Petrolito-Mccort v Latefi
2020 NY Slip Op 34707(U)
October 28, 2020
Supreme Court, Nassau County
Docket Number: Index No. 603150/2017
Judge: Jack L. Libert
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SUPREME COURT - STATE OF NEW YORK

PRESENT: HON. JACK L. LIBERT,
Justice.

TRIAL PART 20
NASSAU COUNTY

VICKIE PETROLITO-MCCORT and DANIELMCCORT,

Plaintiff,

-against-

AHMAD LATEFI, M.D. and NORTHWELL HEALTH PHYSICIAN PARTNERS,

Defendants.

MOTION # 01, 02
INDEX # 603150/2017
MOTION SUBMITTED: JULY 14, 2020

The following papers having been read on this motion:

Notice of Motion/Order to Show Cause.....1
Cross Motion/Answering Affidavits.....2, 3, 4
Reply Affidavits.....

Pursuant to CPLR 3212, defendants move for summary judgment dismissing the complaint (Motion #1). Plaintiff cross moves for leave to amend the complaint to add a cause of action for lack of informed consent (Motion #2).

BACKGROUND

This medical malpractice action arises spinal surgery performed upon plaintiff by defendant Latefi at the facility of defendant Northwell. The following facts are essentially undisputed.

The decedent first presented at Winthrop University Hospital on September 30, 2010 with pancytopenia and a high fever. The moving defendants undertook her care and treatment during her admission and continued to do so until her death on September 26, 2014.

Plaintiff suffered from a long history of chronic pain in her neck, back and extremities. In 2012 she was diagnosed with a herniated disc with multilevel spondylosis, at C4-C5, C5-6 and C6-7. On December 4, 2012, the defendant underwent fusion from C4-C7 (performed by a non-party surgeon). In May of 2013,

the defendant complained of continued neck pain, bilateral scapular pain radiating down to her thoracic spine, arm pain, numbness in her hands, and lower back pain, Following MRI studies earlier in the year on October 24, 2013, plaintiff underwent a lumbar laminectomy decompression for a spondylolysis at L5-S1 (by another nonparty surgeon). None of these surgeries were performed at defendant North Shore.

On or about March 5, 2015, plaintiff presented to Northwell Health Physician Partners/Chiari Institute at Great Neck. She complained of difficulty swallowing, shortness of breath, decreased interest in sexual relations, and decreased sensation in her pelvic function. She reported her prior fusion and intense and unbearable post-operative pain. On March 30, 2015, plaintiff presented to Northwell Health Partners for an initial evaluation with Dr. Rekate. She reported difficulty swallowing and pain when attempting to swallow. Dr. Rekate noted plaintiff's scans revealed a distortion of the esophagus related to bolts used from the prior fusion requiring a major revision of her prior fusion, possible decompression of the esophageal distortion and possible incorporation of the superior adjacent segment. Dr. Rekate referred plaintiff to defendant Latefi for a surgical consultation.

On March 31, 2015, plaintiff presented to Dr. Latefi for the first time. At her initial appointment with Dr. Latefi, plaintiff complained of severe and progressive neck pain radiating to both shoulders and to the base of her skull. Plaintiff also reported difficulty swallowing and breathing. Dr. Latefi performed physical and neurological examinations, reviewed a CT scan of plaintiff's cervical spine taken October 16, 2014 and reviewed an MRI of the cervical spine taken December 1, 2014. Dr. Latefi recommended surgical intervention to remove the previously placed plate and screws from her cervical spine. He also recommended an ENT consult concerning the breathing and swallowing issues.

On April 7, 2015, plaintiff returned to Dr. Latefi's office with continuing complaints of severe neck pain, cough, difficulty swallowing and bilateral shoulder pain. Dr. Latefi again performed physical and neurological examinations and again recommended that the plate be removed and that plaintiff undergo a one level low-profile anterior cervical discectomy and fusion above the level of her existing fusion. He pointed out that she had adjacent level degeneration and subluxation at the C3-C4 level. On April 22, 2015, defendant was admitted to defendant North Shore by Dr. Latefi on April 22, 2015 for the ACDF procedure and spinal hardware removal and re-fixation of the vertebra using a model "ROI-C" cervical cage

(manufactured by "Zimmer Biomet)". Dr. Latefi was familiar with the LDR ROI-C cervical cage, having used it on other surgical patients. The procedure was completed at 3:11 p.m. without complication. Doctor Kadkade, a non party ENT physician assisted with the ENT portion of the surgery. After the surgery plaintiff was transferred to the PACU in stable condition. She was discharged home in stable condition on April 24, 2015 with post operative medications and dietary restrictions.

On May 1, 2015, plaintiff presented for a one week follow-up appointment with Dr. Kadkade. She complained of postnasal drip and moderate difficulty swallowing solids, but was able to tolerate swallowing liquids. Dr. Kadkade's post-operative assessment was edema and chronic allergic rhinitis. On May 5, 2015, plaintiff returned to Dr. Latefi's office and reported that her pain and cough had improved and she was able to ambulate, tolerate soft foods and no longer had shortness of breath. She reported mild pain in the back of her neck.

Dr. Latefi ordered an x-ray of the cervical spine and advised plaintiff follow up with him again after the x-ray was taken. He also instructed plaintiff to begin physical therapy. On May 26, 2015, plaintiff underwent x-rays of the cervical spine, which showed the ROI-cage at C3-4, without evidence of hardware failure or fracture. Plaintiff returned to Dr. Latefi's office on June 2, 2015, with complaints of headaches and right leg pain from the right buttocks down to the lateral aspect of the right leg. She denied any swallowing or breathing difficulty and did not complain about neck pain and associated symptoms. After conducting a physical and neurological examination Dr. Latefi determined that plaintiff's headaches were related to the cervical spine operation and that she had signs of sciatica on the right leg. Dr. Latefi recommended conservative treatment for the headaches and leg pain. On June 16, 2015, plaintiff returned to Dr. Latefi's office and reported intermittent left shoulder and forearm pain. She still complained of frontal headaches around the area of the sinuses. Following a physical and neurological examination, Dr. Lafeti advised plaintiff to return in September 2015 with updated x-rays.

On October 6, 2015, plaintiff returned to Dr. Latefi's office with the new x-rays. The x-rays revealed that the hardware was in place and there was bone fusion across the C3-C4. The physical examination showed a motor strength of 4/5 on plaintiff's left handgrip. The x-rays indicated radiculopathy at C7-T1. Dr. Latefi recommended a cervical MRI, and prescribed a course of steroids. On October 16, 2015, plaintiff

underwent the cervical MRI which showed integration of the ROI-3 device with no evidence of neurological impairment and solid struts of bone bridging the C4-C5.

Plaintiff returned to Dr. Latefi's office on October 20, 2015 and October 27, 2015. Dr. Latefi performed a physical and neurological examination at each visit and he scheduled a further x-ray and CT scan. Plaintiff was placed in a neck collar. An x-ray and a CT scan of the cervical spine were performed October 30, 2015.

On November 3, 2015, plaintiff returned to Dr. Latefi's office complaining of tingling or numbness in the her right arm and right lower extremity as well as neck, shoulder and leg pain. Dr. Latefi reviewed the recent radiology studies, and noted the CT study of the cervical spine revealed a solid fusion from segment C4-C7 and the start of a bony fusion across C3-C4 with hardware in excellent alignment and no evidence of movement or instability. Dr. Latefi found no radiological explanation for the neurological symptoms complained of and referred plaintiff to a neurologist (Stephen Newman, M.D.) for treatment.

On November 13, 2015, plaintiff consulted with non-party orthopedic surgeon, Marc Agulnick. The doctor reviewed plaintiff's radiology studies and found the cervical hardware appeared stable with no evidence of loosening. Dr. Agulnick noted that since plaintiff was only seven months out from her last surgery, it was too soon to tell whether she was completely fused at the C3-C4 level. Dr. Agulnick recommended continued physical therapy and treatment for pain management.

On November 28, 2015, plaintiff presented to the ER at Winthrop University Hospital with complaints of neck and back pain. A CT of the cervical spine did not reveal any evidence of stenosis or bulging discs. An MRI of the cervical spine was taken. The plaintiff was examined by orthopedic resident Dr. Timothy Fei. Plaintiff complained of left sided numbness and voice malopathy. She denied having bowel or urinary incontinence. Dr. Fei reviewed plaintiff's radiology studies and noted, "a "bony bridging at the C3-41evel. C3-4 did not yet appear "completely fused." Dr. Fei noted that plaintiff's symptoms were inconsistent with spinal pathology and she was discharged that same day.

Plaintiff returned to Dr. Agulnick's office on December 2, 2015, complaining of "new neck pain" headaches, and tenderness in her arms. According to Dr. Agulnick there was nothing in any of the radiological studies done suggestive of these symptoms and she was neurologically stable. Dr. Agulnick

recommended repeat x-rays in three months and a follow up CT scan.

Plaintiff returned to Dr. Latefi's office on January 19, 2016, stating that her neck pain had resolved, but she had severe leg, back and groin pain. She reported a recent visit at Winthrop University Hospital which she said was for bladder dysfunction and urinary incontinence. Dr. Latefi advised her to see a urologist, but she failed to do so. Plaintiff returned to Dr. Latefi's office again on January 26, 2016 with similar lumbar complaints.

Plaintiff's last visit with Dr, Latefi's took place on February 24, 2016. At that time she complained of neck pain, joint pain and jaw pain. Dr. Latefi noted the CT scan showed bone fusion at the C3-C4 level and the x-rays did not reveal instability. The doctor performed physical and neurological examinations and concluded that plaintiff's symptoms were not due to the cervical spine surgery.

Plaintiff presented to the Hospital for Special Surgery ("HSS") on February 17, 2016 with complaints of chronic right foot pain since her lumbar surgery in October of 2013. She also reported bilateral foot numbness and paresthesia. Her symptoms were described as a sciatica pain localized to the right groin with pain worse with walking. Dr. Schwab performed a physical examination finding range of motion without elicitation of any pain.

On March 3, 2016, plaintiff returned to Dr. Schwab's office with complaints of neck and arm pain, Following an examination, conservative versus surgical treatment options were discussed. An x-ray of the cervical spine indicated alignment was satisfactory with no abnormal motion on flexion and extension. Plaintiff opted to undergo another fusion surgery. On April 5, 2016, Dr. Schwab performed a posterior fusion at HSS. The ROI-C device utilized by Dr. Latefi was left in place. A CT of the cervical spine from HSS Radiology from October 21, 2016 showed a united interbody fusion at the C3-C4 level. Plaintiff visited Dr. Schwab on April 14, 2017. She reported increased pain following breast cancer surgery, but had been unable to undergo physical therapy for her neck because of her cancer diagnosis. A follow up MRI of the cervical spine showed fusion at the C3-C7 level without cord compression. The CT scan of the cervical spine also showed the fusion.

In 2018, plaintiff treated with non-party neurologist Laurence Haber complaining of neck, arm and shoulder pain and associated dizziness, numbness and headaches. She claimed that the pain was worsened

by movement which was relieved with the use of narcotics. She also reported difficulty ambulating. Dr. Haber ordered MRI studies, which did not show any stenosis. Dr. Haber discussed with plaintiff his concern about extended narcotic use without a identifiable physiologic cause. Dr. Schwab spoke with Dr. Haber and both agreed that plaintiff's symptoms had no cervical spine etiology. On April 5, 2018, plaintiff returned to Dr. Schwab's office. She was again advised that there was a lack of definitive pathology on imaging that explained her symptoms.

DEFENDANT'S EVIDENCE

Moving defendants submitted the affirmed expert reports of Craig H. Sherman, a board certified radiologist; Jack Stern, a board certified neurosurgeon; and Kevin Ong, PhD, a mechanical engineer specializing in biomechanics and biomedical engineering. Doctor Sherman's affirmation contains a thorough and detailed analysis of the care and treatment given to the plaintiff and a review of good and accepted standards of medical practice throughout the course of plaintiff's treatment. Dr. Sherman concluded to a reasonable degree of medical certainty that the moving defendants did not depart from accepted medical care and treatment and that none of the actions of the moving defendants were a substantial factor in causing her claimed injuries. The affirmation of Dr. Stern contains a similar detailed analysis and reaches the same conclusions. He also concludes that informed consent was properly obtained. Dr. Ong reviewed the use of the ROI-C cervical cage and concludes that the device was safe and usage of the device in the surgery performed by Dr. Latefi was appropriate. The latter conclusion goes beyond the scope of Dr. Ong's expertise as a non-physician and was not considered. However, viewed collectively the three expert reports make out a *prima facie* case for summary judgment. The burden then shifts to plaintiff to establish triable issues of fact.

PLAINTIFF"S EVIDENCE

Plaintiff submitted the sworn report of Dr. Schwab, a board certified orthopaedic surgeon and one of the physicians that treated plaintiff after the surgery performed defendant Latefi. As with the expert reports submitted by defendant, the report of Dr. Schwab is detailed and thorough. He concludes"to a

reasonable degree of medical certainty" that the moving defendants deviated from accepted standards of medical care and treatment in a number of respects including misreading information in the radiological studies, using the ROI-C device, using the anterior approach to perform the fusion and not using "appropriate plates and screws". Dr. Schwab concludes that these departures caused the plaintiff to suffer pain and require further treatment including the revision surgery that he performed.

DISCUSSION

The essential elements of medical malpractice are (1) a deviation or departure from accepted medical practice, and (2) evidence that such departure was a proximate cause of injury (*Dimitri v. Monsouri*, 302 AD2d 420, 421). "Thus, on a motion for summary judgment dismissing the complaint in a medical malpractice action, the defendant doctor has the initial burden of establishing the absence of any departure from good and accepted medical practice or that the plaintiff was not injured thereby" *Wexelbaum v. Jean*, 80 AD3d 756, 915 N.Y.S.2d 161 (Second Dept., 2011). If the defendant meets this burden, the plaintiffs are required to produce evidentiary proof in admissible form sufficient to rebut the movant's *prima facie* showing in order to demonstrate the existence of a triable issue of fact (*see Wexelbaum, supra*, at 758).

A defendant seeking summary judgment in a medical malpractice action bears the initial burden of establishing, *prima facie*, either that there was no departure from the applicable standard of care, or that any alleged departure did not proximately cause the injuries. In opposition, the plaintiff must demonstrate the existence of a triable issue of fact as to the elements with respect to which the defendant has met its initial burden (*see Gentile v. McFarlane–Johansson*, 108 A.D.3d 499, 969 N.Y.S.2d 118; *Sukhraj v. New York City Health & Hosps. Corp.*, 106 A.D.3d 809, 965 N.Y.S.2d 532; *Rivers v. Birnbaum*, 102 A.D.3d 26, 43, 953 N.Y.S.2d 232; *Swanson v. Raju*, 95 A.D.3d 1105, 945 N.Y.S.2d 101). "Summary judgment is not appropriate in a medical malpractice action where the parties adduce conflicting medical expert opinions. Such credibility issues can only be resolved by a jury" (*Wexelbaum, supra at* 758).

The case at bar falls well within the ambit of the above-cited cases. The parties have presented expert medical opinions from exceptionally well-credentialed doctors. These opinions are completely in

conflict with respect to both deviations from standard of care and causation. Defendants' motion for summary judgment (Motion #1) is denied.

LACK OF INFORMED CONSENT

Plaintiff seeks leave to amend its complaint to include a specific cause of action for lack of informed consent. Defendants assert that allowing the amendment at this late stage of the proceeding (after the completion of discovery) would be prejudicial. This assertion is belied by the fact that defendants' motion addressed the issue of informed consent at length in its moving papers prior to the cross motion being filed. The issue was also addressed in great detail during discovery. The original complaint and bills of particular contained allegations about lack of informed consent, putting defendants on notice that this issue existed, albeit as a departure rather than a separate cause of action. The cross motion to amend the complaint (Motion #2) is granted.

Any request for relief not specifically granted is denied.

This constitutes the decision and order of the court.

ENTER

DATED: October 28, 2020

HON. JACK L. LIBERT
J. S. C.

ENTERED
Nov 02 2020
NASSAU COUNTY
COUNTY CLERK'S OFFICE