative fracture in light of plaintiff's compromised anterior cortex and known tibial deformity. Plaintiff, however, submits that the implantation of a stem into the femur "was not the intended course for plaintiff's knee replacement," and that Dr. Drucker inappropriately and incorrectly determined the point where to begin drilling, which resulted in the "compromised" or "fractured" femoral cortex. Still, defendants argue that Dr. Drucker did not cause or contribute to plaintiff's alleged injuries, as the perforation had no bearing on the outcome of plaintiff's TKR surgery, and the placement of the stem did not change plaintiff's prognosis. In that regard, while defendants posit that Dr. Drucker recognized and addressed the perforation intra-operatively, and that plaintiff's recovery would have been the same even if the perforation had not occurred, plaintiff underscores that Dr. Drucker's implantation of the stem into the femur, which was already compromised by arthritic deformities, "made a bad situation worse." Accordingly, because there

are triable issues of fact as to whether Dr. Drucker's alleged departures proximately caused "a fracture of the anterior cortex of the femur," summary judgment is denied.

However, plaintiff has not proffered any evidence to show that defendants' alleged departures proximately caused plaintiff's alleged "increased pain and disability." As defendants correctly argue, plaintiff's assertion that the "femur fracture" caused plaintiff "ongoing pain" is speculative and conclusory (*Horth v. Mansur*, 243 A.D.2d 1041, 1043 [3d Dept. 1997] ["[S]peculation cannot substitute for a causal link between defendant's surgery and plaintiff's alleged injury"]). Indeed, plaintiff failed to address or rebut Dr. Bosco's opinions that plaintiff's severe post-traumatic arthritis, use of narcotics prior to the surgery, and non-compliance with physical therapy caused or contributed to his complaints of pain. Plaintiff also fails to substantiate his claim that he experienced the "same or increased pain" after his surgery, especially when juxtaposed against defendants' assertion that plaintiff complained of hip and back pain prior to his treatment with Dr. Drucker. Accordingly, because plaintiff has failed to establish that the TKR surgery caused or contributed to his alleged pain, plaintiff's claims related increased pain and disability are dismissed.

Similarly, while plaintiff avers that the TKR surgery caused "an altered gait, leading to hip and back problems," plaintiff does not submit any evidence to show a causal nexus between the surgery and his altered gait, and hip and back problems. By contrast, defendants proffer undisputed evidence that Dr. Drucker documented plaintiff's antalgic gait during plaintiff's visit on June 7, 2011, and that Dr. Perez documented that the "date of onset" for plaintiff's low back and bilateral leg pain was 30 years ago when plaintiff fractured his right tibia. Accordingly, plaintiff's claim that the TKR surgery caused "an altered gait, leading to hip and back problems" is dismissed.

Likewise, while plaintiff asserts that the implantation of a long stem into the femur during a TKR surgery increases surgical complexities, raises the concern of reduction in bone density, and complicates further revision and secondary replacement surgeries, such generalized observations are insufficient to satisfy the “proximate cause” element required to defeat a motion for summary judgment (*see, Henry v. Duncan*, 169 A.D.3d 421, 421 [1st Dept. 2019]; *Biondi v. Behrman*, 149 A.D.3d 562, 565 [1st Dept. 2017]; *Rodriguez v. Montefiore Med. Ctr.*, 28 A.D.3d 357, 357 [1st Dept. 2006]).

Notably, plaintiff’s claim that he is “certain to be required” to undergo not only a “potential” revision surgery, but also a replacement of the current implant amounts mere speculation (*see, Horth*, 243 A.D.2d at 1043, *supra*). Indeed, plaintiff has not proffered any evidence to show that he will undergo, or is scheduled to undergo a revision surgery or a replacement of his current implant. To be sure, as defendants point out, plaintiff has not undergone any revision surgeries of his right knee as of February 12, 2018.

Similarly, plaintiff speculates in a conclusory manner that any “attempt to replace the hardware” will be “severely complicated” by the stem implant. Notably, plaintiff submits no evidence to substantiate his bald assertion that any future attempt to replace the hardware will be a source of “severe medical difficulties,” especially at an advanced age (*see, Gillespie v. New York Hosp. Queens*, 96 A.D.3d 901, 902 [2d Dept. 2012]; *Rebozo v. Wilen*, 41 A.D.3d 457, 459 [2d Dept. 2007]; *Lisi v. Coco*, 31 A.D.3d 615, 616 [2d Dept. 2006]). By contrast, defendants proffer that none of plaintiff’s medical records show that plaintiff has “excess metal in the right femur and right leg,” or any “loose metal in the right femur” requiring a removal of hardware or a knee revision surgery. Plaintiff also fails to dispute defendants’ contention that plaintiff’s subsequent

treating providers have not documented any "inadequate fixation of fracture," or a failed knee replacement requiring revision. Accordingly, these claims are dismissed.

Additionally, plaintiff's claim for lack of informed consent is dismissed as plaintiff has failed to address or rebut defendants' arguments with respect to the same. Likewise, plaintiff's failure to address or dispute defendants' assertions regarding defendants' post-operative care and treatment warrants dismissal of all claims related to the same.

Moreover, as plaintiff has failed to establish a claim for loss of future earnings with reasonable certainty, plaintiff's claim is dismissed. "The basic rule is that loss of earnings must be established with reasonable certainty, focusing, in part, on the plaintiff's earning capacity both before and after the accident" (*Butts v. Braun*, 204 A.D.2d 1069, 1069–70 [4th Dept. 1994]). Here, plaintiff was unemployed prior to his TKR surgery, and never returned to work post-surgery. As defendants' highlight, plaintiff stopped working full-time in June of 2003, and ceased working altogether in October of 2004, more than seven years prior to his TKR surgery. Plaintiff also applied for disability benefits in 2011 due to "a knee problem," one year prior to his surgery. As such, because plaintiff was not employed prior to or after his surgery, plaintiff cannot establish a causal connection between his alleged loss of earnings and his TKR surgery.

Furthermore, while plaintiff asserts that he had been offered a position, and that he advised his employers that he intended to return to work after his surgery, plaintiff's does not offer any evidence to substantiate his claims. To be sure, plaintiff's assertions that he would "maybe come and work" after the surgery, and would "probably" be able to work for someone he knew is unclear, speculative, and insufficient to establish a claim for loss of earnings (*see, Naveja v. Hillcrest Gen. Hosp.*, 148 A.D.2d 429, 430 [2d Dept. 1989]; *Marmo v. Southside Hosp.*, 143 A.D.2d 891, 893 [2d Dept. 1988]; *cf.*; *Keefe v. E & D Specialty Stands, Inc.*, 272 A.D.2d 949, 949 [4th Dept. 2000]

[plaintiff established the loss of earnings with reasonable certainty where plaintiff "had completed all written and physical tests and had been notified that he would be accepted into the apprenticeship program"]). As such, plaintiff's claim for loss of future earnings is dismissed.

Based on the foregoing, it is hereby

ORDERED that defendants' motion for summary is granted in part; and it is further

ORDERED that the clerk is directed to enter judgment dismissing the aforementioned claims against defendants consistent with this decision; and it is further

ORDERED that the parties are directed to appear for a virtual conference before the court on August 3, 2020 at 11:00 AM.

This constitutes the decision and order of the court.

Dated: July 1, 2020

HON. GEORGE J. SILVER