SCAN

SHORT FORM ORDER

SUPREME COURT - STATE OF NEW YORK

Present:

HON. ROY S. MAHON

Justice

JOSEPH F. MAGEL & GIOVANNA M. MAGEL,	**TRIAL/IAS PART 7**
	INDEX NO. 13642/06
Plaintiff(s),	
	MOTION SEQUENCE NO. 10 & 11 & 12
- against -	
JOHN T. MATHER MEMORIAL HOSPITAL, NORTH SHORE UNIVERSITY HOSPITAL, JAMES D. SULLIVAN III, MD, ALAN STUART KADISON and NORTH SHORE SURGICAL ONCOLOGY ASSOCIATES, PC,	**MOTION SUBMISSION DATE: August 20, 2010**
Defendant(s).	

The following papers read on this motion:

Notice of Motion	**XX**
Notice of Cross Motion	**X**
Affirmation	**X**
Reply Affirmation	**XX**

Upon the foregoing papers, the motion by the defendants James D. Sullivan III, M.D., Alan Stuart Kadison and North Shore Surgical Oncology Associates, P.C. ('NSSOA") for an order pursuant to CPLR 3212 granting them summary judgment dismissing the complaint against them is granted to the extent provided herein.

This motion by the defendant North Shore University Hospital ("NSUH") for an order pursuant to CPLR 3212 granting it summary judgment dismissing the complaint against it is granted, without opposition.

This cross motion by the plaintiffs Joseph F. Magel and Giovanna M. Magel for an order pursuant to CPLR 3212(e) granting them partial summary judgment against the defendants James D. Sullivan III, M.D., Alan Stuart Kadison, M.D. and NSSOA as a consequence of their violation of Public Health Law § 2805-d is granted to the extent provided herein.

The plaintiffs in this action seek to recover damages for medical malpractice, lack of informed consent and loss of consortium. They allege, *inter alia*, that the defendants Drs. Sullivan and Kadison

of NSSOA's recommendation and performance of unnecessary surgery at NSUH caused Mr. Magel internal injuries which necessitated two additional surgeries to repair the resulting damage.

The defendants Dr. Sullivan, Dr. Kadison, NSSOA and NSUH all seek summary judgment dismissing the complaint against them. The plaintiffs have cross moved for summary judgment on their claim pursuant to Public Health Law §2505-d, i.e., lack of informed consent, against Drs. Sullivan and Kadison and NSSOA.

The facts pertinent to the determination of these motions are as follows:

The plaintiff Joseph F. Magel ("Mr. Magel") presented at the emergency room of defendant John T. Mather Memorial Hospital on July 4, 2004 complaining of a change in bowel habits over the previous few weeks and two days of constipation. He described his stool as "flat" and complained that he "feels like he has to go when unable to go." After a physical examination within normal units, Mr. Magel underwent a CT scan with contrast of his pelvis. The handwritten preliminary radiological impression report indicates a "3.8 round intraluminal filling defect in a loop of jejunum. . . [which] may represent a leiomyoma. Cannot exclude lymphoma." Similarly, the typewritten preliminary and final CT scan reports indicate that "there is a round intraluminal filling defect in loop of jejunum. . . This may represent a leiomyoma of the small bowel. The possibility of lymphoma is not excluded." A CT scan of Mr. Magel's abdomen was normal and an x-ray of Mr. Magel's abdomen was negative.

A family friend, non-party Dr. Leonard Farber, referred Mr. Magel to Dr. Sullivan of NSSOA. Dr. Sullivan first saw Mr. Magel on July 12, 2004. Mr. Magel related the circumstances which led him to John T. Mather Memorial Hospital as well as a family history of colon cancer (father) and breast cancer (maternal grandmother) and that he had had a benign tumor removed from his scalp. Dr. Sullivan performed a physical exam and reviewed Mr. Magel's CT scan, observing films as well as the preliminary radiological report in which the radiologist referred to "abdominal 3.8 cm round intraluminal filling defect in the jejunum. . . may represent a small bowel leiomyoma cannot exclude lymphoma." It is unclear whether Dr. Sullivan reviewed the radiologist's two subsequent reports, which provide, *inter alia*, "there is no mass lesion or lymph adenopathy. . . Evaluation of the bowel demonstrates a small bowel leiomyoma, although other differential considerations would include lymphoma. Impression: There is a round intraluminal filling defect in a loop of jejunum. . . [which] may represent a leiomyoma of the small bowel. The possibility of lymphoma is not excluded." Dr. Sullivan's note of July 12, 2004 reads "CT scan 3.8 cm mass loop jejunum (emphasis added)." He recommended an exploratory laparotomy and push enteroscopy. Dr. Sullivan did not recommend any further tests. In fact, at his examination-before-trial, Dr. Sullivan testified that the "patient had a reported tumor in the small bowel which needed to be explored." He also testified that there was no treatment for the tumor other than surgical resection and so with the exception of no surgery, there were no alternatives.

Mr. Magel presented at NSUH on August 3rd for surgery. The surgery was postponed at the anesthesiologist's request because of Mr. Magel's history of sleep apnea. Mr. Magel testified that he met with defendant Dr. Kadison that day and inquired as to whether further testing was warranted whereupon he was shown the CT film and told that the mass "has to be removed" and that there was "some sort of growth." At his examination-before-trial, Dr. Kadison testified that he had no recollection of seeing Mr. Magel that day.

The plaintiff testified that he reported for surgery a second time on August 19, 2004 even though his symptoms had disappeared completely since August 3rd. He had obtained surgical clearance from his gastroenterologist and cardiologist. Dr. Sullivan testified that after asking Mr. Magel if he had done the bowel prep and whether he had any questions or anything else he wanted to discuss, he performed

the surgical procedure assisted by an employee of NSSOA, Dr. Moshe Faynshod, and Dr. Larry Lind, presumably a resident at NSUH. Mr. Magel's post-operative report reads:

> Upon inspection of the abdomen, no intraabdominal pathology was noted, except for one small implant on the small bowel and the proximal jejunum. This was resected and sent to pathology. The frozen section came back as benign. Further exploration of the abdomen failed to reveal the lesion in question. This was reported to be a 3.8 cm intraluminal mass in the proximal jejunum.
>
> The excision was extended superiorly and inferiorly and further exploration of the abdomen including examination of all intraabdominal viscera, retroperitoneum, left kidney and colon failed to reveal any pathology. The patient had a reoperative colonoscopy and this failed to reveal any pathology.
>
> At this point, a pediatric colonscope was used to perform a push enteroscopy at the head of the table, introducing the scope into the esophagus, following the NG tube down into the stomach and examining the small bowel for approximately at least five feet of the proximal jejunum. Excellent viewing of the intraluminal contents were obtained and no abnormalities were noted whatsoever, on antegrade or retrograde examination.

Dr. Kadison saw Mr. Magel post-operatively on August 22, 2004 when plaintiff was afebrile and his abdomen was "soft, non-tender and less distended incision." Post-operative checks on August 23rd, 24th and 25th were normal and Mr. Magel was discharged on August 25th with instructions to follow with Dr. Sullivan in one week. On September 1, 204, Dr. Sullivan removed Mr. Magel's staples and cautioned him to avoid heavy lifting. He authored a letter recommending that Mr. Magel not return to work as expected on October 4th and expressed his expectation that he would be able to return on November 1st. Mr. Magel was seen by Dr. Ricci at NSSOA on September 2, 2004 without incident.

On July 29, 2005, Mr. Magel had to undergo surgical repair of an incisional hernia at St. Francis Hospital. He also underwent surgical removal of scar tissue and a second repair of an incisional hernia at SUNY Hospital at Stony Brook on October 19, 2006.

In this action, the plaintiffs allege that "[t]he defendants failed to obtain Mr. Magel's informed consent for the exploratory laparotomy; failed to review and properly analyze Mr. Magel's CT scan and other diagnostic studies; failed to take a proper medical and surgical history of Mr. Magel during the pre-surgical consult on July 12, 2004 and failed to appreciate the significance of his prior medical/surgical history; failed to order further and additional diagnostic studies, including CT scans, MRI's, [and] upper endoscopy, prior to the exploratory laparotomy; failed to utilize the requisite level of skill in performing the exploratory laparotomy on August 19, 2004, resulting in an incisional hernia; failed to notify the plaintiff of intra-operative complications; and, negligently, carelessly and unskillfully performed an unnecessary exploratory laparotomy, notwithstanding resolution of the plaintiff's earlier symptoms."

"On a motion for summary judgment pursuant to CPLR 3212, the proponent must make a *prima facie* showing of entitlement to judgment as a matter of law, tendering sufficient evidence to demonstrate the absence of any material issues of fact." Sheppard-Mobley v King, 10 AD3d 70, 74 (2d Dept. 2004), aff'd. as mod., 4 NY3d 627 (2005), citing Alvarez v Prospect Hosp., 68 NY2d 320, 324 (1986); Winegrad

v New York Univ. Med. Ctr., 64 NY2d 851, 853 (1985). "Failure to make such *prima facie* showing requires a denial of the motion, regardless of the sufficiency of the opposing papers." Sheppard-Mobley v King, supra, at p. 74; Alvarez v Prospect Hosp., supra; Winegrad v New York Univ. Med. Ctr., supra. Once the movant's burden is met, the burden shifts to the opposing party to establish the existence of a material issue of fact. Alvarez v Prospect Hosp., supra, at p. 324. The evidence presented by the opponents of summary judgment must be accepted as true and they must be given the benefit of every reasonable inference. See, Demishick v Community Housing Management Corp., 34 AD3d 518, 521 (2d Dept. 2006), citing Secof v Greens Condominium, 158 AD2d 591 (2d Dept. 1990).

"To establish a *prima facie* case of liability for medical malpractice, a plaintiff must prove that the defendant deviated from accepted practice, and that such deviation proximately caused his or her injuries." Dehaarte v Ramenovsky, 67 AD3d 724, 725 (2nd Dept. 2009), citing Novik v Godec, 58 AD3d 703 (2nd Dept. 2009); Monroy v Glavas, 57 AD3d 631 (2nd Dept. 2008); Rabinowitz v Elimian, 55 AD3d 813 (2nd Dept. 2008); see also, Castro v New York City Health and Hospitals Corp., 74 AD3d 1005 (2nd Dept. 2010); Ellis v Eng, 70 AD3d 887 (2nd Dept. 2010). "On a motion for summary judgment dismissing the complaint in a medical malpractice action, a defendant physician has the burden of establishing the absence of any departure from good and accepted medical practice, or, if there was a departure, that the plaintiff was not injured thereby." Shectman v Wilson, 68 AD3d 848, 849 (2nd Dept. 2009), citing Murray v Hirsch, 58 AD3d 701 (2nd Dept. 2009), lv den., 12 NY3d 709 (2009); Shahid v New York City Health & Hospitals Corp., 47 AD3d 800 (2nd Dept. 2008); Alvarez v Prospect Hosp., 68 NY2d 320 (1986); see also, Castro v New York City Health and Hospitals Corporation, supra; Ellis v Eng, supra.

Pursuant to New York Public Health Law § 2805-d, a cause of action for lack of informed consent is limited to cases involving non-emergency treatment, procedure or surgery or a diagnostic procedure involving an invasion or disruption of the patient's body. Thus, the "plaintiff must allege that the wrong complained of arose out of some affirmative violation of [his or her] physical integrity." Iazzetta v Vicenzi, 200 AD2d 209 (3rd Dept. 1994), lv den., 85 NY2d 857 (1995); see also, Flanagan v Catskill Regional Medical Center, 65 AD3d 563, 566-567 (2nd Dept. 2009); Smith v Fields, 268 AD2d 579 (2nd Dept. 2000); Campea v Mitra, 267 AD2d 190, 191 (2nd Dept. 1999); Schel v Roth, 242 AD2d 697 (2nd Dept. 1997). Public Health Law § 2805-d(3) provides that "[f]or a cause of action it must . . . be established that a reasonably prudent person in the patient's position *would not* have undergone the treatment or diagnosis if he had been fully informed (emphasis added)." Ellis v Eng, supra at p. 892; Jaycox v Reid, 5 AD3d 994, 995 (4th Dept. 2004), rearg den. 8 AD3d 1132 (4th Dept. 2004).

"[M]edical expert affidavits or affirmations, submitted by a defendant, which fail to address the essential factual allegations in the plaintiff's complaint or bill of particulars fail to establish prima facie entitlement to summary judgment as a matter of law." Rogue v Noble, M.D., 73 AD3d 204 (1st Dept. 2010), citing Cregan v Sachs, 65 AD3d 101, 108 (1st Dept. 2009); Wasserman v Carella, 307 AD2d 225 (1st Dept. 2003); see also, James v Wormuth, M.D., 74 AD3d 1895 (4th Dept. 2010). "[B]are allegations which do not refute the specific factual allegations of medical malpractice in the bill of particulars are insufficient to establish entitlement to judgment as a matter of law." Grant v Hudson Valley Hosp. Center, 55 AD3d 874 (2nd Dept. 2009), citing Berkey v Emma, 291 AD2d 517, 518 (2nd Dept. 2002); Drago v Chung Ho King, 283 AD2d 603, 603-604 (2nd Dept. 2001); Terranova v Finklea, 45 AD3d 572 (2nd Dept. 2007); Kuri v Bhattacharya, 44 AD3d 718 (2nd Dept. 2007).

If the moving defendant meets his burden, "[i]n opposition, a plaintiff must submit the affidavit of a physician attesting to a departure from good and accepted practice, and stating the physician's opinion that the alleged departure was a competent producing cause of the plaintiff's injuries." Shectman v Wilson, supra, citing Sweezey v Montague Rehab & Pain Management, P.C., 59 AD3d 431 (2nd Dept. 2009); Murray v Hirsch, supra; Shahid v New York City Health & Hospitals Corp., supra; see also, Ellis

v Eng, supra. "[G]eneral allegations of medical malpractice which are conclusory in nature and unsupported by competent evidence tending to establish the elements of medical malpractice" do not suffice. Shectman v Wilson, supra, citing Alvarez v Prospect Hosp., supra; Shahid v New York City Health & Hospitals Corp., supra; see also, Diaz v New York Downtown Hosp., 99 NY2d 542 (2002); Romano v Stanley, 90 NY2d 444 (1997); Amatulli by Amatulli v Delhi Const. Corp., 77 NY2d 525 (1991). The plaintiff's expert must set forth the medically accepted standards of care or protocol and explain how it was departed from. Geffner v North Shore University Hosp., 57 AD3d 839, 842 (2nd Dept. 2008), citing Mustello v Berg, 44 AD3d 1018, 1019 (2nd Dept. 2007), lv den., 10 NY3d 711 (2008); Behar v Coren, 21 AD3d 1045, 1047 (2nd Dept. 2005), lv den., 6 NY3d 705 (2006); LaMarque v North Shore University Hosp., 227 AD2d 594, 594-595 (2nd Dept. 1996). And, the plaintiff's expert must address all of the key facts relied on by the defendant's expert. See, Kaplan v Hamilton Medical Associates, P.C., 262 AD2d 609 (2nd Dept. 1999); see also, Geffner v North Shore University Hosp., supra; Rebozo v Wilen, 41 AD3d 457 (2nd Dept. 2007).

An expert's affidavit which lacks evidentiary support in the record or is contradicted thereby is not sufficient to raise a triable issue of fact. Micciola v Sacchi, 36 AD3d 869, 871 (2nd Dept. 2007), citing Schroder v Sunnyside Corp., 297 AD2d 369, 371 (2nd Dept. 2002), lv dism., 100 NY2d 553 (2003), citing Fhima v Maimonides Medical Center, 269 AD2d 559 (2nd Dept. 2000). "[H]indsight reasoning . . . is insufficient to defeat summary judgment." Miccola v Sacchi, supra at p. 871, citing Zawadzki v Knight, 76 NY2d 898 (1990).

"To establish proximate cause, the plaintiff must present 'sufficient evidence from which a reasonable person might conclude that it was more probable than not that' the defendant's deviation was a substantial factor in causing the injury." Alicea v Liguori, 54 AD3d 784, 785 (2nd Dept. 2008), quoting Johnson v Jamaica Hosp. Med. Ctr., 21 AD3d 881, 883 (2nd Dept. 2005), citing Sprain Brook Manor Nursing Home, 253 AD2d 852 (2nd Dept. 1998), lv den., 92 NY2d 818 (1999). The plaintiff's expert need not quantify " 'the extent to which the defendant's act or omission decreased the plaintiff's chance of better outcome or increased [the] injury, as long as evidence is presented from which the jury may infer that the defendant's conduct diminished the plaintiff's chance of a better outcome or increased [the] injury.' " Alicea v Liguori, supra, at p. 786, quoting Flaherty v Fromberg, 46 AD3d 743 (2nd Dept. 2007), citing Barbuto v Winthrop University Hosp., 305 AD2d 623, 624 (2nd Dept. 2003); Wong v Tang, 2 AD3d 840, 841 (2nd Dept. 2003).

"A hospital may not be held liable for injuries suffered by a patient who is under the care of a private attending physician chosen by the patient where the resident physicians and nurses employed by the hospital merely carry out the orders of the private attending physician, unless the hospital staff commits 'independent acts of negligence or the attending physician's orders are contradicted by normal practice.' " Cham v St. Mary's Hosp. of Brooklyn, 72 AD3d 1003 (2nd Dept. 2010), quoting Cerny v Williams, 32 AD 3d 881, 883 (2nd Dept. 2006); citing Hill v St. Clare's Hosp., 67 NY2d 72, 79 (1986); Toth v Community Hosp. at Glen Cove, 22 NY2d 255, 265 (1968); Petty v Pilgrim, 22 AD3d 478, 479 (2nd Dept. 2005); Pearce v Klein, 293 AD2d 593 (2nd Dept. 2002).

"Summary judgment is not appropriate in a medical malpractice action where the parties adduce conflicting expert opinions . . . . Such credibility issues can only be resolved by a jury." Feinberg v Feit, 23 AD3d 517, 519 (2nd Dept. 2005), citing Shields v Baktidy, 11 AD3d 671 (2nd Dept. 2004); Barbuto v Winthrop University Hosp., supra; Halkias v Otolaryngology-Facial Plastic Surgery Associates, P.C., 282 AD2d 650 (2nd Dept. 2001); see also, Roca v Perel, 51 AD3d 757, 759 (2nd Dept. 2008); Graham v Mitchell, 37 AD3d 408 (2nd Dept. 2007).

In support of their application, Drs. Sullivan and Kadison and NSSOA have submitted the

affirmation of Dr. Marvin L. Corman who is Board Certified in the fields of General Surgery and Colon and Rectal Surgery. The Court observes that Dr. Corman's submission is conclusory. He opines to a reasonable degree of medical certainty that Dr. Sullivan "properly evaluated the plaintiff during a pre-surgical examination on July 12, 2004, in that he performed a thorough physical examination, reviewed the patient's personal and family medical history, [and] reviewed the July 4, 2004 CT scan report and films taken at John T. Mather Memorial Hospital." He then opines that he "appropriately and reasonably relied upon the recommendation offered by the radiologist, Jane Testa, M.D., in determining an appropriate and reasonable differential diagnosis, including: Gastrointestinal stromal tumor (GIST), and/or carcinoid tumor of the small intestine (emphasis added)." It is also Dr. Corman's opinion within a reasonable degree of medical certainty that "it was appropriate and prudent for Dr. Sullivan to rely upon the recommendations of consulting surgeon, Evan Geller, M.D., the plaintiff's gastroenterologist, Dean Pappas, M.D. and that of the plaintiff's cardiologist, William Blau, M.D., in providing medical and surgical clearance for the plaintiff's exploratory laparotomy (emphasis added)." He represents that "Dr. Sullivan appropriately and thoroughly reviewed the risks, benefits and alternatives to the contemplated surgery with Mr. Magel and that these same risks, benefits, and alternatives, including having no surgery, were similarly reviewed with the patient by surgeon, Evan Geller, M.D., on July 8, 2004." He opines that Dr. Sullivan "conformed with accepted medical practice in his interaction with care of the plaintiff [and] [a]t no time, did he depart from accepted medical standards in providing care to the plaintiff." It is his opinion that "there is no merit to plaintiff's claims of malpractice as to Dr. Kadison, or any other physician or individual affiliated with defendant, North Shore Surgical Oncology Associates, P.C."

Case law obligates the physician who proscribed or performed the procedure to obtain the patient's informed consent. Barbato v Livingston, 18 Misc.3d 1123(A) (Supreme Court Nassau County 2008), citing Spinosa v Weinstein, 168 AD2d 32, 39-40 (2nd Dept. 1991), citing Blank v Rosenthal, 84 AD2d 688 (1st Dept. 1981), app den., 55 NY2d 974 (1982), app den., 55 NY2d 607 (1982); Nisenholtz v Mount Sinai Hosp., 126 Misc.2d 658 (Supreme Court New York County 1984); Prooth v Wallsh, 105 Misc.2d 603; see also Domaradzki v Glen Cove Ob/Gyn Assoc., 242 AD2d 282 (2nd Dept. 1997).

> "The obligation to procure informed consent continues only if a degree of participation is retained by way of control, consultation or otherwise. To extend that obligation to other medical personnel who have contact with the patient in connection with her treatment could deter a patient from procuring needed care on account of repeated from procuring needed care on account of repeated warnings and cautions and intrude on the patient-doctor relationship." Barbuto v Livingston, supra, at p.7, citing Fiorentino v Wenger, 19 NY2d 407 (1967); Spinosa v Weinstein, supra at pgs. 39-40.

Dr. Kadison did not participate in the surgery, and under the circumstances, neither the surgery nor the alleged lack of informed consent can be attributed to him. His motion is granted and the complaint against him is dismissed. Hill v Seward, 122 Misc2d 375 (N.Y. Sup. Oct. 3, 1983.

Conspicuously absent from Dr. Corman's affirmation is specifically what Dr. Testa's "recommendation" was: One cannot be found in her reports. Similarly lacking in evidentiary support is Dr. Corman's conclusion that the surgery performed by Dr. Sullivan was both necessary and appropriate procedures for Mr. Magel based on the interpretation offered by Dr. Testa, particularly since Dr. Testa's CT scan reports reveal only a possibility of a growth, not a definitive one, as Dr. Corman appears to infer. Additionally, conspicuously absent from Dr. Corman's affirmation is what in Dr. Testa's interpretation rendered the surgery "necessary." Dr. Corman's further opinion that Dr. Sullivan appropriately and properly relied upon the recommendations of consulting surgeon Evan Geller, M.D., the plaintiff's

gastroenterologist, Dr. Dean Pappas, and the plaintiff's cardiologist Dr. William Blau, in providing medical and surgical clearance for the plaintiff's surgery fails. Clearance for surgery hardly equates with a "recommendation" to perform it and again, no evidence of any "recommendations" by these doctors has been cited or found. Dr. Corman's conclusory opinion that "Dr. Sullivan appropriately and thoroughly reviewed the risks, benefits and alternatives to the contemplated surgery with Mr. Magel and that these same risks, benefits, and alternatives, including having no surgery, were similarly reviewed with the patient by surgeon, Evan Geller, M.D., on July 8, 2004" also lacks evidentiary support.

Dr. Corman's conclusion that "additional diagnostic studies were not indicated . . . and that the only definitive means of ruling out the presence of a malignant tumor in Mr. Magel was through surgical exploration of the small intestines" is conclusory because it fails to address in a meaningful fashion the plaintiffs' very specific allegation that further diagnostic testing was warranted in light of the fact that Dr. Testa's radiological report revealed only the possibility of a growth. While this alone requires denial of the defendants Dr. Sullivan and NSSOA's motion, Dr. Corman's conclusion that Mr. Magel's surgery was properly performed suffers from overt conclusiveness, as well.

The submission of an expert's affirmation which is not only conclusory but fails to address a pivotal allegation by the plaintiffs that absent further testing, the surgery performed to remove a growth which was actually never found was unwarranted does not suffice to establish defendants Dr. Sullivan and NSSOA's entitlement to summary judgment.

Nevertheless, as for NSUH, its only role here was its resident Dr. Lind's assisting Dr. Sullivan with Mr. Magel's surgery. In support of its application, NSUH has submitted the affirmation of Dr. Robert Ward, a Board Certified General Surgeon. Having reviewed the plaintiffs' allegations, the pertinent examination-before-trial testimony and Mr. Magel's medical records, he opines to a reasonable degree of medical certainty that all of the acts of negligent alleged by the plaintiffs that relate to NSUH are entirely attributable to Mr. Magel's private attending physician, the defendant Dr. Sullivan, under whose auspices the hospital's staff cared for Mr. Magel. And, here, there are no allegations that Dr. Sullivan's orders were not properly carried out or were contraindicated. In fact, Dr. Ward opines to a reasonable degree of medical certainty that NSUH's employees acted at all times in accordance with good and accepted medical practices with regard to their care of Mr. Magel.

The defendant NSUH has established its entitlement to summary judgment dismissing the complaint against it thereby shifting the burden to the plaintiffs to establish the existence of a material issue of fact. The plaintiffs have not opposed NSUH's motion.

NSUH's motion for summary judgment is granted and the complaint against it is dismissed.

In support of their motion for summary judgment, the plaintiffs have submitted the affirmation of Henry Ferstenberg, a Board Certified General Surgeon. He has reviewed the plaintiffs' Bills of Particulars, the deposition testimony and Mr. Magel's medical records. Dr. Ferstenberg explains and the defendants do not truly dispute that the presence of a filling defect on a CT scan film does not necessarily mean that the patient has a solid mass. A filling defect can also be caused by a transient radiological phenomenon, such as peristalsis. If a solid mass were present, it would appear on subsequent tests, but a transient radiological phenomenon would not. Dr. Ferstenberg states that in 2004, there were several specific tests which could be used to determine whether a filling defect on a CT scan film was a solid mass or not. In view of the fact that that question was specifically raised by Mr. Magel's CT scan, Dr. Ferstenberg opines to a reasonable degree of medical certainty that the defendants' failure to conduct those tests before operating on Mr. Magel was a departure from good and accepted standards of medical care. He further opines that the defendants' errors were exacerbated

in light of the fact that Mr. Magel did not display typical symptoms generally present in patients with cancer like weight loss, nausea, vomiting, night sweats and lack of sleep and his symptoms dissipated several weeks before the exploratory surgery was performed. Dr. Ferstenberg opines that had a laparoscopic examination of Mr. Magel's jejunum been performed, the absence of a solid mass would have been confirmed thereby averting surgery and the ensuing hernias from which Mr. Magel suffered. Dr. Ferstenberg opines that Dr. Sullivan and NSSOA departed from good and accepted standard medical precepts by not informing the Magels that the presence of a filling defect on a CT scan did not necessarily mean that a solid mass is present, let alone a malignant one; by telling the plaintiffs "that there was no alternative to exploratory laparotomy surgery in his case;" "by not providing the plaintiffs with sufficient information to make an informed decision on whether to proceed with exploratory laparotomy surgery;" and, "by not obtaining an informed consent to do exploratory laparotomy surgery from the plaintiffs." He opines that:

> "[a] reasonable surgeon under similar circumstances would have disclosed the alternatives to exploratory laparotomy surgery available in 2004 to a patient with Mr. Magel's medical history in a manner that would have permitted him to make a knowledgeable evaluation of the alternatives to exploratory laparotomy surgery"

and that

> "[a] reasonably prudent person fully informed of his options would not have given consent to exploratory laparotomy surgery in 2004 if he were made aware of the options available to him at that time."

Dr. Ferstenberg concludes that the surgery caused the incisional hernias.

The plaintiffs have established their entitlement to summary judgment on their claim for lack of informed consent as against Dr. Sullivan and NSSOA, thereby shifting the burden to them to establish the existence of material issues of fact.

The defendants' continued reliance on the role of the radiologist at John T. Mather Memorial Hospital diagnosing the presence of a "mass" and their alleged justifiable reliance on that diagnosis fails because again, Dr. Testa made no such definitive diagnosis. And, counsel's admitted averment that "[t]he remote risk of finding no mass upon exploratory surgery after one was identified on CT scan is not a risk which would be reasonably disclosed to a patient" fails, too, because again, a mass had not been definitively identified and it was on that premise that surgery was being recommended. And again, Dr. Sullivan's reliance on his allegedly telling the plaintiffs that Dr. Magel had two choices, surgery or no surgery, fails to address the plaintiffs' establishment of the option of other tests to confirm or disprove the presence of a mass, of which Dr. Sullivan clearly failed to advise them. The defendants Dr. Sullivan and NSSOA have failed to establish the existence of a material issue of fact with respect to the plaintiffs' claim for lack of informed consent.

In conclusion:

The defendants Dr. Sullivan and NSSOA's motion is **denied**.

Dr. Kadison's motion is granted and the complaint against him is **dismissed**.

NSUH's motion is granted and the complaint against it is **dismissed, without opposition.**

The plaintiffs are **granted partial summary judgment** with respect to liability on their cause of action against Dr. Sullivan and NSSOA for lack of informed consent.

SO ORDERED:

DATED: 10/15/2010

Kay L. Walker
J.S.C.

ENTERED
OCT 19 2010
NASSAU COUNTY
COUNTY CLERK'S OFFICE