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

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LINDSAY LEE,

Plaintiff,

Index No. 805436/2016
Motion Seq. 002

-v-

DIMITRIOS PASAGELIS,

DECISION & ORDER

-and

STEVEN M. GREEN, M.D., ELMHURST HOPSITAL CENTER and NEW YORK CITY HEALTH AND HOSPITALS CORPORATION,

Defendants.

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

In this medical malpractice action, defendants STEVEN MARSHALL GREEN, M.D., s/h/a STEVEN M. GREEN, M.D. ("Dr. Green") and NEW YORK CITY HEALTH and HOSPITALS CORPORATION ("NYCHHC"), s/h/a, ELMHURST HOSPITAL CENTER ("Elmhurst Hospital" collectively "defendants"),[1] move for summary judgment. Plaintiff LINDSAY LEE ("plaintiff") opposes the motion. For the reasons discussed below, the court denies the motion.[2]

On August 9, 2015, plaintiff, then 28-years-old, was riding a bicycle when she was struck by a car in Astoria, Queens. Plaintiff was taken to Elmhurst Hospital by ambulance where she had a laceration and multiple fractures to her left hand. Plaintiff's hand was swollen with a decreased

[1] The initial motor vehicle action against defendant DIMITIOS PASAGELIS, which was consolidated with the medical malpractice action on March 22, 2018, is not at issue in the instant motion. Accordingly, this decision will only address the medical malpractice aspect of the consolidated actions.
[2] Pursuant to a stipulation dated May 7, 2019, this action was discontinued against defendants MARTIN A. POSNER, M.D. and STEVEN M. GREEN, M.D., P.C.

range of motion, but plaintiff did not experience any numbness. Radiological studies in the Emergency Department ("ED") showed a second metacarpal neck fracture with mild displacement, a fracture of the third metacarpal shaft with dorsal displacement of the distal fragment, and a fracture of the index finger proximal phalanx extending into the based with minimal displacement. Plaintiff's flexion was intact, and her anterior interosseous, posterior interosseous, and ulnar nerves were intact. Plaintiff's radial pulse was two plus, and her fingers were warm and well-perfused. Plaintiff was admitted to the hospital where her third metacarpal fracture was reduced, her finger was splinted, and her hand was casted. Plaintiff's laceration was also sutured.[3]

On August 11, 2015, Dr. Green, an orthopedic surgeon at Elmhurst Hospital, examined plaintiff and reviewed her x-rays. Dr. Green determined that plaintiff required surgery in her left hand, and that plaintiff required fixation and immobilization, which would be better than using a cast or a splint. That same day, Dr. Green performed a closed reduction and percutaneous pinning of plaintiff's left-hand fractures. Post-operatively, plaintiff received IV ketorolac, morphine, and dilaudid. Plaintiff's splint was clean, dry, and intact, and plaintiff's fingers were warm and well-perfused with sensations intact to light touch. On August 12, 2015, plaintiff was discharged home with instructions to follow up with Dr. Green on September 1, 2015 for further x-rays. Plaintiff was also directed not to remove the dressing, to keep the splint and dressing dry, and to elevate her hand to prevent swelling. Plaintiff was also prescribed with hydromorphone and ibuprofen.

On August 28, 2015, plaintiff presented to Elmhurst Hospital's ED with complaints of pain at her pin-sites. Plaintiff also reported that her cast was loose. Plaintiff denied numbness, and her fingers were pink with good capillary refill. Dr. Green was not contacted at that time, however,

[3] Plaintiff does not allege any negligence/malpractice with respect to her treatment at Elmhurst Hospital's ED.

physicians in the ED removed plaintiff's cast and examined her pin-sites and hand. Plaintiff had decreased swelling, and her pin-sites were clean, dry, and intact. Plaintiff did not have drainage or erythema, and the physicians could passively extend and flex the fingers on her left hand. Plaintiff's dressing was changed, and plaintiff received a new cast. Plaintiff was also prescribed with Percocet, and subsequently discharged home.

On September 15, 2015, plaintiff saw Dr. Green at Elmhurst Hospital's hand clinic ("hand clinic"). Plaintiff's second and third metacarpal fractures were healing with acceptable alignment. Dr. Green removed the pins, and instructed plaintiff to do the same. X-rays taken that day showed that plaintiff's fracture fragments were in an "improved position," and that plaintiff's joint alignment was normal. Plaintiff's pin-sites were clean, dry, and intact, and plaintiff's hand was neurovascularly intact. Plaintiff's sensation was intact to light touch, and her range of motion was "very limited." Dr. Green advised plaintiff to start active and passive range of motion of her hand once or twice an hour to regain flexibility and to recover traction in her left hand.

On September 29, 2015, plaintiff saw Dr. Green at the hand clinic for a follow-up visit. Plaintiff performed a range of motion exercises, but complained of ongoing pain in her hand. Plaintiff was almost able to make a complete fist, and her second metacarpophalangeal ("MCP") joint flexed to 80 degrees. Plaintiff's proximal interphalangeal joint and distal interphalangeal joint had full flexion, but with some pain. Plaintiff was instructed to continue range of motion exercises, and to return to the hand clinic on November 13, 2015 for further x-rays and re-evaluation. However, plaintiff never returned to Elmhurst Hospital.

On October 12, 2015, plaintiff presented to Dr. Mark Pruzansky ("Dr. Pruzansky"), a hand surgeon. Dr. Pruzansky found some medial deviation of plaintiff's index finger with prominence of the second metacarpal head. Plaintiff's index finger flexed to 45 degrees at the MCP joint, the

middle finger to 60 degrees, and the ring finger to 80 degrees. X-rays taken that day showed a malunion[4] of the second and third metacarpals. Dr. Pruzansky also noted "dorsal angulation" of the third metacarpal and "medical displacement" of the second metacarpal. Dr. Pruzansky believed that plaintiff would need an osteotomy[5] and capsulotomy,[6] and planned for plaintiff to undergo surgery.

On October 14, 2015, plaintiff saw Dr. Stephen Nicholas ("Dr. Nicholas"), an orthopedist. Dr. Nicholas found that plaintiff's second metacarpal had dorsal angulation, and that the third metacarpal had mild angular deformity. Dr. Nicholas believed that plaintiff might need further surgery, and recommended that Dr. Steven Lee ("Dr. Lee"), a hand surgeon at his office, perform the procedure. Upon plaintiff's presentation, Dr. Lee ordered a CT scan of plaintiff's left hand.

The following day, plaintiff underwent a CT scan of her left hand, which revealed callus formation involving the third metacarpal shaft consistent with a delayed union and partial healing of the second metacarpal fracture. Dr. Lee reviewed the CT scan, and advised plaintiff that she needed surgery.

On November 13, 2015, Dr. Lee operated on plaintiff's left hand at Surgicare of Manhattan under regional sedation. The pre-operative diagnosis was a left middle finger metacarpal nonunion[7] and a left metacarpal head malunion. The surgery required insertion of additional hardware (plates and screws).

Plaintiff alleges that defendants failed to obtain adequate consent for her August 11, 2015 surgery, and improperly performed said surgery.

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[4] Malunion refers to a fracture that has healed, but in less than an optimal position. It is the union of the ends of a broken bone resulting in a deformity or a crooked limb.
[5] An osteotomy is a surgery that cuts and reshapes the bones.
[6] A capsulotomy is an incision of a capsule, as that of the lens, the kidney, or a joint.
[7] Nonunion refers to the failure of the ends of a fractured bone to unite.

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 Robert Strauch, M.D. ("Dr. Strauch"), a physician board-certified in orthopedic surgery and hand surgery. Dr. Strauch opines that Dr. Green appropriately planned to treat plaintiff's fractures with a pinning procedure as opposed to open surgery. Specifically, Dr. Strauch asserts that Dr. Green's decision to perform a closed pinning procedure allowed plaintiff to achieve the best result while avoiding the risks of an open procedure. According to Dr. Strauch, a closed pinning is a common method of treating fractures such as those sustained by plaintiff, and typically involves less trauma to the soft tissue and bones than an open procedure, which involves plates and screws. As such, Dr. Strauch concludes that Dr. Green's determination that he could achieve the best reduction by performing a closed procedure with percutaneous pinning when choosing between multiple surgical and non-surgical options was within Dr. Green's surgical judgment and the standard of care.

In Dr. Strauch's opinion, Dr. Green properly performed plaintiff's August 11, 2015 procedure. Dr. Strauch notes that Dr. Green timely performed the procedure two days after plaintiff's accident, and that plaintiff's hand was properly casted. Dr. Strauch also highlights that defendants timely and appropriately administered antibiotics, and that plaintiff's left-hand wounds never became infected. As such, Dr. Strauch concludes that plaintiff's alleged nonunion or malunion of the metacarpals eight weeks after her surgery does not "take away" from the appropriateness of Dr. Green's plan or execution of plaintiff's surgical procedure.

Dr. Strauch also opines that defendants provided plaintiff with appropriate instructions, recommendations, and follow-up care upon her discharge on August 12, 2015. Dr. Strauch points out that plaintiff's hand was neurovascularly intact at discharge, and that plaintiff was discharged with a splint and advice to be non-weight bearing on her left hand. Dr. Strauch also notes that upon discharge, defendants scheduled plaintiff for a follow-up visit at the hand clinic on September 1, 2015 to undergo further radiological studies.

Similarly, Dr. Strauch opines that defendants appropriately treated plaintiff on August 28, 2015. Dr. Strauch highlights that when plaintiff presented to Elmhurst Hospital's ED on August 28, 2015 with complaints of worsening pain in her left hand, and that her cast was loose, defendants properly removed the cast. Dr. Strauch also notes that an examination revealed that plaintiff's hand had decreased in swelling, and that her pin-sites were clean, dry, and intact. Additionally, Dr. Strauch highlights that there was passive extension and flexion of plaintiff's fingers with no infection or numbness. Dr. Strauch also notes that plaintiff received a new cast, and that defendants instructed plaintiff to return to the hand clinic for follow up care. Dr. Strauch further points out that plaintiff's left hand was healing as Dr. Green had anticipated.

Likewise, Dr. Strauch opines that defendants appropriately treated plaintiff during her follow-up visit on September 15, 2015. Dr. Strauch notes that plaintiff's pins were removed, and that plaintiff's pin sites were clean, dry, and intact. Dr. Strauch also points out that plaintiff's hand was neurovascularly intact although plaintiff had a limited range of motion in the hand and fingers, which was an unavoidable complication "of any treatment for the injury" plaintiff had suffered. Dr. Strauch further observes that radiological studies showed that plaintiff's fractures were healing properly and were in acceptable alignment, and that there were no signs or symptoms of nonunion

or malunion. As such, Dr. Strauch posits that Dr. Green appropriately started plaintiff with range of motion exercises to minimize finger stiffness.

Lastly, Dr. Strauch opines that plaintiff gave informed consent for her August 11, 2015 procedure. Dr. Strauch asserts that because Elmhurst Hospital's records document that plaintiff executed a written consent form on August 10, 2015, which referenced her left-hand procedure, and states that further surgery may be required, plaintiff received proper information as to the risks, benefits, complications, and alternatives of the procedure. Dr. Strauch also submits that all hand surgeries have risks, including, infection, scarring, and the loss of motion of the fingers and hand.

In opposition, plaintiff argues that Dr. Strauch's opinions are conclusory, as Dr. Strauch does not explain why a percutaneous "pinning" was "well within [acceptable] surgical judgment" other than a general reference to the "risks of an open procedure" and "less trauma to the soft tissues of the bone." Similarly, plaintiff posits that Dr. Strauch does not explain why Dr. Green could not attain a better reduction, or how or why a "mal-union" could not be avoided. Likewise, plaintiff contends that Dr. Strauch does not address the sufficiency of plaintiff's informed consent for the procedure.

In support of her opposition, plaintiff annexes the affirmation of Richard Matza, M.D. ("Dr. Matza"), an orthopedic surgeon. Dr. Matza opines that Dr. Green departed from the standard of care, and that Dr. Green's departures caused plaintiff's injuries, including the need for a second (revision) surgery and compromise to plaintiff's residual outcome.

In Dr. Matza's opinion, Dr. Green's pre-operative discussion with plaintiff was inadequate to give plaintiff a meaningful opportunity to decide whether she wanted a closed procedure using wires or an open procedure using plates and screws. According to Dr. Matza, while there is often some surgical judgment involved in the choice of surgical hardware, in the case of a hand surgery,

and particularly in choosing between a closed procedure using "K-wires" versus an open procedure using plates and screws, the standard of care requires the surgeon to explain that there are anticipated differences and tradeoffs between the two approaches. Dr. Matza points out that plaintiff testified that although Dr. Green stated that he might use K-wires or possibly a plates-and-screws approach, she did not know which approach Dr. Green intended to use. Rather, plaintiff asserts that she was told that defendants would make the decision once they operated. According to Dr. Katza, a hand surgeon in this situation was required to give the patient a more descriptive understanding of the tradeoffs between the two approaches, and consider the advantages of the plates-and-screws approach as this approach may have been able to achieve a better anatomical position of the hand and a greater residual function. In that regard, Dr. Katza underscores that plaintiff did not have a meaningful opportunity to decide which hardware she wanted since Dr. Green's explanation of her surgical options was inadequate.[8]

Dr. Katza also opines that Dr. Green failed to achieve adequate reduction of plaintiff's fractures during plaintiff's August 11, 2015 surgery. According to Dr. Matza, it is mandatory for an orthopedist, unless prevented by some other medical consideration, to achieve the best possible reduction to optimize healing and to have the "best chance" to restore the "best possible degree of residual function." However, Dr. Matza notes that plaintiff's September 15, 2015 x-rays and October 15, 2015 MRI show that plaintiff's second metacarpal neck fracture was barely reduced, and that the residual reduction appeared to be greater than 20 degrees. Dr. Matza also highlights that plaintiff's third metacarpal fracture, while reduced somewhat, still showed poor reduction with excessive angulation. According to Dr. Matza, there is no acceptable reason why Dr. Green should

[8] Dr. Katza highlights that plaintiff had a specific vocational need as she worked in construction, and therefore, she needed to optimize hand strength and stability which was not likely to be achieved through K-wire pinning alone.

not have been able to achieve anatomical, or near anatomical reduction during plaintiff's procedure. Dr. Matza explains that if such reduction was not achievable by using K-wires, then it was mandatory for Dr. Green to use a more "open" approach with fixation screws.

In Dr. Matza's opinion, the inadequate reduction of plaintiff's second and third metacarpal fractures caused malunion, excessive interference with ligaments and tendons adjacent to the second and third metacarpals, which contributed to a significant and unnecessary residual deformity of plaintiff's hand, increased pain in the use of the hand, and the need for a second surgery. In that regard, Dr. Matza disagrees with Dr. Strauch's assertion that, "Radiological studies [post operative] showed [that] the fractures were healing and were in acceptable alignment." Rather, Dr. Matza notes that Dr. Strauch fails to quantify either pre-reduction or post-reduction angulation, or the extent to which Dr. Green achieved reduction. As such, Dr. Matza concludes that given the lack of any "meaningful reduction" in the second metacarpal reduction, and only minimal reduction of the third metacarpal fracture, neither reduction was acceptable.

Additionally, Dr. Matza opines that Dr. Green deviated from the standard of care by impinging upon the soft tissues of plaintiff's hand in a manner in which the hand could not be adequately mobilized in the post-operative period. According to Dr. Matza, early mobilization is essential to minimize internal scarring and to optimize residual hand function. Dr. Matza notes that this is particularly true with the intra-articular injury demonstrated on plaintiff's x-rays, which causes bleeding into the joints. However, Dr. Matza observes that Dr. Green's placement of the K-wires rendered proper mobilization of plaintiff's hand impossible, and caused poor early mobilization, which resulted in unnecessary and excessive scar tissue formation, additional residual stiffness, and pain in plaintiff's hand. According to Dr. Matza, Dr. Green's failure to use

stabilizing hardware exacerbated plaintiff's poor early mobilization, and when combined with Dr. Green's improper K-wire placement, prevented early mobilization.

Dr. Matza further opines that Dr. Green departed from accepted practice by failing to prescribe a course of intensive and supervised physical therapy following plaintiff's August 11, 2015 surgery. According to Dr. Matza, Dr. Green's departure contributed to plaintiff's poor early mobilization, which led to her development of excessive scar tissue, capsulitis, and need for a second surgery. In that regard, Dr. Matza highlights that Dr. Green's September 29, 2015 measurements contradict Dr. Pruzansky's October 12, 2015 physical examination of plaintiff's hand, which found an index finger flexion of 45 degrees, middle finger flexion of 60 degrees, ring finger flexion of 80 degrees, and little finger flexion of 90 degrees, and malunion of the second and third metacarpals. Instead, Dr. Matza maintains that Dr. Pruzansky's x-ray and physical exam are consistent with poor early mobilization, which would be a predictable consequence of poor stabilization (failing to use plates), improper use of K-wires (impinging on soft tissues to prevent mobilization), and lack of early physical therapy (the accepted way to best achieve such mobilization). As such, Dr. Katza concludes that the lack of early physical therapy was an additional and significant cause of plaintiff's development of capsulitis and formation of excessive scar tissue.

Finally, Dr. Katza submits that plaintiff's second surgery, which was due to the malunions and capsulitis, contributed to plaintiff's further scar formation internally, and compromised the residual function of plaintiff's hand. Similarly, Dr. Katza posits that Dr. Green's improper surgical management and post-operative care of plaintiff caused plaintiff residual stiffness, discomfort, lack of mobility, and lack of strength in plaintiff's left hand.

In reply, defendants argue that there is no evidence that plaintiff did not give her informed consent for the procedure, and that plaintiff never told Dr. Green that it was imperative to perform an open procedure. Defendants also contends that it was not necessary for Dr. Green to order plaintiff to start occupational therapy. Rather, defendants maintain that Dr. Green properly instructed plaintiff to perform home exercises to start mobilization of her hand as plaintiff was "moving her hand well."

Additionally, defendants argue that although the reduction of the second and third metacarpals was not anatomic, plaintiff's function was "still very good" following her procedure. Defendants contend that had plaintiff returned to Dr. Green with complaints of reduced motion after the procedure, hand therapy could have been initiated with significant improvement over time, which would have potentially avoided the need for repeat surgeries. Defendants also reiterate that a malunion is a known complication of the procedure, which can occur without malpractice.

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* showing 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 comported 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'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 Dr. Matza is not licensed to practice medicine 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 Dr. Matza, and decide the motion on its merits.

Substantively, plaintiff has raised triable issues of fact sufficient to preclude summary judgment. For example, the parties disagree as to whether Dr. Green's recommendation and decision to perform a closed pinning procedure on plaintiff's left hand comported with the standard of care. Notably, while defendants argue that Dr. Green appropriately planned to treat plaintiff's fractures with a pinning procedure as opposed to an open surgery, plaintiff maintains that Dr. Green failed to adequately provide plaintiff with a meaningful opportunity to decide whether she preferred a closed procedure using K-wires or an open procedure using plates and screws. By contrast, defendants submit that Dr. Green's decision to perform a closed pinning procedure allowed plaintiff to achieve the best result while avoiding the risks of an open procedure since a closed pinning procedure typically involves less trauma to the soft tissue and bones as opposed to an open procedure. Because these issues cannot be resolved by the facts before the court, summary judgment must be denied.

The parties also disagree as to whether Dr. Green properly performed plaintiff's August 11, 2015 procedure. While defendants assert that Dr. Green timely performed a closed reduction and percutaneous pinning of plaintiff's left-hand fractures two days after plaintiff's accident, plaintiff submits that Dr. Green failed to achieve adequate reduction of her fractures. Specifically, plaintiff underscores her September 15, 2015 x-rays and October 15, 2015 MRI demonstrate that her second metacarpal neck fracture was barely reduced, and that her third metacarpal fracture showed poor reduction with excessive angulation. Defendants, on the other hand, posit that although the reduction of plaintiff's second and third metacarpals was not anatomic, plaintiff's

function was "still very good" after her procedure. Indeed, defendants highlight that an examination on August 28, 2015 showed that plaintiff's left hand was healing as Dr. Green had anticipated, and that radiological studies on September 15, 2015 showed that plaintiff's fractures were healing properly with acceptable alignment and no signs or symptoms of nonunion or malunion. Still, plaintiff argues that it is mandatory for an orthopedist to achieve the best possible reduction when treating a fracture to optimize healing and to have the "best chance" to restore the "best possible degree of residual function." Plaintiff further underscores that if this was not achievable with the use of K-wires, then it was mandatory for Dr. Green to use a more "open" approach with fixation screws. Because there are triable issues of fact as to whether Dr. Green properly performed plaintiff's August 11, 2015 procedure, summary judgment must be denied.

Significantly, plaintiff has also raised a triable issue of fact as to whether Dr. Green's alleged failure to achieve an adequate reduction of plaintiff's fractures proximately caused plaintiff's alleged injuries. For instance, plaintiff avers that Dr. Green's placement of K-wires caused poor early mobilization, and rendered proper mobilization of plaintiff's hand impossible, thereby resulting in excessive scar tissue, additional residual stiffness, and pain in plaintiff's hand. Defendants, on the other hand, reiterate that radiological studies showed that plaintiff's fractures were healing properly, and were in acceptable alignment with no signs or symptoms of nonunion or malunion. In that regard, defendants emphasize that plaintiff's alleged nonunion or malunion of the metacarpals eight weeks post-surgery does not "take away" from the appropriateness of Dr. Green's decision to perform a closed reduction and percutaneous pinning of plaintiff's left-hand fractures, or Dr. Green's performance of the same. However, in challenging defendants' assertion, plaintiff argues that defendants failed to quantify either pre-reduction or post-reduction angulation, or the extent to which Dr. Green achieved reduction. Instead, plaintiff highlights that Dr. Green's

September 29, 2015 measurements contradict Dr. Pruzansky's October 12, 2015 physical examination of plaintiff which revealed malunion of the second and third metacarpals. In response, defendants maintain that a malunion is a known complication of the procedure which can occur without malpractice. Accordingly, there are triable issues of fact here sufficient to preclude summary judgment.

Moreover, plaintiff has raised a triable issue of fact as to whether defendants provided appropriate care and treatment following plaintiff's discharge on August 12, 2015. Specifically, while plaintiff argues that Dr. Green failed to prescribe a course of intensive and supervised physical therapy after plaintiff's surgery, defendants assert that Dr. Green properly instructed plaintiff to be non-weight bearing on her left hand, and to perform home exercises post-surgery. In further refuting plaintiff's argument that Dr. Green's failure to prescribe physical therapy caused plaintiff's additional injuries and the need for a second surgery, defendants submit that had plaintiff returned to Dr. Green with complaints of reduced motion post-surgery, Dr. Green could have initiated hand therapy, which would have resulted in significant improvement over time, and avoided the need for any repeat surgeries. Similarly, while defendants assert that plaintiff was appropriately treated on August 28, 2015 and September 15, 2015, plaintiff posits that Dr. Green's improper surgical management and post-operative care caused plaintiff residual stiffness, discomfort, and lack of mobility and strength in plaintiff's left hand. Because these issues cannot be resolved by the facts before the court, summary judgment must be denied.

Finally, the parties disagree as to whether defendants properly obtained plaintiff's informed consent for her August 11, 2015 procedure. Notably, defendants argue that plaintiff received proper information as to the risks, benefits, complications, and alternatives of the procedure, and that Elmhurst Hospital's records document that plaintiff executed a written consent form on

August 10, 2015, which stated that further surgery may be required. By contrast, plaintiff avers that although Dr. Green stated that he might use K-wires or possibly a plates-and-screws approach, she did not know which method Dr. Green intended to use. Moreover, plaintiff maintains that because she had a specific vocational need since she worked in construction, and needed to optimize her hand strength and stability, Dr. Green should have provided a more descriptive understanding of the tradeoffs between the two approaches. Defendants, however, argue that plaintiff never told Dr. Green that it was imperative to perform an open procedure, and that all hand surgeries have risks, including scarring and the loss of motion of the fingers and hand. Because these issues cannot be resolved by the facts before the court, 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 parties are directed to appear for a virtual pre-trial conference on July 15, 2020 at a time to be determined 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.

Date: June 15, 2020

George J. Silver
HON. GEORGE J. SILVER

GEORGE J. SILVER