Finkel v Lobo
2018 NY Slip Op 31450(U)
July 3, 2018
Supreme Court, New York County
Docket Number: 805144/14
Judge: Martin Shulman

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NEW YORK
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AMY FINKEL,

Plaintiff,

-against-

ROGERIO LOBO, M.D., COLUMBIA UNIVERSITY MEDICAL CENTER, NEW YORK PRESBYTERIAN HOSPITAL and CENTER FOR WOMEN'S REPRODUCTIVE CARE,

Defendants.
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Index No. 805144/14

Decision & Order

Motion Seq. 002

Martin Shulman, J.:

In this action alleging medical malpractice, defendants Rogerio Lobo, M.D. (Dr. Lobo), New York Presbyterian Hospital (NYPH) and Center for Women's Reproductive Care[1] (collectively, defendants) move pursuant to CPLR 3212 for summary judgment dismissing the complaint.[2] Plaintiff Amy Finkel (Ms. Finkel or plaintiff) opposes the motion.[3] In addition to arguing that defendants failed to establish prima facie entitlement to summary judgment as a matter of law, plaintiff also claims the motion was untimely, their supporting expert's affirmation is not in admissible form and the expert affirmation should be disregarded based

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[1] This defendant appeared in this action as "The Trustees of Columbia University in the City of New York, s/h/a Center for Women's Reproductive Care" but is referred to in the motion papers as Center for Women's Reproductive Care.

[2] Defendant The Trustees of Columbia University in the City of New York, s/h/a Columbia University Medical Center is not named as a movant but presumably is one and the same as co-defendant The Trustees of Columbia University in the City of New York, s/h/a Center for Women's Reproductive Care.

[3] In her opposition to the motion, plaintiff withdraws her cause of action alleging lack of informed consent.

upon noncompliance with CPLR §3101(d). Plaintiff also disputes defendants' claim that any alleged acts of malpractice occurring more than two and one half years prior to this action's commencement (to wit, prior to December 4, 2011) are time barred.

Ms. Finkel alleges that defendants misdiagnosed her as having polycystic ovarian syndrome (PCOS)[4] throughout her 13 years of treatment with them, disregarding other possible causes of her symptomology. She specifically asserts that defendants failed to timely diagnose and treat endometriosis,[5] low egg reserves/premature ovarian failure and early menopause. Plaintiff claims that the alleged misdiagnosis caused her substantial pain and suffering, as well as resulted in her missing the opportunity to take steps, such as oocyte cryopreservation (egg freezing), to preserve her fertility so that she could bear her own biological children.

Factual Background

Ms. Finkel first presented to defendants Dr. Lobo and the Center for Women's Reproductive Care on July 14, 2000 for an annual gynecological

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[4] According to plaintiff's expert, PCOS "is a hormonal disorder the hallmarks of which are hyperandrogenism and chronic anovulation in women associated with infrequent or irregular menstrual periods. . . . Hyperandrogenism refers to excess levels of androgens which are male sex hormones such as testosterone." Hurst Aff. in Opp., ¶ 80.

[5] Plaintiff's expert describes endometriosis as "an estrogen-dependent, inflammatory disease . . . defined as the presence of endometrial tissue outside of the uterus. Endometriosis occurs when the tissue that lines the uterus (endometrium) is found in regions outside of the uterus where the tissue should not be." Hurst Aff. in Opp., ¶103.

examination. She continued treating with him for yearly exams and on an as needed basis, including telephone calls to the office for consultations and prescription refills, through March 2013. Plaintiff's opposition notes that she was in contact with Dr. Lobo or his office 83 times during this approximately 13 year period.

At the initial visit plaintiff complained of premenstrual syndrome (PMS) symptoms, including painful menstrual periods and fluid retention. Blood work revealed low testosterone levels. Dr. Lobo diagnosed PMS and prescribed a diuretic and a pain medication.

After her initial visit plaintiff's next annual exam with Dr. Lobo was on October 10, 2002. A pelvic ultrasound performed on that date revealed cystic ovaries "but not enough for PCOS". Dr. Lobo noted his impression as insulin resistance/acne/PMS and possible PCOS.

Prior to this second visit to Dr. Lobo, plaintiff saw endocrinologists Loren Greene, M.D. (Dr. Greene) and Maria New, M.D. (Dr. New). Testing Dr. Greene ordered was performed on April 5, 2002 and indicated insulin resistance. Dr. New issued a letter report dated October 25, 2002 to Dr. Greene, on which Dr. Lobo was copied, indicating elevated testosterone levels. This letter referenced Dr. Greene's previous diagnosis of insulin resistance and noted plaintiff's complaints of acne and difficulty with weight loss. Dr. New agreed with Dr. Greene's plan to start plaintiff on Metformin (Glucophage) to treat her insulin resistance and oral contraceptive pills (birth control pills) to lower her testosterone levels and reduce her PMS complaints.

From 2002 through 2013 Dr. Lobo prescribed oral contraceptives to alleviate plaintiff's various symptoms attributable to PMS and painful menstrual periods. Dr. Lobo testified that he first diagnosed PCOS at plaintiff's January 14, 2004 annual exam and ultrasound, noting that it was "not bad", and documented her complaint regarding weight gain. At her next annual exam on March 17, 2005 an ultrasound revealed that Ms. Finkel's ovaries were smaller. Blood work performed on May 25, 2005 indicated that plaintiff had abnormally low androgen levels. At a September 20, 2007 office visit Ms. Finkel complained of constipation and advised that she had seen a gastroenterologist. Her ovaries were again noted as small at a January 3, 2008 annual exam and no cysts were noted. On July 24, 2008 plaintiff presented with symptoms of dizziness and faintness at the time of her periods. This condition had resolved by the time of a January 14, 2010 office visit. At her March 31, 2011 annual exam Ms. Finkel complained of anxiety and sleep issues. An ultrasound performed at that time still noted PCOS, but Dr. Lobo did not count the number of cysts present.

On April 14, 2011 plaintiff underwent a pelvic MRI ordered by her gastroenterologist for purposes of evaluating possible endometriosis. This test revealed no sign of endometriosis. The MRI also revealed a simple cyst on the left ovary.

At her March 19, 2012 annual exam Ms. Finkel reported anxiety and premenstrual mood changes. Ultrasound results indicated the size of her ovaries but did not mention cysts. Dr. Lobo's assessment remained PCOS and premenstrual dysphoric disorder (PMDD).

Ms. Finkel testified that she first learned of oocyte cryopreservation in 2013 and discussed it with Dr. Lobo at a March 21, 2013 office visit. At plaintiff's request Dr. Lobo performed antimullerian hormone (AMH) testing of her ovarian reserves. The test results indicated premature ovarian failure and a repeat AMH test confirmed the result. This was plaintiff's last visit to Dr. Lobo.

In the ensuing months plaintiff attempted egg harvesting for cryopreservation but was found to have no viable eggs. Subsequently, she treated with gynecologist Po Ching Fong, M.D. (Dr. Fong) for annual exams from January 13, 2014 through June 18, 2015,[6] and discontinued oral contraceptives in December 2014 or January 2015. At no point did Dr. Fong diagnose endometriosis. Dr. Fong referred her to reproductive endocrinologist Khaled Zeitoun, M.D. (Dr. Zeitoun) who also did not diagnose endometriosis after performing ultrasounds on August 11, 2015 and September 1, 2015.

Ms. Finkel next consulted with gynecologist Ruth Tessler, M.D. (Dr. Tessler) on September 16, 2015 for severe pelvic pain and frequent menstrual periods after discontinuing birth control pills. These new symptoms led Dr. Tessler to suspect endometriosis and she referred plaintiff for a transvaginal sonogram. After reviewing the October 1, 2015 study Dr. Tessler removed endometriosis from her diagnosis and started Ms. Finkel back on oral contraceptives.

[6] Plaintiff commenced this action on May 4, 2014.

At some point thereafter plaintiff consulted with Dr. Tamer Seckin, M.D. (Dr. Seckin), who "holds himself out as a specialist in endometriosis."[7] A second pelvic MRI performed on February 4, 2016 showed thickening of the posterior lower uterine segment of the uterus and bilateral uteral sequel ligaments with minimal superior tethering and retraction of the posterior vaginal fornix suggestive of endometriosis.

Dr. Seckin performed laparoscopic surgery on March 11, 2016. Plaintiff testified that he removed ten lesions later identified as endometriosis, some of which were white in appearance.

EXPERT'S CONTENTIONS

In support of their motion for summary judgment dismissing the complaint, defendants argue that they did not depart from accepted medical standards in treating plaintiff. They submit an expert affirmation from Hugh S. Taylor, M.D. (Dr. Taylor), who is board certified in obstetrics and gynecology, reproductive endocrinology and infertility. Dr. Taylor opines as follows:

- the results of endocrine testing in the fall of 2002 support a diagnosis of PCOS;
- plaintiff did not present as having "classic" PCOS in that she did not report irregular menses, however, the laboratory evidence of androgen excess and her symptoms (including insulin resistance and difficulty losing weight) supported a PCOS diagnosis;
- a polycystic appearance of the ovaries on sonograms may be suggestive of PCOS, but is not necessary for its diagnosis;

[7] Defense counsel notes that Dr. Seckin refused to provide his medical records.

- ovary size is not a diagnostic criteria for PCOS and there are no guidelines as to normal size or what size ovaries would indicate premature ovarian failure;

- the standard of care did not require defendants to take plaintiff off birth control pills periodically to test for fluctuations in androgen levels for the purpose of reconfirming the PCOS diagnosis;

- none of the common causes of premature ovarian failure applied to plaintiff (such as having undergone chemotherapy or radiation for cancer treatment, exposure to various toxins, genetic causes or autoimmune causes), thus defendants had no reason to suspect she might develop this condition and it was not with the standard of care for defendants to test for it;

- AMH testing has no medically significant predictive value as to the longevity of a woman's fertility;

- it was not the standard of care between 2002 and 2013 to perform AMH testing on women who were not actively but unsuccessfully attempting to conceive simply to evaluate current or future likelihood of their fertility, and in any event, the results would not be reliable, and here, Dr. Lobo performed AMH testing when plaintiff requested it;

- prior to October 2012, egg freezing in an attempt to preserve fertility was considered experimental for women with certain cancers planning to undergo chemotherapy and women about to undergo bone marrow transplantation, and was not the standard of care, nor is it recommended for the sole purpose of deferred childbearing;

- endometriosis is extremely difficult to diagnose and the only diagnostic test is surgery, which has the risk of causing abdominal adhesions resulting in a worsening of symptoms, thus it is not the standard of care to perform such diagnostic surgery, particularly where, as here, oral contraceptives adequately controlled plaintiff's symptoms;

- no signs of endometriosis were seen on a 2011 MRI and a 2015 sonogram performed by a subsequent gynecologist;

- the appropriate treatment for endometriosis is oral contraception, which plaintiff took from 2002 through at least 2013;

- endometriosis does not cause or increase the possibility of developing premature ovarian failure; and

- Dr. Lobo was not treating plaintiff when she developed symptoms severe enough to suggest endometriosis, which occurred after she stopped taking birth control pills and underwent ovarian stimulation, which exacerbates endometriosis.

In opposition, Ms. Finkel submits an affidavit from Fred Hurst, M.D. (Dr. Hurst), a physician board certified in obstetrics and gynecology who states that he has over 40 years of experience in these fields. Plaintiff's expert avers within a reasonable degree of medical certainty that the care defendants rendered to Ms. Finkel deviated from the applicable standards of good and accepted medical practice. Dr. Hurst concludes the following:

- defendants departed from the standard of care by misdiagnosing PCOS on multiple visits when she did not meet the criteria for the condition (to wit, she had no history of irregular periods and/or symptoms of hyperandrogenism such as hirsutism or male pattern baldness), nor did sonograms reveal the multiple small cysts characteristic of PCOS;

- contrary to Dr. Taylor's conclusions, Dr. Lobo would have been able to diagnose declining egg reserves had he properly interpreted sonogram images showing decreasing numbers of ovarian follicles and cysts, and had he taken note of the abnormally small size of plaintiff's ovaries;

- defendants departed from the standard of care by failing to run androgen panels from 2003 through 2013 while maintaining PCOS as the working diagnosis, which would have required defendants to have plaintiff cease taking oral contraceptives and re-run testosterone and androgen blood panels periodically throughout the course of her treatment;

- contrary to Dr. Taylor's opinion, egg freezing was a viable option for plaintiff;

- defendants failed to correctly diagnose endometriosis when plaintiff presented with symptoms indicative thereof such as chronic pelvic pain and this departure caused her endometriosis to grow unchecked for years, causing infertility, pain and suffering; and

- prescribing oral contraceptives[8] does not stop endometriosis from progressing, thus defendants should have performed a diagnostic laparoscopy and prescribed hormonal treatment such as Lupron or Danazol to halt the advancement of endometriosis.

DISCUSSION

Timeliness of Motion

Among plaintiff's arguments in opposition is the claim that defendants' motion for summary judgment is untimely. Defense counsel avers in her supporting affirmation that the last conference order in this case dated October 3, 2017 provided for the note of issue to be filed on or before November 3, 2017. Plaintiff filed the note of issue on October 10, 2017. Defense counsel served and filed this motion on January 2, 2018 and states that it is timely because this court extended the time to move for summary judgment to January 3, 2018 during a December 19, 2017 conference call with counsel.

Plaintiff's counsel argues that the motion is untimely because it was not served within 60 days of the note of issue's filing as required by the preliminary conference order dated April 17, 2015. By plaintiff's counsel's estimate, the last day for defendants to move for summary judgment was December 12, 2017. Acknowledging that this court has authority to extend the deadline for filing such motions upon leave of court and a showing of good cause,[9] plaintiff's counsel, while not denying that this court extended the deadline to January 3, 2018, notes

[8] Dr. Hurst also faults defendants for not prescribing a birth control pill having a lower dosage of estrogen, which spurs the growth of endometrial tissue.

[9] *See* CPLR 3212(a).

that no motion was made for an extension of time and denies that defendants made a showing of good cause sufficient to justify the extension.[10] In reply, defense counsel maintains that this court already addressed the issue of good cause during the conference call by extending the date.

Defendants' motion is timely. Implicit in this court's oral directive extending the deadline for filing motions for summary judgment was a finding of good cause. This court heard and considered plaintiff's opposition to the extension request and therefore she has not been prejudiced. Nor did plaintiff take any steps to vacate this court's directive.

Alleged Defects in Defendants' Expert's Affidavit

Plaintiff also argues that Dr. Taylor's affirmation should be disregarded as inadmissible and the motion denied. Specifically, plaintiff argues that the affirmation is not properly notarized and fails to comply with CPLR §2309[c],[11] which provides as follows:

> An oath or affirmation taken without the state shall be treated as if taken within the state if it is accompanied by such certificate or certificates as would be required to entitle a deed acknowledged without the state to be recorded within the state if such deed had been acknowledged before the officer who administered the oath or affirmation.

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[10] Plaintiff's counsel states that defendants' only proffered reason for requesting an extension, presumably made during the December 19, 2017 conference call, was that an associate was busy.

[11] Dr. Taylor states that he is a physician licensed in Connecticut. Unlike physicians who are licensed in New York state, out of state physicians' signatures must be notarized and accompanied by a certificate of conformity.

With respect to the claim that Dr. Taylor's affirmation does not appear to be properly notarized, plaintiff notes that it is unclear whether it was sworn to out of state before a licensed notary or merely witnessed, since it contains no licensure information. Plaintiff further notes that the affirmation is not accompanied by a certificate of conformity.

In reply, defendants re-submit Dr. Taylor's affirmation, now labeled an affidavit, with licensure information identifying the notary public who witnessed Dr. Taylor's signature in California.[12] Defendants also include a certificate of conformity and cite CPLR §2001, which permits the court to permit defects and irregularities to be corrected and, if no substantial right of a party is prejudiced, to disregard the defect or irregularity.

This is not a situation where defendants attempt to raise new arguments for the first time in their reply papers. Ms. Finkel has responded to the identical averments on the merits and will not be prejudiced by permitting defendants to rectify such ministerial defects in their reply papers. *See Redlich v Stone*, 152 AD3d 432, 433 (1st Dept 2017) (lower court properly considered affidavit notarized in Florida even though it lacked a certificate of conformity); CPLR §2001. Accordingly, this court finds that plaintiff's objections lack merit.

Expert Witness Disclosure

Plaintiff also argues that Dr. Taylor's expert affirmation should not be considered because defendants failed to serve expert disclosure pursuant to

[12] Defense counsel maintains that the original notary's raised seal was not visible as the affirmation was electronically filed.

CPLR §3101(d) prior to bringing this motion. Plaintiff cites a December 22, 2015 status conference order which provides for defendants to serve expert disclosure within 60 days of plaintiff's expert disclosure. Ms. Finkel disclosed her expert disclosure on January 12, 2016.

Plaintiff relies upon *Rivers v Birnbaum*, 102 AD3d 26 (2d Dept 2012) in support of this argument. However, the Second Department acknowledged in that decision that CPLR §3101(d) "does not specify when a party must disclose its expected trial experts upon receiving a demand . . ." *Id.* at 35. Further, a trial court has discretion to allow expert testimony where the expert was disclosed near the commencement of a trial. *Id.* at 36-37. As such, "there is no basis for concluding that a court must reject a party's submission of an expert's affidavit or affirmation in support of, or in opposition to, a timely motion for summary judgment solely because the expert was not disclosed pursuant to CPLR 3101 (d) (1) (i) . . . prior to the making of the motion." *Id.* at 39. Indeed, precluding an expert's affidavit under these circumstances "is not consistent with the purpose and procedural posture of a motion for summary judgment." *Id.* at 42.

Here, plaintiff does not claim any prejudice as a result of defendants' failure to timely provide expert disclosure, nor does she claim that the default was willful or intentional. *See also Yampolskiy v Baron*, 150 AD3d 795, 796 (2d Dept 2017). Notably, Ms. Finkel had sufficient time to respond to defendants' expert affidavit. *Browne v Smith*, 65 AD3d 996, 997 (2d Dept 2009). Accordingly, this argument is rejected.

Summary Judgment

An award of summary judgment is appropriate when no issues of fact exist. *See* CPLR 3212(b); *Sun Yau Ko v Lincoln Sav. Bank*, 99 AD2d 943 (1st Dept), *aff'd* 62 NY2d 938 (1984); *Andrea v Pomeroy*, 35 NY2d 361 (1974). In order to prevail on a motion for summary judgment, the proponent must make a prima facie showing of entitlement to judgment as a matter of law by providing sufficient evidence to eliminate any material issues of fact. *Winegrad v New York Univ. Med. Ctr.*, 64 NY2d 851, 853 (1985); *Alvarez v Prospect Hosp.*, 68 NY2d 320, 324 (1986). Indeed, the moving party has the burden to present evidentiary facts to establish his cause sufficiently to entitle him to judgment as a matter of law. *Friends of Animals, Inc. v Associated Fur Mfrs., Inc.*, 46 NY2d 1065 (1979).

In deciding the motion, the court views the evidence in the light most favorable to the nonmoving party and gives him the benefit of all reasonable inferences that can be drawn from the evidence. *See Negri v Stop & Shop, Inc.*, 65 NY2d 625, 626 (1985). Moreover, the court should not pass on issues of credibility. *Assaf v Ropog Cab Corp.*, 153 AD2d 520, 521 (1st Dept 1989). While the moving party has the initial burden of proving entitlement to summary judgment (*Winegrad*, *supra*), once such proof has been offered, in order to defend the summary judgment motion, the opposing party must "show facts sufficient to require a trial of any issue of fact." CPLR 3212(b); *Zuckerman v City of New York*, 49 NY2d 557, 562 (1980); *Freedman v Chemical Constr. Corp.*, 43 NY2d 260 (1977); see also, *Friends of Animals, Inc.*, *supra*.

1. Medical Malpractice

"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) (citation omitted). A defendant physician seeking summary judgment must make a prima facie showing establishing the absence of a triable issue of fact as to the alleged departure from accepted standards of medical practice (*id*).

In opposition, "a plaintiff must produce expert testimony regarding specific acts of malpractice, and not just testimony that alleges '[g]eneral allegations of medical malpractice, merely conclusory and unsupported by competent evidence tending to establish the essential elements of medical malpractice'." *Id.*, citing *Alvarez v Prospect Hosp.*, 68 NY2d at 325. "In most instances, the opinion of a qualified expert that the plaintiff's injuries resulted from a deviation from relevant industry or medical standards is sufficient to preclude a grant of summary judgment in a defendant's favor (citation omitted)." *Id.* However, where an expert's ultimate assertions are speculative or unsupported by any evidentiary foundation, the opinion should be given no probative force and is insufficient to withstand summary judgment. *Id.*, citing *Diaz v New York Downtown Hosp.*, 99 NY2d 542, 544 (2002).

In this case, the record reveals that both plaintiff's expert and defendants' experts have extensive experience in the specialty of gynecology. Additionally, they both base their opinions on their review of Ms. Finkel's medical records as

well as the pleadings and deposition transcripts herein. Therefore, both experts appear to be are qualified to offer their opinions. *See Frye v Montefiore Med. Ctr.*, 70 AD3d at 24-25; *Guzman v 4030 Bronx Blvd. Assoc. L.L.C.*, 54 AD3d 42, 49 (1st Dept 2008) ("whether a witness is qualified to give expert testimony is entrusted to the sound discretion of the trial court . . .").

In opposition, plaintiff denies that defendants have established prima facie entitlement to summary judgment dismissing the complaint, particularly on the issue of proximate cause. Characterizing defendants' expert's affirmation as conclusory, plaintiff disputes that defendants refuted her allegations of malpractice. While plaintiff claims defendants' showing is insufficient to shift the burden of proof to her and warrants denial of their summary judgment motion, nonetheless, in the event this court determines otherwise, Ms. Finkel argues that her expert's affidavit raises issues of fact as to whether defendants departed from the applicable standard of care, thus warranting a trial.

Contrary to Ms. Finkel's claim, defendants have established their prima facie entitlement to summary judgment as a matter of law by submitting Dr. Taylor's affirmation specifically addressing Ms. Finkel's allegations. Based on a reasonable degree of medical certainty, Dr. Taylor opines that Dr. Lobo's treatment of plaintiff did not proximately cause her infertility or deprive her of the opportunity to take steps to preserve it.

Upon defendants establishing their prima facie case the burden shifted to plaintiff to present facts in admissible form sufficient to raise genuine, triable

issues of fact. *Zuckerman v City of New York, supra.* Here, Ms. Finkel fails to meet this burden and summary judgment is granted in defendants' favor.

Misdiagnosis of PCOS

The parties' experts disagree as to whether Ms. Finkel's symptoms met the criteria for a PCOS diagnosis. While both experts substantiate their conflicting opinions, arguably creating an issue of fact, plaintiff nonetheless fails to establish that this alleged departure proximately caused her injury, to wit, infertility and loss of opportunity to preserve her fertility.

Rather, her infertility was caused by premature ovarian failure and nothing in Dr. Hurst's affirmation links this injury to the PCOS diagnosis. He only summarily opines that the alleged misdiagnosis "prevented Ms. Finkel from getting proper treatment, caused Ms. Finkel to receive treatment which did not help her and caused her harm, and deprived Ms. Finkel of the opportunity to be apprised of her true condition." Hurst Aff. in Opp., ¶94.

Dr. Hurst does not elaborate what "proper treatment" entailed or even identify any specific harm to plaintiff as a result of the alleged departure. Similarly, he fails to support his conclusory opinion that the standard of care required defendants, from 2004 through 2013, to periodically re-test Ms. Finkel's androgen levels to confirm the PCOS diagnosis.

Finally, plaintiff does not claim that Dr. Lobo's treatment for PCOS (to wit, prescribing a diuretic and oral contraceptives) caused her any injury. Parenthetically, even after Ms. Finkel discontinued treatment with Dr. Lobo she continued to be prescribed a diuretic and birth control pills just as Dr. Lobo

prescribed. For the foregoing reasons plaintiff fails to refute that defendants did not depart from the standard of care by misdiagnosing PCOS.

Failure to Diagnose Premature Ovarian Failure/Low Egg Reserves

With respect to the claim that defendants departed from the standard of care by failing to diagnose and treat plaintiff's low egg reserves and premature ovarian failure, thus depriving her of the opportunity to take steps, such as egg freezing, to preserve her fertility, Dr. Hurst opines that Dr. Lobo, rather than attributing her symptoms to PCOS, should have suspected Ms. Finkel had low egg reserves based upon the small size of her ovaries. However, Dr. Hurst cites no support for his implicit conclusion that ovary size is indicative of the amount of egg reserves and premature ovarian failure.

Dr. Hurst further maintains that if hormone blood panels had been taken periodically "it would have been possible for defendants to catch these conditions before they resulted in infertility." Hurst Aff. in Opp., ¶121. Dr. Hurst's affirmation cites no support for his conclusory opinion that the standard of care required such testing.

Significantly, Dr. Hurst fails to refute Dr. Taylor's opinions that: (1) this condition can only be identified in women, unlike Ms. Finkel, who are actively but unsuccessfully trying to conceive; (2) the condition cannot be prevented or treated; (3) it was not the standard of care to perform AMH testing in the ordinary course of annual gynecological examinations, particularly on women who were not actively trying to conceive, for the mere purpose of evaluating their future fertility; and (4) there was no reason for Dr. Lobo to suspect possible diminished

egg reserves and premature ovarian failure since plaintiff had never been exposed to any of its potential causes (to wit, radiation, chemotherapy, etc.).

Dr. Taylor supports his opinion "that AMH testing has no medically significant predictive value about the longevity or future possibility of any woman's fertility prospects" by citing a 2017 study published in the Journal of the American Medical Association. Taylor Aff. in Supp., ¶22. This study concluded that low AMH values, believed to suggest diminished ovarian reserves, were not associated with diminished fecundability. *Id.* at ¶23. Dr. Hurst does not refute that AMH testing does not predict infertility, instead responding only that he does "not think it is good practice for Dr. Taylor to base his entire opinion about the role of AMH on one singular study." Hurst Aff. in Opp., ¶128.

Nor does Dr. Hurst even address Dr. Taylor's statement that oocyte cryopreservation for purposes of attempting to preserve fertility was considered experimental prior to 2012 and still is not recommended for this purpose. Dr. Taylor supports this opinion with various published guidelines from a joint practice committee of the American Society for Reproductive Medicine and the Society for Assisted Reproductive Technology, which the American College of Obstetricians and Gynecologists. Dr. Hurst responds with the unsupported conclusory statement that "oocyte cryopreservation is a viable option, and was a viable option during Ms. Finkel's treatment with defendants, for patients who are looking for means to preserve fertility." Hurst Aff. in Opp., ¶132. For all of the foregoing reasons plaintiff fails to refute that defendants did not depart from the standard of care by misdiagnosing PCOS.

Failure to Diagnose Endometriosis

With respect to the failure to diagnose endometriosis, plaintiff last treated with defendants in 2013 and her endometriosis was diagnosed and surgically removed in 2016. Nothing in this record supports Ms. Finkel's expert's conclusory statement that the failure to diagnose endometriosis caused her infertility, rather than her diagnosed low egg reserves and premature ovarian failure. Plaintiff thus fails to establish proximate cause and fails to refute that defendants did not depart from the standard of care by not diagnosing endometriosis.

Even if plaintiff had established proximate cause, no other factual issues exist on this point. For example, plaintiff's expert avers that upon surgical excision, plaintiff's endometriosis lesions were white in appearance, thus indicating that they had existed "for years". This vague statement is insufficient to establish that Ms. Finkel developed endometriosis while under Dr. Lobo's care. Nonetheless, even if plaintiff had developed endometriosis while under Dr. Lobo's care, her expert does not dispute that prescribing birth control and pain medication, as Dr. Lobo did, is an appropriate treatment for the condition despite the fact that it does not halt its progression.[13]

Additionally, while both experts agree that endometriosis can only be definitively diagnosed by laparoscopic surgery, Dr. Hurst does not address Dr.

[13] Parenthetically, it is notable that, between 2013 and 2015, three subsequent treating physicians tested plaintiff for endometriosis but did not diagnose it, while also continuing to prescribe oral contraception and pain medication.

Taylor's claim that the procedure carries the risk of developing abdominal adhesions, which would result in plaintiff's symptoms worsening. Thus, Dr. Hurst does not refute that the standard of care does not require diagnostic surgery where the symptoms of suspected endometriosis can be controlled by other means.

Summary judgment is appropriate where the nonmovant's opposition to the motion is entirely conjectural and there is no genuine issue of fact to be resolved. *See, Shaw v Time-Life Records,* 38 NY2d 201, 207 (1975). Here, plaintiff offers only conjecture and speculation in response to Dr. Taylor's statements in an attempt to create an issue of fact. Plaintiff thus fails to meet her burden of rebutting defendants' prima facie case.

For the foregoing reasons, Dr. Hurst's conclusory and speculative affidavit fails to raise any questions of fact as to whether defendants departed from accepted medical practice and the cause of action alleging medical malpractice must be dismissed.

2. Negligent Supervision

Summary judgment is similarly granted dismissing plaintiff's cause of action against defendants NYPH, Columbia University Medical Center and Center for Women's Reproductive Care for negligent supervision. Other than Dr. Lobo, plaintiff fails to identify any other individuals for whom these institutional defendants might be vicariously liable. As this court has determined that Dr. Lobo was not negligent in treating plaintiff, there can be no claim that he was negligently supervised.

Statute of Limitations

This court's decision granting summary judgment in defendants' favor based upon the finding that defendants did not deviate from the standard of care presumes that all of the complaint's allegations are timely. However, the court makes no specific determination as to the continuous treatment doctrine's applicability in this case.

Accordingly, it is

ORDERED that defendants' motion for summary judgment dismissing the complaint is granted and the Clerk is directed to enter judgment in favor of all defendants dismissing this action with prejudice, together with costs and disbursements as taxed by the Clerk upon the submission of an appropriate bill of costs.

The foregoing constitutes this court's Decision and Order.

Dated: New York, New York
July 3, 2018

HON. MARTIN SHULMAN, J.S.C