SUPREME COURT OF THE STATE OF NEW YORK
NEW YORK COUNTY

PRESENT: **HON. KATHY J. KING** **PART** **06**

Justice

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JAKE KAUFMAN,

Plaintiff,

- v -

NYU LANGONE HEALTH SYSTEM, NYU LANGONE MEDICAL CENTER, NYU LANGONE HOSPITALS, NYU HOSPITALS CENTER, THOMAS J. ERRICO

Defendant.

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INDEX NO. 805269/2019

MOTION DATE 09/06/2022

MOTION SEQ. NO. 001

DECISION + ORDER ON MOTION

The following e-filed documents, listed by NYSCEF document number (Motion 001) 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70

were read on this motion to/for JUDGMENT - SUMMARY.

Upon the foregoing documents, and after oral argument herein, defendants NYU Langone Health System ("Health System"), NYU Langone Hospitals s/h/a "NYU Langone Medical Center, NYU Langone Hospitals, NYU Hospitals Center" ("NYU") and Thomas J. Errico, M.D. ("Dr. Errico) seek an order in this medical malpractice action dismissing all claims against the Health System, NYU and Dr. Errico, on the grounds that no material issues of fact exist and that defendants are entitled to summary judgment as a matter of law pursuant to CPLR § 3212.

Plaintiff opposes the motion.

BACKGROUND

On May 11, 2017, plaintiff, who was 19 years of age, presented to Dr. Errico's office with complaints of severe and debilitating mid-back pain and an inability to stand upright. It was noted that plaintiff had a history of compression fractures at T7, T8, T9 and T10. An x-ray was performed, which revealed that plaintiff had kyphosis[1] with curve progression and severe pain, as well as possible Scheuermann's kyphosis. Dr. Errico's plan was to obtain an MRI of the spine,

[1] The expert affirmations define kyphosis as a curvature of the spine that causes the top of the back to appear more rounded than normal, and is also referred to as hunchback.

and to perform surgery which involved spinal fusion and the insertion of hardware and screws to correct the condition. In the past, conservative treatment modalities had been unsuccessful in managing the condition and alleviating plaintiff's back pain and physical activity limitations. Dr. Errico testified that at the initial visit he explained the procedure to plaintiff in detail, including the risk of infection, and the alternative to surgery, which was to continue conservative care. Plaintiff chose to proceed with the surgery.

Plaintiff presented to NYU for preoperative testing on June 7, 2017. An MRI of the spine confirmed the diagnosis of kyphosis in the mid to lower thoracic spine, and slight left-sided "c"-shaped curvature of the lumbar spine. Plaintiff signed a consent for the procedure on June 8, 2017, and handwrote that he fully understood the terms of the consent form. At his deposition, plaintiff acknowledged that he understood the terms of the consent form when he signed it, including the risks and benefits of the surgery.

The spinal surgery was performed at NYU on June 13, 2017, by Dr. Errico, who was assisted by Charla R. Fischer, M.D. ("Dr. Fischer") and Subaraman Ramchandran, M.D. ("Dr. Ramchandran"). An infusion of intravenous antibiotics was given. Portions of the paraspinal muscles were excised, and bony prominences which were impinging on nerves were removed to facilitate the placement of pedicle screws from T2 to L2. At his deposition, Dr. Errico testified that the paraspinal muscles were incised (cut into) and not excised. However, Dr. Fischer testified at his deposition that during that type of procedure small pieces of the paraspinal muscles are excised. After the screws were inserted, rods were placed through the screws to correct the deformity. A second dose of antibiotics was administered before the surgery was completed. Plaintiff received two packs of red blood cells intra-operatively. Dr. Errico testified that at the completion of surgery the wound was washed out to prevent infection; sterile dressings were applied, and plaintiff would have received antibiotics for approximately 24 hours.

Plaintiff was given antibiotics and pain management medications post-operatively. Laboratory studies revealed that plaintiff had an elevated white blood cell count of 19.2 (normal

is under 10) and anemia from the blood loss. The following day, plaintiff continued to receive antibiotic therapy, and his white blood cell count was trending downward. On June 15, 2017, it was noted that plaintiff was febrile, with a temperature of 102.9 degrees, and he complained of extreme pain along the incision site. Plaintiff was given fluids and Tylenol; cold packs were applied, and laboratory studies were done. Early on the morning of June 16, 2017, plaintiff's temperature was 98.7 degrees, his white blood cell count was 16.7, and he was still experiencing extreme pain at the surgical site. Pain medications were adjusted. The wound drain was removed later that day, with moderate serosanguineous drainage noted.

On June 17, 2017, plaintiff was afebrile, however part of the incision skin edges was observed to be slightly separated and draining. The next day, it was documented that upon examination there were no signs and symptoms of infection, although the wound was still draining. A wound vacuum assisted closure dressing ("VAC") was applied over the inferior half of the wound and five to six sutures were applied to seal the wound. Dr. Errico testified that if the edges of the wound are not completely sealed, material can enter the wound that should not be there and cause infection. When plaintiff was discharged on June 19, 2017, he was afebrile with normal vital signs. He was instructed to notify Dr. Errico if he observed signs and symptoms of infection, separation of skin, increased pain or redness at the incision site, or a temperature of 101.5 degrees, and to follow up with Dr. Errico in one week.

On June 20, 2017, plaintiff presented to NYU's Samuels Orthopedic Immediate Care Center ("ICARE") with complaints of increased incisional drainage that completely filled the VAC the night before. There were no signs and symptoms of infection. One suture was placed on the inferior aspect of the wound, which was covered by dry dressings, and plaintiff was discharged home. Plaintiff presented to Dr. Errico on June 29, 2017, and one-half inch of dehiscence (wound separation) of the proximal incision was noted. Dr. Errico testified that he did not observe any signs of infection at the surgical site, and that a small dehiscence should be left to heal on its own. On July 7, 2017, plaintiff presented to Internist Katie E. Kunamneni, M.D. at Jersey Shore

Medical Associates, and purulent drainage from the wound was observed. Plaintiff complained of dizziness and having a fever for the past two days. Plaintiff was referred to the Emergency Room for immediate evaluation.

Later that day, plaintiff was admitted to Dr. Errico's service at NYU with an admitting diagnosis of "deep wound infection" and possible sepsis. A spinal CT scan revealed intact hardware, and an abscess from C7 to T5. Plaintiff was started on antibiotics and blood cultures were positive for Staphylococcus infection. Antibiotic therapy was adjusted, and the wound was debrided and irrigated by Plastic Surgeon Michael S. Margiotta, M.D. ("Dr. Margiotta") the following day. A PICC line was placed on July 13, 2017, for a six-week course of antibiotics, and plaintiff was discharged home on July 14, 2017. Plaintiff saw Dr. Errico until July 19, 2018, at which time x-rays performed did not reveal any movement of the screws. Dr. Errico left NYU in August of 2018, and did not see plaintiff thereafter.

Dr. Fischer continued plaintiff's care, and on September 6, 2018, plaintiff presented to Dr. Fischer's office complaining of severe pain. On September 14, 2018, Dr. Fischer reviewed with plaintiff the CT scan findings, which showed that the left T2 screw was lateral with a halo around it, and non-union of the posterior lamina at T7-T8. Dr. Fischer also observed that some of the left screws were in close proximity to the aorta. The CT scan findings were discussed with plaintiff, and he was provided with the options of either conservative treatment or surgical intervention for exploration of the non-union and repositioning of the screws. Plaintiff chose to proceed with the surgery. The procedure was scheduled for October 15, 2018, however plaintiff chose to cancel the surgery while he was in the pre-operative holding area because he was anxious about the procedure. Plaintiff did not return to NYU or to Dr. Fischer for follow-up care or the surgery.

On January 4, 2019, plaintiff presented to New York Presbyterian Hospital for an exploration of the fusion and removal of a left T2 vertebral screw, which was performed by Orthopedic Surgeon Christopher Reid, M.D. ("Dr. Reid"). Dr. Reid noted pseudoarthrosis at T7-T8, and performed a revision of the spinal fusion. When plaintiff returned to Dr. Reid's office for

a post-operative visit, on February 19, 2019, his condition was stable, however he complained that the pain had shifted from the operative site to the muscles on the left side between the shoulder blade and spine.

Thereafter, plaintiff commenced the underlying medical malpractice action which sets forth a single cause of action for medical malpractice. Plaintiff alleges that Dr. Errico and the staff at NYU negligently performed a posterior instrumented spinal fusion from level T2-to-L2 on June 13, 2017, and allegedly failed to prevent, diagnose, and treat a post operative infection at the surgical site and became septic one month after discharge, requiring additional surgical procedures, including debridement, placement of a peripherally inserted central catheter ("PICC") line for IV antibiotics, and removal of loose left-sided vertebral screw at T-2.

Plaintiff further alleges that the staff improperly managed plaintiff's post-operative care from June 13, 2017, through July 14, 2017, which included prematurely discharging plaintiff from the hospital. Plaintiff's medical malpractice cause of action includes a claim for lack of informed consent by defendants concerning the risks associated with the spinal fusion surgery, and negligent hiring and credentialing.

DISCUSSION

"To sustain a cause of action for medical malpractice, a plaintiff must prove two essential elements: (1) a deviation or departure from accepted practice, and (2) evidence that such departure was a proximate cause of plaintiff's injury" (*Frye v Montefiore Med. Ctr.*, 70 AD3d 15, 24 [1st Dept 2009]; *see Roques v Noble*, 73 AD3d 204 [1st Dept 2010]; *Elias v Bash*, 54 AD3d 354 [2d Dept 2008]; *DeFilippo v New York Downtown Hosp.*, 10 AD3d 521 [1st Dept 2004]). A defendant physician moving for summary judgment must make a prima facie showing of entitlement to judgment as a matter of law by establishing the absence of a triable issue of fact as to his or her alleged departure from accepted standards of medical practice (*Alvarez v Prospect Hosp.*, 68 NY2d 320, 324 [1986]; *Frye v Montefiore Med. Ctr.*, 70 AD3d at 24), or by establishing that the plaintiff was not injured by such treatment (*see McGuigan v Centereach Mgt. Group, Inc.*, 94 AD3d 955

[2d Dept 2012]; *Sharp v Weber*, 77 AD3d 812 [2d Dept 2010]; *see generally Stukas v Streiter*, 83 AD3d 18 [2d Dept 2011]). To satisfy this burden, a defendant must present expert opinion testimony that is supported by the facts in the record, addresses the essential allegations in the complaint or the bill of particulars, and is detailed, specific, and factual in nature (*see Roques v Noble*, 73 AD3d at 206; *Joyner-Pack v. Sykes*, 54 AD3d 727 [2d Dept 2008] ; *Koi Hou Chan v Yeung*, 66 AD3d 642 [2d Dept 2009]; *Jones v Ricciardelli*, 40 AD3d 935 [2d Dept 2007]). Furthermore, to satisfy his or her burden on a motion for summary judgment, a defendant must address and rebut specific allegations of malpractice set forth in the plaintiff's bill of particulars (*see Wall v Flushing Hosp. Med. Ctr.*, 78 AD3d 1043 [2d Dept 2010]; *Grant v Hudson Val. Hosp. Ctr*., 55 AD3d 874 [2d Dept 2008]; *Terranova v Finklea*, 45 AD3d 572 [2d Dept 2007]).

Once defendant establishes *prima facie* entitlement to judgment as a matter of law, the burden shifts to the plaintiff to demonstrate the existence of a triable issue of fact by submitting an expert's affidavit or affirmation attesting to a departure from accepted medical practice and opining that the defendant's acts or omissions were a competent producing cause of the plaintiff's injuries (*see Roques v Noble*, 73 AD3d at 207; *Landry v Jakubowitz*, 68 AD3d 728 [2d Dept 2009]; *Luu v Paskowski*, 57 AD3d 856 [2d Dept 2008]).

In support of their motion, defendants submit the pleadings, plaintiff's medical records, deposition transcripts of plaintiff and Drs. Errico and Fischer, and the expert affirmations of Wesley Carrion, M.D. ("Dr. Carrion"), a board-certified Orthopedic Surgeon, and Bruce Farber, M.D. ("Dr. Farber"), a board-certified Infectious Disease Specialist, who proffer their opinions to a reasonable degree of medical certainty. Dr. Carrion opines that it was appropriate for Dr. Errico to recommend spinal fusion surgery to plaintiff, since there were no contraindications, and past conservative treatment had been unsuccessful in alleviating plaintiff's unrelenting back pain and physical activity limitations. Dr. Carrion also opines that the spinal fusion surgery was properly performed, the types and amounts of prophylactic antibiotics administered to plaintiff were appropriate, and wound closure was properly performed at the end of the surgery. He further

opines that the excision of muscle during the spinal fusion procedure was necessary, did not have an impact on wound healing, and any risks associated with excision of muscle are inherent in this type of surgery.

Dr. Carrion further opines that plaintiff's post-operative care and treatment was properly managed. In particular, Dr. Carrion opines that plaintiff's claim that defendants failed to diagnose infection is without merit, since plaintiff's post-operative symptoms of an elevated white blood cell count and fever, which are known to accompany infection, were transient and could have been attributed to several other factors. Further, Dr. Carrion opines that plaintiff's post-operative pain was unrelated to wound infection, and was normal in light of the significant spinal surgery that was performed. It is Dr. Carrion's opinion that defendants properly managed post-operative wound healing, as demonstrated by the lack of swelling, redness or pus at the incision site; the placement of drains following surgery, and the placement of nylon sutures to close the wound by Dr. Errico five days after the procedure to ensure that the wound remained closed and sterile, and to prevent infection. Further, Dr. Carrion opines that the placement of a VAC after the sutures were inserted was appropriate to increase the rate of wound healing, and may even be used in the presence of a diagnosed infection.

Dr. Carrion also opines that defendant provided plaintiff with appropriate discharge instructions, and that there was no need to give plaintiff an antibiotic regimen since there were no clinical signs and symptoms of infection. Further, when plaintiff presented to NYU's ICARE the day after discharge, plaintiff's complaints related to excess drainage, and there were no signs of infection. The placement of an additional suture to prevent infection was appropriate. Dr. Carrion opines that plaintiff's condition remained stable following discharge, up until July 7, 2017, when he presented to Jersey Shore Medical Associates with complaints of a fever for the past two days, and purulent wound drainage. The plaintiff was appropriately referred to the Emergency Room, and Dr. Carrion opines that defendants exercised good medical care in treating the clinical symptoms of an ongoing infection by collecting wound cultures, consulting with Infectious

Disease and Wound Care Specialists, administering high dose antibiotics, performing a spinal CT scan, and performing a wound debridement. The insertion of a PICC line for six weeks was within the standard of care in order to eradicate and prevent further spread of the infection. Dr. Carrion opines that plaintiff would have required these interventions, including long-term antibiotic use, regardless of when the infection was diagnosed, and that the infection was a known risk of the surgery and not caused by any acts or omissions by defendants. Finally, Dr. Carrion opines that none of the acts or omissions of defendants led to the failed fusion surgery and the need for revision surgery on January 4, 2019, since hardware failure and non-union of bone is an accepted complication of all spinal fusion surgeries, and was caused by the severity of plaintiff's kyphosis and mechanical stress on the wound.

Dr. Farber, defendants' Infectious Disease expert, opines that defendants exercised good medical judgment in the pre-operative, peri-operative and post-operative periods, and that the infection sustained by plaintiff was not a result of negligence, and is a well-known risk of any surgery. Dr. Farber opines with a reasonable degree of medical certainty, that the prophylactic antibiotics administered to plaintiff during the surgery were appropriate, and that the infection was in the "incubation" period, i.e., not yet diagnosable, from the time of surgery through plaintiff's post-operative visit with Dr. Errico on June 29, 2017. Further, Dr. Farber opines that plaintiff's post-operative febrile episodes are very common after surgery and not indicative of infection as long as it resolves, which occurred here. The plaintiff's elevated white blood cell count could have been caused by the administration of a steroid during surgery, which Dr. Farber opines is likely the cause in these circumstances since the count trended downward, and was normal at the time of plaintiff's discharge. Dr. Farber concurs with Dr. Carrion's opinion that the placement of sutures and insertion of the VAC was appropriate, as there were no signs of infection, and the VAC does not worsen infection. Dr. Farber opines that there was no need to provide plaintiff with antibiotic therapy at the time of discharge since there was no clinical signs of infection, and that plaintiff did not present with signs of infection until July 7, 2017, at which time defendants acted appropriately

in treating it and preventing the infection from spreading. Dr. Farber notes that it is significant that the CT scan showed an abscess, but intact spinal hardware at that time. Dr. Farber also concurs with Dr. Carrion's opinion that plaintiff would have required long-term antibiotic therapy, debridement, placement of a PICC line regardless of when the infection was diagnosed.

Drs. Carrion and Farber opine, with a reasonable degree of medical certainty, that Dr. Errico obtained proper informed consent from plaintiff prior to surgery, based on Dr. Errico's deposition testimony that he explained the risks and alternatives of the spinal surgery. Defendants also assert that the risks and alternatives of the surgery were delineated in the consent form provided to plaintiff, which he acknowledged reviewing prior to signing and initialing them.

Likewise, defendants' medical experts opine, with a reasonable degree of medical certainty, that defendants provided good medical care to plaintiff, and that there is no evidence that Dr. Errico or the staff at NYU were not adequately credentialed, trained and/or supervised or lacked the requisite education, training and experience to provide medical care and treatment to plaintiff.

Based on the foregoing, defendants have established their *prima facie* entitlement to summary judgment as a matter of law, based on the expert affirmations of Drs. Carrion and Farber, and the deposition testimony of plaintiff, and Drs. Errico and Fischer. Dr. Carrion's affirmation demonstrates that Dr. Errico and the staff at NYU, did not depart from good and accepted medical care in treating plaintiff during the pre-operative, perioperative or post- operative period. Dr. Errico appropriately recommended spinal fusion surgery based on the severity of plaintiff's condition, plaintiff's complaints of severe and constant back pain for the previous six months, and limitations of daily physical activity, which had not been alleviated by conservative treatment. Dr. Carrion further established that according to the medical records and deposition testimony, the spinal fusion surgery was properly performed, and the excision of muscle during the procedure had no impact on wound healing. There was no indication of infection at the end of the procedure, and the type and amount of prophylactic antibiotics given to plaintiff intraoperatively was appropriate.

The affirmations of Drs. Carrion and Farber further established that Dr. Errico and the NYU staff exercised good judgment during the post-operative period, in placing drains and sutures to close the wound at the incision site to prevent infection, and that prophylactic antibiotic administration was not necessary because there were no signs of infection.

Plaintiff's condition remained stable after discharge up until two days prior to readmission on July 7, 2017, when he presented with a diagnosis of abscess and sepsis. Drs. Carrion and Farber have demonstrated that Dr. Errico and the NYU staff acted in accord with acceptable standards of medical care in treating plaintiff during the July 7, 2017, admission. Notably, based on the opinion of both medical experts, infection is a well-known risk of the spinal surgery, and further surgical procedures, such as debridement and spinal fusion revision, as well as long-term antibiotic therapy, would have been required regardless of when the infection was diagnosed.

In opposition to defendants' motion, plaintiff submits the affirmation of Gary Tebor, M.D. ("Dr. Tebor"), a board-certified Orthopedic Surgeon, who specializes in Pediatric Orthopedics and Reconstructive Surgery and in the treatment of neuromuscular conditions, such as scoliosis and kyphosis. Based on review of the record, Dr. Tebor opines, to a reasonable degree of medical certainty, that defendants deviated from accepted standards of care in spinal fusion surgery, by excising plaintiff's paraspinal muscles which resulted in excessive bleeding, and creation of more fluid in the wound, thus increasing the likelihood of wound infection. Dr. Tebor opines that it is apparent that a significant amount of paraspinal muscles were excised, based on the extent of muscle dissection and grafting done by Plastic Surgeon Dr. Margiotta during plaintiff's post operative July 7, 2017, admission for abscess and sepsis. Consistent with his opinion, Dr. Tebor cites a discrepancy between Dr. Errico's testimony which stated that paraspinal muscles were not excised during surgery, and Dr. Errico's operative note, stating that the muscles were excised.

Dr. Tebor further opines, that defendants failed to properly address and treat plaintiff's wound and incision by sealing the wound with five or six sutures to prevent further drainage and reapplying the VAC dressing. By sealing the wound shut, bacteria were trapped, and the wound

could not properly drain, greatly increasing plaintiff's risk of developing an infection. Dr. Tebor opines that to a reasonable degree of medical certainty, the sealing of the wound and failure to provide antibiotics afterward, was a substantial contributing factor to plaintiff's development of wound infection and sepsis, and increased plaintiff's risk of developing post-operative complications.

Plaintiff, in opposition, has rebutted defendants' *prima facie* showing based on the opinion of his expert, Dr. Tebor, regarding whether Dr. Errico excised plaintiff's paraspinal muscles during the surgery and if so, whether excision of the muscles caused excessive bleeding and wound drainage, thereby increasing the likelihood of infection. Plaintiff has also raised an issue of fact with respect to whether defendants adequately addressed and treated plaintiff's wound and infection increasing the risk of complications post-surgery. Additionally, Dr. Tebor raises an issue of fact as to whether prophylactic antibiotics should have been provided to plaintiff when the wound was sutured closed to counter the exposure to bacteria and lower the risk of infection.

The Court notes that plaintiff did not oppose the branch of defendants' motion seeking dismissal of all claims relating to negligent credentialing, hiring and/or supervision, and defendant the Health System did not render patient care to plaintiff. As such, those claims must be dismissed.

Plaintiff's lack of informed consent claims must also be dismissed. The Court has reviewed the complaint, and bills of particulars, and finds that plaintiff has failed to plead a cause of action alleging lack of informed consent. Lack of informed consent is "a distinct cause of action which requires proof of facts not contemplated by an action based merely on allegations of negligence" (*Jolly v Russell*, 203 AD2d 527, 528 [2d Dept 1994]; *see Pagan v State of New York*, 124 Misc 2d 366 [Ct Cl 1984]). Here, plaintiff's claims of lack of informed consent are contained within the complaint's first cause of action for malpractice, and do not provide the distinction required to be made between allegations of general negligence and allegations of lack of informed consent (*see Jolly v Russell*, 203 AD2d at 528 -529 [holding that "[i]n creating the cause of action [of lack of informed consent], the Legislature not only established the unique factual allegations

which support such a cause of action, but also established equally unique defenses to liability, and placed specific limitations on the types of cases in which the cause of action may be asserted]).

Accordingly, it is hereby

ORDERED, that the branch of defendants' motion seeking dismissal of all claims relating to negligent credentialing, hiring and/or supervision, and dismissal as to the NYU Langone Health System, is granted; and it is further

ORDERED, that the branch of defendants' motion seeking dismissal of plaintiff's claims based on lack of informed consent is granted; and it is further

ORDERED, that in all other respects the motion is denied it its entirety.

This constitutes the decision and order of the Court.

11/1/2023
DATE

KATHY J. KING, J.S.C.

CHECK ONE:		CASE DISPOSED			X	NON-FINAL DISPOSITION	
		GRANTED		DENIED	X	GRANTED IN PART	OTHER
APPLICATION:		SETTLE ORDER				SUBMIT ORDER	
CHECK IF APPROPRIATE:		INCLUDES TRANSFER/REASSIGN				FIDUCIARY APPOINTMENT	REFERENCE