Loccisano v Ascher
2019 NY Slip Op 30371(U)
January 30, 2019
Supreme Court, Kings Court
Docket Number: 504883/15
Judge: Ellen M. Spodek
Cases posted with a "30000" identifier, i.e., 2013 NY Slip Op 30001(U), are republished from various New York State and local government sources, including the New York State Unified Court System's eCourts Service.
This opinion is uncorrected and not selected for official publication.

At an IAS Part 63 of the Supreme Court of the State of New York, held in and for the County of Kings, at the Courthouse, at Civic Center, Brooklyn, New York, on the 30 day of January, 2019.

P R E S E N T:

HON. ELLEN M. SPODEK,
Justice.

----------X

ROCCO LOCCISANO,

Plaintiff,

- against -

Index No. 504883/15

MS # 4 & 5

ENRICO ASCHER, M.D., LUTHERAN MEDICAL CENTER, ANIL HINGORANI, M.D., TOTAL VASCULAR CARE, PLLC, and VASCULAR INSTITUTE OF NEW YORK,

Defendants.

----------X

The following e-filed read herein:	NYSCEF #:
Notice of Motion/Order to Show Cause/ Petition/Cross Motion and Affidavits (Affirmations) Annexed	48 - 70; 72 - 81
Opposing Affidavits (Affirmations)	84 - 89; 90 - 97
Reply Affidavits (Affirmations)	98
Other Papers Reply Affirmation	Not e-filed

Upon the foregoing papers, motion sequence numbers 4 and 5 are consolidated for disposition. Defendant Lutheran Medical Center (Lutheran) moves in sequence number 4; and Enrico Ascher, M.D. (Dr. Ascher), Anil Hingorani, M.D. (Dr. Hingorani), Total Vascular Care, PLLC (Total Vascular), and Vascular Institute of New York (Vascular Institute) (the Doctors) collectively move in sequence number 5; in each instance, for an order, pursuant to CPLR 3212, granting summary judgment dismissing the complaint of plaintiff Rocco Loccisano (plaintiff).

Introduction

This is a consolidated action for medical malpractice and lack of informed consent to recover damages for personal injuries arising from defendants' alleged negligence in, among other things, prescribing plaintiff thrombolytic therapy and in rendering other medical care to him. Plaintiff contends that defendants negligently treated an occlusion of the iliac vein in his left leg by implanting a stent and by improperly administering Alteplase (a tissue plasminogen activator abbreviated as "tPA") two times, ultimately causing him to suffer a hemorrhagic stroke which he alleges defendants failed to timely diagnose. Plaintiff further alleges that defendants failed to inform him of the risks and benefits of the three sets of separate procedures he received and of the treatment alternatives.

Plaintiff's Medical History and Treatment

Plaintiff's Treatment in 2012

Dr. Ascher first treated plaintiff on October 21, 2012 at his private office, upon referral by plaintiff's primary care physician, nonparty Dr. Jeffrey Hyman (Dr. Hyman), for complaints of swelling and pain in his legs following a venous laser treatment. A physical examination revealed discoloration of his left leg, skin thickening, and dryness. He reported weakness, a recent appetite decrease, anxiety-related palpations, abdominal pain in the suprapubic area, headache, and lower-back numbness. Dr. Ascher, after performing a duplex venous scan, diagnosed plaintiff with bilateral varicose veins and recommended continued observation to decide whether plaintiff's complaints were the result of dermatitis or an adverse reaction to his earlier laser treatment. Dr. Ascher sent his consultation note and findings to plaintiff's primary care physician Dr. Hyman.

On October 31, 2012, plaintiff saw Dr. Hingorani, an associate of Dr. Ascher, with complaints of (1) swelling, discoloration, and weakness in both legs (worse on the left); (2) pain and a rash on the left leg; and (3) lower-back discomfort. Plaintiff also reported chills, some weakness, appetite decrease, palpitations, shortness of breath with anxiety, dizziness upon change in body position, headache, and numbness in the legs. An ultrasound of his lower extremities revealed that at least four veins were "incompetent" or not working well: (1) left short saphenous vein, (2) left accessory vein, (3) right greater saphenous vein, and (4) right short saphenous vein. Dr. Hingorani observed that plaintiff's left greater saphenous vein had been obliterated. Dr. Hingorani's impression was that the varicose veins in plaintiff's legs were caused by venous insufficiency. Dr. Hingorani prescribed the antibiotic Keflex, an antibiotic, to treat a suspected infection in the left leg, and sent Dr. Hyman a consultation note from that visit.

When Dr. Hingorani next saw plaintiff on November 2, 2012, plaintiff reported a reduction in his lower extremity pain and some decreased swelling with the antibiotic. No other complaints were noted in plaintiff's chart. An iliac vein duplex ultrasound was performed, showed no clots in the inferior vena cava nor in the iliac veins. Dr. Hingorani prescribed compression stockings, plus a skin cream, and sent Dr. Hyman a consultation note from that visit.

Dr. Hingorani saw plaintiff again on November 30, 2012, when plaintiff complained of lower extremity pain and swelling. On December 7, 2012, Dr. Hingorani performed a radio-frequency ablation procedure to seal a non-functioning vein.

Dr. Ascher then saw plaintiff on December 10, 2012 and performed another venous duplex scan, which showed that the ablation procedure was successful. Consultation notes from both visits were sent to Dr. Hyman.

Plaintiff's Treatment in 2014

Plaintiff did not return to Total Vascular (the practice of Drs. Ascher and Hingorani) until 15 months later, on March 18, 2014, when he complained of pain and swelling in both legs, worse on the left, with brownish discoloration. Lipodermatosclerosis of the lower extremities – a sign of venous insufficiency – was noted.

Plaintiff next went to Total Vascular on August 3, 2014, complaining of increased swelling, discoloration, and pain in his left leg. He also complained of weakness, shortness of breath upon minimal exertion, dizziness with changes in body position, unsteady gait, and headache. Dr. Ascher performed a duplex venous scan and found that plaintiff's left great and small saphenous veins had been obliterated, albeit without evidence of deep vein thrombosis (DVT) or of superficial vein thrombophlebitis. Dr. Ascher recommended a venogram with possible iliac stenting, and requested that plaintiff obtain a preoperative medical clearance from his primary care physician. Dr. Ascher sent to Dr. Hyman a consultation note from that visit, and on August 14, 2014, Dr. Hyman cleared plaintiff for surgery.

On August 24, 2014, Dr. Ascher performed both (1) a venogram (the Aug. 24th venogram) which revealed a 60%-70% mid-common iliac vein stenosis, and (2) a stent-implant procedure (the stent-implant procedure), the outcome of which was memorialized in Dr. Ascher's operative report (Dr. Ascher's operative report) and in his assistant's

operating room case notes. Plaintiff was discharged home the same day with instructions to return to Total Vascular for a follow-up on August 28, 2014.

When plaintiff returned to Total Vascular on August 28, 2014, his left leg was noted to be edematous with brown discoloration and varicose veins. He was nauseous, but without a headache, shortness of breath, dizziness, or unsteady gait. An iliac vein duplex scan revealed an acute, occlusive DVT in plaintiff's left external and common iliac veins. Dr. Ascher instructed plaintiff to go immediately to Lutheran's emergency room.

Later in the day, plaintiff was admitted through Lutheran's emergency room, to Dr. Ascher's service. The following day, August 29, 2014, Dr. Ascher performed a combined mechanical thrombectomy and pharmacological thrombectomy to relieve an acute obstruction of plaintiff's left external and common iliac veins (the thrombectomy). In the mechanical thrombectomy part of the procedure, Dr. Ascher suctioned out the bulk of the clots from plaintiff's left iliac vein and partially removed some clots from his common femoral vein. In the pharmacological thrombectomy part of the procedure, Dr. Ascher injected a tPA to dissolve the clots. A post-procedure venogram showed marked improvement in plaintiff's venous condition, with only a few remaining clots. Dr. Ascher determined that plaintiff should remain hospitalized at Lutheran for a follow-up venogram and for possible additional thrombolysis to dissolve the remaining clots.

Between August 29, 2014 and September 2, 2014, plaintiff continued on Heparin, as his INR, (a measure of blood coagulability), was closely monitored. At approximately 11:55 a.m. on September 2, 2014, Dr. Hingorani performed a follow-up venogram on plaintiff. In that venogram, Dr. Hingorani observed a 50% stenosis (or occlusion) of the stent that had

been placed eight days earlier during the stent-implant procedure. To address this finding, Dr. Hingorani inserted an infusion catheter into plaintiff's stent to enable a direct administration of tPA into his clotted veins (the infusion-catheter procedure). Dr. Hingorani continued Heparin and a tPA infusion, with plaintiff being closely monitored overnight for potential bleeding in Lutheran's Intensive Care Unit (ICU). At that time, plaintiff had no complaints, apart from some mild facial swelling and an itching back, both of which were resolved with the administration of Benadryl.

At 6 a.m. on September 3, 2014, plaintiff was observed talking to an ICU nurse and using a urinal. A half-hour later, however, he was found with an acute onset of slurred speech and a left-side weakness. A CT scan without contrast – ordered at 6:34 a.m., performed at 6:48 a.m., and reviewed at 7:01 a.m. – showed an acute right frontoparietal parenchymal hemorrhage. The results were orally reported at 7:06 a.m., and a stroke code was called at 7:14 a.m. The stroke team, in consultation with an attending neurologist, issued orders shortly thereafter. The tPA and Heparin were discontinued and reversed; plaintiff was intubated for airway protection. A CT angiogram with contrast, performed at 7:37 a.m., ruled out an aneurysm or an arteriovenous malformation (AVM). An MRI of the brain, with and without contrast, were later performed on September 18, 2014 and ruled out an AVM. Plaintiff remained hospitalized at Lutheran until November 17, 2014 when he was discharged for rehabilitation. On discharge from Lutheran, he was allegedly permanently paralyzed on his left side and was suffering from residual neurological deficits.

I.
Plaintiff's Request for Spoliation Sanctions

In his opposition papers, plaintiff requests an order imposing sanctions against the Doctors, premised on their alleged spoliation of evidence. He argues that the Doctors' answer should be stricken or that a lesser sanction of an adverse inference charge at trial should be given because of their alleged destruction of or their failure to produce any images from the Aug. 24th venogram. The Court, as a threshold matter, will address plaintiff's request for the imposition of spoliation sanctions.

Plaintiff's Contentions

In support of his request for spoliation sanctions, plaintiff relies on the affirmation of his expert – a board-certified general and vascular surgeon (plaintiff's expert) – who opines that the absence of the Aug. 24th venogram images from plaintiff's chart is suspicious because his chart contains at least nine of his other imaging studies performed over the course of his two years of treatment at Total Vascular. Plaintiff's expert asserts that, as a general matter, a vascular surgery practice must preserve such studies in its patients' records as the justification for treatment. More particular to this case, plaintiff's expert opines that plaintiff's "run of the mill" venous insufficiency did *not* warrant a highly invasive stent-implant procedure because its risks far outweighed its benefits. Plaintiff's expert posits that the Aug. 24th venogram images may have been withheld because the actual findings therein did not correspond to Dr. Ascher's findings during the stent-implant procedure. Further, plaintiff's expert asserts that only the images from the Aug. 24th venogram could reflect the actual, *pre-stent* appearance or pathology of plaintiff's left iliac vein.

Accordingly, plaintiff's expert concludes that he is unable, without the Aug. 24th venogram images, to properly evaluate the Doctors' assessment of plaintiff's condition before the stent-implant procedure.

The Doctors' Response

In response, the Doctors contend that plaintiff overlooks a submission from a Total Vascular technician who was present during the Aug. 24th venogram (the technician) and who in her affidavit addresses (1) in general, how imaging studies were recorded and preserved at Total Vascular in 2014, and (2) specifically to this case, the results of her search for the Aug. 24th venogram images. The technician's affidavit was produced on December 15, 2017 and served on all parties both electronically and by regular mail as part of the Doctors' further response to plaintiff's discovery demands.

The technician's affidavit states that the affiant was unable to recall whether any images were recorded during the Aug. 24th venogram. The technician explained that in 2014, surgeons and surgical staff had the ability to view x-ray images taken intraoperatively, in real time, for the purpose of intraoperative fluoroscopic guidance. The technician's averment is corroborated by Dr. Ascher's affirmation and his deposition testimony that he would not have reviewed fluoroscopy images on a CD/DVD during the procedure, as discs were only used to preserve images that may have been temporarily recorded on the x-ray machine's hard drive. Although the technician was able to locate the CD/DVD that would have been used to preserve any fluoroscopic images that may have been temporarily recorded on the x-ray machine's hard drive during the Aug. 24th venogram, the CD/DVD contained no images. Even assuming, arguendo, that fluoroscopic images were temporarily recorded on the x-ray

machine's hard drive but inadvertently were not copied onto the CD/DVD for their contemporaneous preservation, that omission would not demonstrate spoliation of evidence, as the failure to preserve the Aug. 24th venogram imaging would have occurred at or around the time of that venogram, well before the Doctors were on notice that the images might be needed for future litigation.

Discussion

Initially, the Court observes that plaintiff made no motion or cross motion for an order imposing spoliation sanctions on the Doctors. Because plaintiff is seeking this relief by way of his opposition to defendants' summary judgment motions, his request is procedurally improper (*see generally* CPLR 2214, 2215; *Khaolaead v Leisure Video*, 18 AD3d 820, 821 [2d Dept 2005]). Nonetheless, as the Doctors oppose plaintiff's request on the merits, the Court will address the issue.

As the Appellate Division, Second Department, summarized the law in this area:

> "Under the common-law doctrine of spoliation, when a party negligently loses or intentionally destroys key evidence, thereby depriving the nonresponsible party of the ability to prove its claim, the responsible party may be sanctioned by the striking of its pleading. However, a less severe sanction is appropriate where the absence of the missing evidence does not deprive the moving party of the ability to establish his or her case. The determination of a sanction for spoliation is within the broad discretion of the court."

(*Gotto v Eusebe-Carter*, 69 AD3d 566, 567-568 [2010] [internal citations omitted]).

The Court finds that plaintiff has failed to establish that the Doctors destroyed or lost the Aug. 24th venogram imaging *after* they were placed on notice that it might be needed for future litigation. Dr. Ascher was not aware that the Aug. 24th venogram imaging may be relevant to this litigation until after an amended bill of particulars was served on him in

January 2018. Because this was over four years after the imaging at issue would have been recorded (if at all), plaintiff cannot establish that the Doctors intentionally or negligently failed to preserve it (*see Dessources v Good Samaritan Hosp.*, 65 AD3d 1008, 1010 [2d Dept 2009], *lv denied* 13 NY3d 713 [2009]; *Sloane v Costco Wholesale Corp.*, 49 AD3d 522, 523 [2d Dept 2008]). "Where a party did not discard crucial evidence in an effort to frustrate discovery, and cannot be presumed to be responsible for the disappearance of such evidence, spoliation sanctions are inappropriate" (*Cordero v Mirecle Cab Corp.*, 51 AD3d 707, 709 [2d Dept 2008]).

Further, the technician's affidavit makes a prima facie showing that the Aug. 24th venogram imaging may not have been saved on a CD/DVD and that even if it had been so saved, a diligent search only produced a blank CD/DVD. Plaintiff has failed to refute the Doctors' showing in that regard. "The careless loss of a record is not willful" (*Tawedros v St. Vincent's Hosp. of N.Y.*, 281 AD2d 184, 184 [1st Dept 2001]).

More fundamentally, the Aug. 24th venogram imaging is not necessary for plaintiff to prove his case. The condition of plaintiff's veins at the time of the stent-implant procedure is reflected in, among other things, the contemporaneous notes prepared by Dr. Ascher and his operative assistant. Because other records contain the same information that plaintiff claims is missing, he has failed to establish that the unavailability of the Aug. 24th venogram imaging fatally compromises his ability to prove his case (*see Coleman v Putnam Hosp. Ctr.*, 74 AD3d 1009, 1011 [2d Dept 2010], *lv dismissed* 16 NY3d 857 and 884 [2011]; *Geffner v North Shore Univ. Hosp.*, 57 AD3d 839, 841 [2d Dept 2008]).

Accordingly, the Court declines to impose any sanctions on the Doctors for their alleged spoliation of the Aug. 24th venogram imaging.

II.
The Medical Malpractice Claim Against the Doctors and Lutheran; The Negligent Hiring and Credentialing Claim Against Lutheran

The Doctors' Contentions

In support of their summary judgment motion, the Doctors assert that they did not deviate from good and accepted medical practice in their care and treatment of plaintiff. In so arguing, they rely on an expert affirmation from Peter L. Faries, M.D., a board certified general and vascular surgeon. According to Dr. Faries, plaintiff suffered from *preexisting* chronic and debilitating venous insufficiency, as reflected by his complaints on his initial presentation to Total Vascular in October 2012 and thereafter, as such complaints were repeatedly confirmed by the tests and procedures performed on him. Dr. Faries notes that plaintiff's symptoms, despite various treatments, including the use of compression stockings and a December 2012 radio-frequency ablation, did not abate and, in fact, worsened by the time he returned to Total Vascular in March 2014, when lipodermatosclerosis was noted. Dr. Faries further notes that by August 2014, plaintiff was no longer able to wear compression stockings and that he continued to have pain, edema, and discoloration of his lower extremities. Dr. Faries concludes that in light of plaintiff's clinical history and symptoms, it was appropriate for the Doctors to diagnose plaintiff with venous insufficiency.

Dr. Faries is further of the opinion that Dr. Ascher appropriately recommended on August 3, 2014 a lower extremity venogram with a possibly ensuing stent-implant procedure. Dr. Faries explains that the common iliac veins lie deep in the pelvis, a potential stenosis of

these veins often cannot be observed on an ordinary ultrasound study but can be accurately visualized only on a venogram. Because plaintiff's clinical history and symptoms were consistent with chronic venous insufficiency, and because prior, more conservative methods to alleviate his insufficiency had failed, it was appropriate, in Dr. Faries' opinion, for Dr. Ascher to consider additional factors that may have contributed to plaintiff's unremitting symptoms, including stenosis of the common iliac veins.

Dr. Faries characterizes as baseless the plaintiff's contention that Dr. Ascher erroneously diagnosed him with severe venous disease and that the stent-implant procedure was medically contraindicated. Dr. Faries emphasizes that plaintiff's clinical history and symptoms (*i.e.*, pain, swelling, and discoloration of his lower extremities) was strongly indicative of significant venous disease. Further, Dr. Faries points out that a 60%-70% stenosis of the mid-common iliac vein, as was observed on the Aug. 24th venogram, exceeded the 50% threshold for stent placement in patients, such as plaintiff, with the clinical history and symptoms of venous disease. Dr. Faries observes that stent placement is commonly used to correct venous stenosis, carries few risks, and represents the standard of care in the venous disease treatment. Thus, according to Dr. Faries, no medical basis exists to conclude that Dr. Archer's diagnosis and/or treatment of plaintiff was in any way improper.

Dr. Faries next addresses plaintiff's charge that he should have been immediately placed on anticoagulation therapy following the stent-implant procedure. In Dr. Faries' view, there was no absolute indication that plaintiff needed anticoagulation therapy at that time because venous stents rarely become thrombosed. Dr. Faries notes that anticoagulation therapy carries its own separate risks, including that of hemorrhage, and thus ought not to be

commenced prophylactically. Dr. Faries further notes that although plaintiff's stent ultimately became thrombosed, his opinion remains unchanged because hindsight may not be used in evaluating the propriety of a physician's medical judgment.

Dr. Faries next opines that plaintiff was appropriately monitored following the stent-implant procedure. Plaintiff was discharged home with a scheduled follow-up appointment in four days. When plaintiff timely returned to Total Vascular for a follow-up on August 28, 2014, his complaint of an acute, occlusive DVT was promptly diagnosed, and he was referred to Lutheran where he was admitted the same day. Dr. Faries underscores the importance of promptly treating a patient, like plaintiff, for an occluded venous stent because (1) blood clots pool over time making them more difficult to remove; (2) not treating a partially occluded stent may entail the occlusion of the entire vessel; and (3) blood clots may travel to the heart, lungs, and brain, potentially causing fatal pulmonary embolism. Dr. Faries explains that unlike Heparin, Coumadin and other anticoagulants, only a thrombolytic agent, such as tPA, is capable of dissolving blood clots. In Dr. Faries' opinion, thrombectomy was an appropriate therapy for the treatment of an occluded stent under the circumstances because, compared to the administration of anticoagulation alone, it can achieve significant improvement in the patients' symptoms. Dr. Faries further opines that it was appropriate for intravenous Heparin to be administered in tandem with a thrombolytic agent to prevent the development of new blood clots. Dr. Faries observes that intravenous Heparin was in plaintiff's case a more effective anticoagulation agent than oral Coumadin because Heparin (1) is faster acting, (2) can be discontinued and reversed more quickly in the event of a complication, and (3) can be administered more precisely.

Addressing plaintiff's claim that his history of headaches, dizziness, and unsteady gait were not properly appreciated, Dr. Faries notes that his complaints were not vascular in nature and were thus appropriately followed by his primary care physician, Dr. Hyman, who was kept abreast of the Doctors' treatment of plaintiff. Dr. Faries points out that Drs. Ascher and Hingorani as consulting physicians were only responsible for addressing complaints related to the specific condition for which they were consulted (*i.e.*, lower extremity venous insufficiency). Dr. Faries further points out that Dr. Ascher requested and obtained a medical clearance from Dr. Hyman before the stent-implant procedure and thus satisfied his (Dr. Ascher's) responsibility to ensure that plaintiff was medically cleared for the procedure.

Dr. Faries next addresses plaintiff's contentions that Drs. Ascher and Hingorani failed to (1) complete an adequate neurologic or vascular examination, (2) obtain a neurology consultation, or (3) to conduct a work up for an aneurysm, AVM, or other brain abnormality before administering a thrombolytic agent. Dr. Faries summarily rejects these contentions as medically unsupported – it is *not* the accepted standard of care to obtain a neurology consultation/clearance before performing a venogram, implanting a stent, or performing thrombolysis for an occluded stent in the lower extremities. Dr. Faries maintains that intracranial bleeding is a known risk of thrombolysis that may occur with (or without) the presence of other neurological or vascular conditions, and that the risk of such bleeding is so insignificant (1-2%) that a prior neurological or other screening was *not* required. As a general matter, according to Dr. Faries, brain MRIs or other brain-imaging studies performed before thrombolysis have *not* been demonstrated to reduce the incidence of intracranial bleeding.

Dr. Faries concludes that appropriate vascular imaging studies were performed to identify plaintiff's vein stenosis, to diagnose his occluded stent, and to identify the presence of residual clots. In fact, an aneurysm and AVM were ruled out by a subsequent CT angiogram study and an MRI at Lutheran.

Dr. Faries opines that Dr. Ascher properly performed the thrombectomy. In Dr. Faries' view, the dose of tPA which Dr. Ascher administered into the occluded segment, as well as his efforts to suction out as many of the clots as possible, were both appropriate. According to Dr. Faries, the performance of an intraoperative venogram following the thrombectomy was a standard practice, as it allowed Dr. Ascher to determine if the procedure was successful and if any other clots remained. Here, the post-thrombectomy venogram reflected considerable improvement in plaintiff's condition. That a few clots remained in the left iliac and the common femoral veins after thrombectomy did not, according to Dr. Faries, demonstrate that it was improperly performed, as the lysing of a large clot can leave residual clots that may be difficult to remove immediately with a suction catheter. Dr. Faries notes that inasmuch as the residual clots could consolidate and thus pose further risks to a patient's health, it was appropriate for Dr. Ascher to manage plaintiff's venous thrombosis and anticoagulation in a hospital setting and to recommend a follow-up venogram and possible thrombolysis depending on the presence, size, and location of the remaining clots. To this end, Dr. Faries points out that Lutheran's records reflect that plaintiff was appropriately continued on Heparin to prevent the development of further clots and that his anticoagulation status was closely monitored.

Dr. Faries next opines that the infusion-catheter procedure on September 2, 2014 was indicated and was properly performed by Dr. Hingorani in accordance with the standard of care. The pre-procedure venogram revealed an approximately 50% thrombosis of the stent – a finding that plainly justified (1) the placement of an infusion catheter for the direct administration of tPA, and (2) the continuation of Heparin. In Dr. Faries' view, appropriate dosages of both medications were administered because (1) Heparin alone would not have dissolved plaintiff's then-existing clot; and (2) a failure to treat the remaining stent occlusion would entail complications. Dr. Faries notes that between the infusion-catheter procedure on September 2, 2014 and the following morning, plaintiff was closely monitored in Lutheran's ICU for any signs of bleeding. In this regard, Dr. Faries notes that Lutheran's records reflect that he had no complaints overnight apart from a mild allergy unrelated to the administration of tPA. Dr. Faries further notes that when an acute deterioration in plaintiff's mental state was first noted in the morning of September 3, 2014, he was quickly diagnosed with a stroke and came under the care of a stroke team, a neurologist, and a neurosurgeon. Appropriate steps were promptly taken to ensure plaintiff's continued safety, including discontinuing and reversing the tPA and Heparin, and intubating him for airway access. Dr. Faries opines that these facts refute plaintiff's allegations that he was not closely monitored for signs of hemorrhage and that his stroke was not promptly diagnosed and addressed once it occurred.

Dr. Faries concludes that although it was unfortunate that plaintiff suffered a stroke, its occurrence, in and of itself, is not reflective of a deviation from good and accepted

medical practice. It is inevitable that some patients will experience adverse treatment outcomes despite receiving the best possible medical care.

Lutheran's Contentions

In support of its separate summary judgment motion, Lutheran submits that plaintiff's private physicians, Dr. Ascher and Dr. Hingorani, directed and controlled all of his treatment during his hospitalization at Lutheran, and that the Lutheran staff followed all of the Doctors' orders properly and promptly. Lutheran submits that no order by the Doctors was so clearly contraindicated by normal medical practice that its staff should have intervened or questioned their judgment.

Lutheran's position is supported by an affirmation from Nicholas J. Morrisey, M.D. (Dr. Morrisey), a board-certified surgeon and vascular surgeon. Dr. Morrisey opines that the development of blood clots, or a DVT, is a generally known risk of stent placement and that plaintiff developed a clot in his left leg days after the stent-implant procedure. Dr. Morrisey further opines that plaintiff's contentions that Lutheran departed from the standard of care by failing to obtain an adequate history of his condition is belied by the record.

Dr. Morrisey opines that plaintiff's claim that the Lutheran staff negligently failed to obtain a pre-thrombectomy MRI/MRA, is without merit, as decisions concerning *preoperative* testing and treatment of plaintiff were within the exclusive purview of the private physicians. Dr. Morrisey further opines that, in any event, the Lutheran staff's decision to omit these tests was appropriate because the standard of care did not require the performance of an MRI/MRA before the inception of the DVT treatment. Dr. Morrisey next

opines that (1) there was no departure from the standard of care, on the Lutheran staff's part, in administering tPA and Heparin to treat the DVT because – again – it was within the purview of plaintiff's private physicians to determine his course of treatment; and (2) in any event, the management of his DVT by his private physicians was based on sound medical judgment, and was not contraindicated by his age, clinical history, and/or symptoms.

Dr. Morrisey next opines that there is no merit to plaintiff's claim that the Lutheran staff failed to timely and properly diagnose and treat his stroke. As noted, when the Lutheran staff first observed that plaintiff had a drooping lip in the morning of September 3, 2014, its ICU staff immediately discontinued plaintiff's tPA and Heparin and ordered a stat brain CT scan. Dr. Morrisey notes that the Lutheran staff promptly called a stroke code and followed all stroke protocols, with plaintiff receiving treatment from specialists in the areas of intensive care, neurology, and neurosurgery.

Lastly, Dr. Morrisey rejects plaintiff's claim that the Lutheran staff failed to properly monitor his INR levels. In this regard, Dr. Morrisey points out that Dr. Ascher and Dr. Hingorani each testified at their pretrial depositions that each would routinely monitor plaintiff's INR after the infusion-catheter procedure. According to Dr. Morrisey, nothing that Dr. Ascher and Dr. Hingorani allegedly did or failed to do concerning plaintiff's INR level was so clearly contraindicated by normal medical practice that the Lutheran staff should have intervened in their treatment plan of plaintiff.

Apart from Dr. Morrisey's affirmation, Lutheran relies on an affidavit from Deborah Hackshaw (Hackshaw), an employee of the Department of Risk Management at NYU Langone Hospitals (NYU) which merged with Lutheran in January 2016. Ms. Hackshaw

avers in her affidavit that between 2012 and 2015, both Drs. Ascher and Hingorani were physicians in private practice, with privileges to admit and treat their private patients at Lutheran. Ms. Hackshaw explains that although Dr. Ascher was the Chief of the Division of Vascular and Endovascular Surgery at Lutheran, and Dr. Hingorani acted as his assistant in his absence, neither of them provided any patient care in that capacity; in their administrative role, each of them provided divisional leadership, administrative oversight, teaching, and supervision. Lutheran argues that it cannot be held vicariously liable for the alleged negligence of either Dr. Ascher or Dr. Hingorani by virtue of their purely administrative positions at Lutheran.

Lastly, Lutheran contends that plaintiff in his complaint asserted only two causes of action; namely, medical malpractice and lack of informed consent. In his bill of particulars, however, plaintiff further asserted that Lutheran was negligent in hiring and/or credentialing of Drs. Ascher and Hingorani. Lutheran submits that since the negligent hiring and/or credentialing claim is not pleaded in the complaint, it is entitled to summary judgment dismissing such claim.

Plaintiff's Opposition

In opposition to the summary judgment motions, plaintiff contends, based on the affirmation of his expert that there were numerous departures from good and accepted standards of medical care by each of the defendants. Plaintiff's expert contends that the injuries that plaintiff sustained were caused (1) initially by the negligent and medically unjustified stent-implant procedure performed by Dr. Ascher on August 24, 2014 in his office; (2) the negligent use of tPA as part of the thrombectomy performed by Dr. Ascher on

August 29, 2014 at Lutheran; and (3) the negligent use of tPA as part of the infusion-catheter procedure performed by Dr. Hingorani on September 2, 2014 also at Lutheran. In addition, plaintiff's expert claims that the Lutheran staff, which allegedly includes Drs. Ascher and Hingorani, committed medical malpractice in connection with plaintiff's emergency room admission on August 28, 2014 for the occluded stent. Plaintiff's expert further claims that Dr. Ascher, Dr. Hingorani, and other members of the Lutheran staff failed to obtain an accurate history of plaintiff's illness and to order additional consults to rule out any abnormal brain pathology (*e.g.*, an aneurysm or an AVM) before administering tPA to him.

Plaintiff's expert asserts that for at least two years before the treatment at issue and while plaintiff remained under Dr. Ascher's and Dr. Hingorani's care, he manifested overt signs and symptoms of an AVM/aneurysm, such as severe and chronic headaches. Plaintiff's expert opines that since his procedures were not performed on an emergency basis and he was in stable condition, there was ample time to perform testing to rule out any abnormal brain pathology *before* considering the administration of tPA. Plaintiff's expert further asserts that plaintiff's signs and symptoms (which, in their opinion, manifested a potential for an intracranial bleeding) were completely overlooked. According to plaintiff's expert, it was not until after plaintiff suffered a stroke at Lutheran on September 3, 2014 that a CT scan was performed, confirming a ruptured/bleeding AVM/aneurysm in his brain. Plaintiff's expert opines that the Lutheran staff, including Drs. Ascher and Hingorani, critically erred in their treatment of plaintiff's non-emergent DVT, which, in lieu of the stent-implant procedure, should have been treated with standard anticoagulation alone. Plaintiff's expert further opines that plaintiff's condition, already worsened by the unnecessary stent-implant

procedure, was exacerbated by Dr. Ascher's and Dr. Hingorani's negligence in administering tPA to him not once but twice – initially on August 29, 2014 as part of the thrombectomy and subsequently on September 2, 2014 as part of the infusion-catheter procedure.

Plaintiff's expert avers that all of plaintiff's injuries were completely iatrogenic in nature and totally avoidable if the appropriate and medically indicated care had been provided to him in accordance with good and accepted medical practice. Plaintiff's expert maintains that plaintiff's condition was not the type of the severe end-stage venous insufficiency that required the implantation of a stent, anticoagulation, and a tPA administration. Plaintiff's expert avers that implanting a stent into plaintiff's left iliac vein, as opposed to the right vein or bilaterally, would have been appropriate to treat several fairly unique syndromes or conditions which plaintiff definitively did not have. Plaintiff's expert submits that because plaintiff was stable when he was admitted to Lutheran with an occluded stent only, he should not have had a thrombolytic administered to him.

Plaintiff's expert points out that during the course of the approximately two years of his preceding treatment at Total Vascular, the appearance and symptomatology of his venous insufficiency remained essentially unchanged. Plaintiff's expert explains that in order to document disease progression, vascular surgeons commonly employ a classification system known as "C-E-A-P," which stands for Clinical, Etiology, Anatomy, and Pathophysiology. The C-E-A-P classification identifies what the practitioner finds on physical examination ("Clinical"), the cause of the problem ("Etiology"), the location in the leg ("Anatomy"), and the mechanism responsible ("Pathophysiology"). Plaintiff's expert emphasizes that at no point, either before 2012 or after plaintiff presented in March 2014, did Dr. Ascher ever

document (1) plaintiff's bilateral lower extremity measurements which would have included his peripheral pressure measurements; (2) his peripheral pulses; (3) descriptions of his varicose veins, including the size or location of varicosities; and (4) photographs or evaluations of his alleged vascular insufficiency. In fact, plaintiff's expert points out, the photographs of plaintiff's lower legs reflect no significant findings.

Plaintiff's expert explains that there are many forms of treatment for venous insufficiency, ranging from the least invasive, such as exercise, diet, and compression stockings, to pharmacology, skin and ulcer care, laser ablation procedures, sclerotherapy, and ultimately surgery. Plaintiff's expert notes that stent-implant procedures which involve an intravascular placement of a foreign body inside a diseased vein are reserved for the most severe cases where, unlike plaintiff's case, significant blood flow to the patient's legs is compromised. In plaintiff's case, however, physical examinations documented normal peripheral pulses, some skin dryness, and no observed vascular obstructions. Plaintiff's expert notes that Dr. Ascher's examination of plaintiff's legs during the March 18, 2014 visit indicated that (1) his peripheral pulses and venous mapping were normal; (2) there was no evidence of thrombosis; and (3) no vascular abnormalities were noted. Plaintiff's expert further notes that the only conservative measures that were employed to treat plaintiff's minor complaints were the use of compression stockings and a single session of the radio-frequency ablation.

Plaintiff's expert opines that the standard of care for the treatment of plaintiff's DVT would be a starting loading dose of Heparin, followed by an infusion of Heparin, followed by oral anticoagulants, such as Warfarin or Coumadin. Plaintiff's expert asserts that an acute

cerebral hemorrhage in plaintiff's case was directly caused by his undergoing thrombolysis/tPA, which, in his opinion, was unnecessary and medically contraindicated.

Plaintiff's expert next contends that plaintiff's most notable complaints, as documented in his medical chart at Total Vascular, were severe and chronic headaches, weakness, palpitations, shortness of breath, and numbness in the low back. Plaintiff's expert points out that plaintiff's complaints notwithstanding, neither Doctor performed a neurological or other evaluation to determine the origin of the complaints. Plaintiff's expert rejects the Doctors' claim that a neurological work-up was outside their realm of expertise, or that it was uncalled for, since both of them are vascular specialists, well trained and equipped to work up vascular brain anomalies.

In addressing Lutheran's alleged negligence, plaintiff's expert notes that plaintiff's hospital chart reveals that, apart from the Doctors, there were countless other physicians and staff members at Lutheran who were involved in his care, including the ICU physicians, attendings, residents, interns and nursing staff, none of whom plaintiff met before his hospitalization at Lutheran. Plaintiff's expert refers to Dr. Ascher's pretrial testimony stating that although he (Dr. Ascher) was the admitting physician, he was not in charge of plaintiff's care at all times; rather, whoever was on call that day was in charge of examining him and in managing his care. Plaintiff's expert also refers to Dr. Ascher's pretrial testimony stating that on plaintiff's admission to the ICU, the ICU physicians took over his care. Plaintiff's expert notes that Lutheran should be held liable because plaintiff was admitted, through its emergency room, to Dr. Ascher's service. Plaintiff's expert next asserts that Drs. Ascher and Hingorani were not merely private attending physicians, but were employed, respectively,

as the Chief and Assistant Chief of Vascular Surgery at Lutheran, and thus Lutheran should be held vicariously liable for their acts or omissions.

Plaintiff's expert underscores that on plaintiff's admission to Lutheran on August 28, 2014, not a single Lutheran physician requested a neurological consult, took adequate history, conducted an adequate physical examination, or noted his previously well-documented neurological deficits. According to plaintiff's expert, the Lutheran staff failed to rule out a vascular anomaly in plaintiff's brain or to appreciate the potential for his intracranial bleeding.

Plaintiff's expert further asserts that Lutheran has a serious problem maintaining complete records, which is also a departure from good and accepted standards of medical care. Plaintiff's expert notes that during Dr. Hingorani's deposition, it became apparent that a large portion of Lutheran's paper records were lost during their scanning into digital form. Plaintiff's expert observes that plaintiff's chart contains not a single consult note by either Doctor, which, in his opinion, constitutes a departure from the accepted standards of care, particularly because Dr. Hingorani performed the infusion-catheter procedure at Lutheran. Plaintiff's expert finds this to be extremely troubling, considering that plaintiff suffered a stroke in the early morning of the day following the infusion-catheter procedure.

The Doctors' Reply

In reply, the Doctors urge the Court not to consider the affidavit of plaintiff's expert because plaintiff's contention that he suffered from an undiagnosed vascular brain anomaly is belied by the record. The Doctors point out that when plaintiff first exhibited signs of a stroke on September 3, 2014, appropriate testing was immediately ordered, and he was

properly treated. The Doctors emphasize that none of the subsequent studies performed at Lutheran indicate that plaintiff suffered from an aneurysm or an AVM. The Doctors note that although plaintiff's expert asserts a potential nexus between plaintiff's headaches and his other alleged neurological complaints, plaintiff's expert does *not* opine whether any of his neurological symptoms were, in fact, exhibited during his visits to Total Vascular between November 2012 and August 2014, or during his preoperative clearance by Dr. Hyman in August 2014. The Doctors contend that plaintiff's expert ignores the transient nature of plaintiff's neurological complaints. The Doctors further contend that although plaintiff alleges that he suffered anxiety and some numbness in the lower back, his expert fails to note that plaintiff was taking Prozac (an antidepressant) for two years prior, and that he had back injuries from a prior (2011) automobile accident.

The Doctors note that whereas it is undisputed that an intracranial hemorrhage is an unlikely but known risk of thrombectomy, plaintiff's expert offers no *other* basis for his/her opinion of its contraindication. In this regard, plaintiff's expert offers no support for his or her opinion that a DVT should have been treated with Heparin, followed by oral anticoagulants, and that all that plaintiff needed was anticoagulation, as his body's natural processes, on their own, would have lysed the clot. The Doctors assert that plaintiff's expert's opinion fails to respond to Dr. Faries' points that (1) anticoagulants do not dissolve clots; (2) only thrombolytics, like tPA, dissolve existing clots; (3) anticoagulants may be given in tandem with a thrombolytic to prevent the development of new clots; (3) it is rare for the body's natural processes to lyse clots on their own and that, when it does happen, it happens months or years later and, in any event, does not restore normal venous function; and

(4) failing to promptly treat an occluded stent carries significant risks, including occlusion of the entire vessel and pulmonary embolism. The Doctors argue that by failing to address any of the considerations propounded by Dr. Faries, plaintiff has failed to demonstrate a question of fact as to whether thrombolysis was indicated, since there can be no dispute that thrombolysis was the only treatment available to timely address plaintiff's occluded stent and that, as noted above, failing to use thrombolysis carried significant risks.

The Doctors next reject plaintiff's expert's opinion that the stent-implant procedure was medically unnecessary. In the Doctors' view, plaintiff's expert has failed to recognize that plaintiff had been suffering from a severe venous insufficiency and that his venous condition had deteriorated over time. The Doctors emphasize that the Aug. 24th venogram revealed a 60-to-70 percent mid-common iliac vein stenosis, as manifested by the bull's eye sign – a radiological appearance of severe stenosis on fluoroscopy. The Doctors contend that these undisputed facts and test results (which are not mentioned by plaintiff's expert or counsel in opposition) conclusively demonstrate the severity of plaintiff's venous condition and his urgent need to undergo a stent-implant procedure.

The Doctors note that although plaintiff's expert argues that more conservative treatments should have been employed, plaintiff's expert neglects to identify any such treatments and fails to explain how they would have alleviated plaintiff's venous symptoms. The Doctors further note that plaintiff's expert concedes that stenting is reserved for severe cases of venous insufficiency where significant blood flow to the legs is compromised, which, the Doctors submit, was the case with plaintiff. The Doctors point out that plaintiff had a significant compromise of the blood flow to his legs because of a 60%-70% stenosis

of the mid-common iliac vein – significantly in excess of the 50% threshold for stent placement. The Doctors further point out that plaintiff's expert does not propound any alternative forms of treatment for his venous stenosis.

Discussion

A defendant establishes a prima facie entitlement to judgment as a matter of law by demonstrating, through the deposition testimony, medical records, and the affirmation of their expert, that there was no departure from good and accepted medical practice, and, in any event, that any alleged departure was not a proximate cause of the plaintiff's injuries (*see Lahara v Auteri*, 97 AD3d 799 [2d Dept 2012]). "[T]o sustain this burden, the defendant is only required to address and rebut the specific allegations of malpractice set forth in the plaintiff's complaint and bill of particulars" (*Schuck v Stony Brook Surgical Assoc.*, 140 AD3d 725, 726 [2d Dept 2016]).

"In opposition, a plaintiff then must submit material or evidentiary facts to rebut the defendant's prima facie showing that he or she was not negligent in treating the plaintiff" (*Dolan v Halpern*, 73 AD3d 1117, 1118 [2d Dept 2010] [internal quotation marks omitted]). "[P]laintiff need only raise a triable issue of fact regarding the element or elements on which the defendant has made its prima facie showing" (*McCarthy v Northern Westchester Hosp.*, 139 AD3d 825, 826 [2d Dept 2016] [internal quotation marks omitted]). Further, "general allegations of medical malpractice that are conclusory and unsupported by competent evidence tending to establish the essential elements of medical malpractice are insufficient to defeat a malpractice defendant's motion for summary dismissal" (*Melendez v Parkchester Med. Servs., P.C.*, 76 AD3d 927, 927 [1st Dept 2010]).

It has been held that "[t]o defeat summary judgment, the [plaintiff's] expert's opinion must demonstrate the requisite nexus between the malpractice allegedly committed and the harm suffered" (*Anyie B. v Bronx Lebanon Hosp.*, 128 AD3d 1, 3 [1st Dept 2015] [internal quotation marks omitted]). In other words, a plaintiff's expert must address the issue of causation (*see generally Ducasse v New York City Health & Hosps. Corp.*, 148 AD3d 434, 436 [1st Dept 2017]).

It is also well settled that summary judgment may not be awarded in a medical malpractice action where the parties offer conflicting expert opinions, which present a credibility question requiring a jury's resolution (*see e.g. Loaiza v Lam*, 107 AD3d 951, 953 [2d Dept 2013]; *Dandrea v Hertz*, 23 AD3d 332, 333 [2d Dept 2005]).

In addressing the alleged liability of a hospital to whom a private patient is admitted, it has been held that:

> "Generally speaking, a hospital may not be held vicariously liable for the negligence of a private attending physician chosen by the patient. Moreover, so long as the resident physicians and nurses employed by the hospital have merely carried out that private attending physician's orders, a hospital may not be held vicariously liable for resulting injuries. These rules will not, however, shield a hospital from liability in three situations. The first is when the private physician's orders so greatly deviate from normal medical practice that the hospital's employees should be held liable for failing to intervene. . . . . Second, a hospital may be held liable when its employees have committed independent acts of negligence. Third, a hospital may be held liable for the negligence of a private, nonemployee physician on a theory of ostensible or apparent agency."

(*Doria v Benisch*, 130 AD3d 777, 777-778 [2d Dept 2015] [internal quotation marks, citations, and alterations omitted]).

It is equally well settled that "while a hospital would not ordinarily be vicariously liable for the malpractice of a physician who is not an employee, an exception to the general rule exists where a patient comes to the emergency room seeking treatment from the hospital and not from a particular physician of the patient's choosing" (*Smolian v Port Auth. of N.Y. & N.J.*, 128 AD3d 796, 801 [2d Dept 2015] [internal quotation marks omitted]; *see generally Mduba v Benedictine Hosp.*, 52 AD2d 450, 453 [3d Dept 1976]). "Thus, in order to establish its entitlement to judgment as a matter of law defeating a claim of vicarious liability, a hospital must demonstrate that the physician alleged to have committed the malpractice was an independent contractor and not a hospital employee and that the exception to the general rule did not apply" (*Muslim v Horizon Med. Group, P.C.*, 118 AD3d 681, 683 [2d Dept 2014] [internal quotation marks omitted]).

Further, it must be noted that:

> "Although physicians owe a general duty of care to their patients, that duty may be limited to those medical functions undertaken by the physician and relied on by the patient. The question of whether a physician owes a duty to the plaintiff is a question for the court, and is not an appropriate subject for expert opinion."

(*Donnelly v Parikh*, 150 AD3d 820, 822 [2d Dept 2017] [internal quotation marks, citations, and alterations omitted]).

As is also relevant here, it has been held that:

> "It was improper for the plaintiff to assert, for the first time in her bill of particulars, a cause of action alleging negligent supervision of [the infant plaintiff]. Although a bill of particulars may be used to amplify the allegations in a complaint, and considered in determining the sufficiency of a pleaded cause of action, *a bill of particulars may not be used*

> *to supply allegations essential to a cause of action that was not pleaded in the complaint.*"

(*Alami v 215 E. 68th St., L.P.*, 88 AD3d 924, 925-926 [2d Dept 2011] [internal citations omitted; emphasis added]; *accord Sullivan v St. Francis Hosp.*, 45 AD3d 833, 834 [2d Dept 2007]).

Disposition of Doctors' Summary Judgment Motion on Medical Malpractice Claim

The court initially finds that Dr. Ascher and Dr. Hingorani have made a prima facie showing of entitlement to summary judgment by submitting Dr. Faries' expert affirmation which, as described in detail above, demonstrates that there was no departure from accepted standards of care in their care and treatment of plaintiff (*see generally Sukhraj v New York City Health & Hosps. Corp.*, 106 AD3d 809, 810 [2d Dept 2013]). The Court's finding is further supported by Dr. Morrisey's expert affirmation submitted on Lutheran's behalf.

The Court further finds that plaintiff has not made a showing sufficient to refute the Doctors' entitlement to summary judgment, as plaintiff's expert failed to address the specific issues raised by defendants' experts. Plaintiff's medical records do not support his claim that the injuries that he sustained were proximately caused by the Doctors' alleged acts or omissions. Plaintiff's medical records at Total Vascular indicate that he had been suffering from serious vascular issues in his legs *long before* he presented to the Doctors for treatment, considering that Dr. Hingorani noted that plaintiff's left greater saphenous vein had been previously obliterated. Plaintiff's expert is silent on this significant point. Further, the contention of plaintiff's expert that plaintiff's venous condition remained substantially the same in the two years during which he was treated at Total Vascular is unsupported. Plaintiff continued to return to see the Doctors with the complaints of increasing pain, and his

physical examinations, as described in detail above, revealed that his condition was worsening. In addition, although plaintiff's expert claims that treatment that was less invasive than the stent-implant procedure could have been undertaken to treat plaintiff, his expert fails to consider that prior conservative treatment, including compression socks and a radio-frequency ablation, failed to correct his condition or to provide him with lasting relief. Plaintiff's expert further fails to identify any other less invasive measures that could have been undertaken. Plaintiff's expert ignores the crucial fact that the Aug. 24th venogram, performed before the stent-implant procedure, revealed a 60-to-70 percent mid-common iliac vein stenosis, as manifested by the bull's eye sign.

The Court further rejects plaintiff's expert's opinion that plaintiff should not have been given the medications prescribed by the Doctors. In this regard, plaintiff's expert's assertion that plaintiff's body would have lysed the clots in the occluded stent on its own without the further procedures performed at Lutheran, is factually unsupported. Indeed, despite the administration of Heparin and tPA, the clots in plaintiff's leg continued to worsen. Inasmuch as plaintiff's expert again offers no alternative treatments that he or she believes would have restored function to plaintiff's veins, the only reasonable conclusion is that absent the Doctors' treatment, plaintiff's venous circulation would have continued to deteriorate.

Plaintiff's expert's claim that the Doctors should have subjected plaintiff to neurological studies and should have treated his headaches and backaches, does not withstand scrutiny. There is no support for plaintiff's expert's blanket assertion that the headaches and backaches were a continuing cause of concern, since no medical records

substantiating that claim have been submitted from Dr. Hyman. The Doctors, as specialists specifically retained to treat the veins in plaintiff's legs, owed him no general duty of care (*see e.g. Donnelly*, 150 AD3d at 822; *see Mosezhnik v Berenstein*, 33 AD3d 895, 897 [2d Dept 2006]; *see generally Wasserman v Staten Is. Radiological Assoc.*, 2 AD3d 713, 714 [2d Dept 2003] [radiologist defendants established their prima facie entitlement to summary judgment by presenting evidence that they did not depart from good and accepted medical practice because they only examined plaintiff's X-ray films, did not treat her, and deferred to the orthopedic specialists for her assessment and treatment]).

Accordingly, the Doctors' motion for summary judgment dismissing the medical malpractice claim against them is granted, and such claim is dismissed.

Disposition of Lutheran's Summary Judgment Motion on Medical Malpractice Claim and Negligent Hiring/Credentialing Claim

Having granted summary judgment to Dr. Ascher and Dr. Hingorani, the Court finds that Lutheran is also entitled to summary judgment dismissing plaintiff's medical malpractice claim. Accordingly, the court need not reach the issue whether the Doctors were (or were not) Lutheran's employees.

The branch of Lutheran's motion for summary judgment dismissing plaintiff's claim for negligent hiring and/or credentialing of the Doctors or any other of its employees or staff is also *granted*. As noted, it was improper for plaintiff to assert such a claim for the first time in his bill of particulars (*see Alami*, 88 AD3d at 925-926; *Sullivan*, 45 AD3d at 834). In any

event, plaintiff's opposition has failed to allege any facts that would support his claim for negligent hiring and/or credentialing.

III.
Lack of Informed Consent Claim

The Doctors' Contentions

In support of this branch of their summary judgment on plaintiff's lack of informed consent claim, the Doctors contend that as per the treatment plan first established by Dr. Ascher, the option for a venogram with possible thrombectomy was presented to plaintiff on September 1, 2014, the day before the infusion-catheter procedure. After the risk, benefits, and alternatives, including the possibility of intracranial bleeding, were explained to plaintiff, he elected to proceed and signed a consent form for the infusion-catheter procedure. That Dr. Ascher's (rather than Dr. Hingorani's) name erroneously appeared on the consent form for the infusion-catheter procedure was a scrivener's error, since the record is clear that plaintiff knew that Dr. Hingorani (rather than Dr. Ascher) would be performing it.

As to the stent-implant procedure, the records and pretrial testimony reflect that plaintiff was specifically informed that the stent could become occluded by blood clots. As to the thrombectomy at Lutheran (the procedure that was performed in between the stent-implant procedure and the infusion-catheter procedure), plaintiff was again apprised of its risks, benefits, and alternatives, including intracranial bleeding, but he elected to proceed with the procedure anyway and signed a consent form. As was the case with the stent-implant procedure, a reasonably prudent patient, particularly one with a long history of

morbidity on account of venous insufficiency, would, in Dr. Faries' opinion, consent to the thrombectomy despite a remote possibility of intracranial bleeding.

Lutheran's Contentions

In support of this branch of its motion for summary judgment dismissing plaintiff's lack of informed consent claim, Lutheran similarly contends that Dr. Ascher properly informed plaintiff of the risks of the stent-implant procedure and explained that the goal of stenting was to improve venous blood flow. Next, Lutheran points out, that the night before the thrombectomy, plaintiff executed a consent form authorizing its performance. Then, the day before the infusion-catheter procedure, plaintiff executed a consent form authorizing the performance of a left lower extremity venogram, possible thrombectomy, thrombolysis and angioplasty of the left iliac vein.

Plaintiff's Opposition

In opposition, plaintiff's expert emphasizes that defendants failed to obtain plaintiff's informed consent to the stent-implant procedure. According to plaintiff's expert, the records and pretrial testimony indicate the lack of a detailed discussion with plaintiff apprising him of (1) the true state of his medical condition; (2) the reasons, or the lack thereof, for the placement of the stent; and (3) the risks and benefits of placing the stent in the first place. In plaintiff's expert's view, had plaintiff been fully apprised of the actual risks and benefits of the stent-implant, procedure, it is reasonable to assume that he would have declined it.

Discussion

Public Health Law § 2805-d provides that the claim for:

> "[L]ack of informed consent means the failure of the person providing the professional treatment or diagnosis to disclose to the patient such alternatives thereto and the reasonably foreseeable risks and benefits involved as a reasonable medical . . . practitioner under similar circumstances would have disclosed, in a manner permitting the patient to make a knowledgeable evaluation."

"Lack of informed consent is a distinct cause of action requiring proof of facts not contemplated by an action based merely on allegations of negligence" (*Figueroa-Burgos v Bieniewicz*, 135 AD3d 810, 811 [2d Dept 2016] [internal quotation marks omitted]). It is well settled that a hospital is *not* obligated to obtain a patient's informed consent when the patient is treated by his own private attending physician unless it knew or should have known that the physician was acting or would act without the patient's informed consent (*see Tomeo v Beccia*, 127 AD3d 1071, 1074 [2d Dept 2008]; *see also Doha v Benisch*, 130 AD3d 777, 778 [2d Dept 2015] [where a private physician attends his patient at a hospital, it is the duty of the physician, not the hospital, to obtain the patient's informed consent]).

It is undisputed here both the thrombectomy and the infusion-catheter procedure were performed at Lutheran by plaintiff's private attending physicians, Dr. Ascher and Dr. Hingorani. Plaintiff has made no showing that Lutheran had any reason to know that plaintiff's private physicians would perform either procedure without first obtaining plaintiff's informed consent. Hence, Lutheran was under no obligation to obtain, on its own, the plaintiff's informed consent to either procedure.

Moreover, the record includes the consent forms which plaintiff personally executed before the applicable procedure at Lutheran. His pretrial testimony reflects that he was informed of the risks, benefits, and alternatives to both procedures. Accordingly, plaintiff's lack of consent claim against the Doctors and Lutheran are dismissed.

Conclusion

Accordingly, based on the foregoing and after oral argument, it is

ORDERED that in Seq. No. 4, Lutheran's motion for summary judgment is *granted in its entirety*, and all of plaintiff's claims against Lutheran are dismissed without costs or disbursements; and it is further

ORDERED that in Seq. No. 5, the Doctors' motion for summary judgment is *granted in its entirety*, and all of plaintiff's claims against the Doctors (as defined in this decision, order, and judgment) are dismissed without costs or disbursements; and it is further

ORDERED that all other relief requested is denied.

The foregoing constitutes the decision, order, and judgment of this Court.

E N T E R,

Ellen M. Spodek, J.S.C.