Thompson-Cassie v Sarabanchong
2020 NY Slip Op 30654(U)
February 25, 2020
Supreme Court, Kings County
Docket Number: 508316/16
Judge: Bernard J. Graham
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At an IAS Term, Part 36 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 25th day of February, 2020.

PRESENT:

HON. BERNARD J. GRAHAM,
Justice.

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LEVONIE THOMPSON-CASSIE and EVON CASSIE,

Plaintiffs,

- against -

Index No. 508316/16

VORAVUT ORD SARABANCHONG, M.D., PAUL SCOTT AARONSON, M.D., MARINA ARTIOUKHINA, M.D., MARINA ARTIOUKHINA MEDICAL P.C. and MT. SINAI HOSPITAL OF QUEENS,

Defendants.

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The following e-filed papers read herein:	NYSCEF Docket No.:
Notice of Motion/Cross Motion and Affidavits (Affirmations) and Exhibits Annexed	89-91, 108-110, 138-139, 152
Opposing Affidavits (Affirmations)	159-160, 169
Reply Affidavits (Affirmations)	171, 172-173

Upon the foregoing papers, defendant Paul Scott Aaronson, M.D., (motion sequence number 4), defendants Voravut Ord Sarabanchong, M.D. and The Mount Sinai Hospital s/h/a Mt. Sinai Hospital of Queens (Mount Sinai) (motion sequence number 5), and defendants Marina Artioukhina, M.D., and Marina Artioukhina Medical, P.C., (motion sequence number

6) move, by way of separate motions, for an order, pursuant to CPLR 3212, granting them summary judgment dismissing the complaint as against them.

Dr. Aaronson's motion (motion sequence number 4) is granted to the extent that the lack of informed consent cause of action is dismissed and the medical malpractice cause of action is dismissed with respect to any claim relating to treatment rendered prior to August 18, 2014 and after August 21, 2014. Dr. Aaronson's motion is otherwise denied.

The portion of Dr. Sarabanchong and Mount Sinai's motion (motion sequence number 5) relating to the care rendered by Dr. Sarabanchong is granted and the complaint is dismissed as against Dr. Sarabanchong. The portion of Dr. Sarabanchong and Mount Sinai's motion relating to Mount Sinai is granted to the extent that Mount Sinai's liability is based on the care rendered by Dr. Sarabanchong, Dr. Artioukhina, and Mount Sinai's hospital staff, but is denied to the extent that Mount Sinai's liability is premised on Mount Sinai's vicarious liability for the actions of Dr. Aaronson, as an agent or apparent or ostensible agent of Mount Sinai, relating to his treatment of plaintiff between the period August 18, 2014 and August 21, 2014.

Dr. Artioukhina and Marina Artioukhina Medical P.C.'s motion (motion sequence number 6) is granted, and the complaint is dismissed as against them.

In this action involving causes of action premised on medical malpractice and lack of informed consent, plaintiff Levonie Thompson-Cassie[1] alleges that defendants' malpractice

[1] Plaintiff Evon Cassie's claims are derivative only. All singular references to plaintiff relate to plaintiff Levonie Thompson-Cassie.

during a laparoscopic supracervical hysterectomy and right bilateral salpingectomy, performed on August 18, 2014, caused a thermal injury to plaintiff's right ureter and that plaintiff suffered from unnecessary complications as a result of defendants' malpractice during the follow-up care relating to the injury to the right ureter.

Plaintiff first saw Dr. Artioukhina, a gynecologist, in August 2013, and at that time, she had already been diagnosed by her primary care doctor as suffering from fibroids and menometrorrhagia, a condition which involves abnormally heavy, prolonged, and irregular uterine bleeding. Because Dr. Artioukhina did not perform surgeries, she referred plaintiff to Dr. Sarabanchong.

To address this condition, Dr. Sarabanchong, with the assistance of Dr. Artioukhina, performed laparoscopic surgery on August 18, 2014. While Dr. Artioukhina assisted in this procedure, she asserted in her deposition testimony that she did not manipulate any instruments during the surgery. Toward the end of the surgery, Dr. Sarabanchong performed a cystoscopy to assess the condition of the ureters,[2] and found that no urine was being effluxed from the right ureter into the bladder. Believing that the instruments used to cut and cauterize during the surgery might have caused a thermal or burn injury to the right ureter, Dr. Sarabanchong contacted Dr. Aaronson, the on-call attending urologist, regarding the issue, and Dr. Aaronson thereafter came to the operating room to evaluate and assess the ureter.

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[2] The ureters are the tubes that carry urine from the kidneys to the bladder.

After a intravenous pyelogram study failed to provide any useful information, Dr. Aaronson then conducted a retrograde pyeloureterogram, which involved the insertion of a small catheter through the bladder and into the kidney, and the release of dye viewable on a flouroscope as the catheter was withdrawn from the ureter. Given that Dr. Aaronson was able to insert the catheter all the way into the kidney, he determined that there was no obstruction in the ureter. The study, however, was inconclusive in that it did not show the dye flowing all the way into the bladder from the kidney, but it also did not show dye leaking out of the ureter into the body cavity. As he could not rule out an injury to the ureter, Dr. Aaronson decided to reinstate the catheter all the way into the kidney for the time being.

Dr. Sarabanchong thereafter proceeded with the laparoscopy. Prior to closing the surgical field, Dr. Sarabanchong performed an inspection of the ureters, and noticed that he could see the blue catheter[3] through the mucosa or wall of the ureter. Upon observing this catheter, Dr. Sarabanchong called Dr. Aaronson, who was on his way home at the time. At his deposition, Dr. Aaronson stated that the ability to see the catheter through the mucosa of the ureter suggested that the ureter had suffered a thermal injury. Dr. Aaronson, however, decided not to return to the operating room to further evaluate the injury to the ureter because he had decided to proceed with a conservative course of treatment, which included leaving the catheter in the ureter. The fact that plaintiff may have suffered a thermal injury did not

[3] Although Dr. Sarabanchong identified what he saw as a stent, Dr. Aaronson testified that what he had installed in the ureter was a catheter, not a stent.

change Dr. Aaronson's mind pertaining to his prescribed course of treatment for plaintiff at that time.

On August 21, 2014, Dr. Aaronson saw plaintiff, who was still at Mount Sinai following her surgery, and on that day conducted further testing that demonstrated that the right kidney was performing properly, but failed to definitively show the cause of the injury to the ureter. During the procedure, Dr. Aaronson removed the catheter from the ureter that he had installed on August 18, 2014, and inserted a stent[4] into the ureter that ran from the kidney to the bladder. Dr. Aaronson testified at his deposition that his intention was to proceed conservatively by leaving the stent in for two to three weeks, with the hope that the ureter would heal itself in that time period.

Plaintiff presented at Dr. Aaronson's office on September 5, 2014 with complaints of severe pain in the area of the stent and Dr. Aaronson removed the stent and ordered a follow-up ultrasound and prescribed antibiotics. On September 7, 2014, plaintiff went to Mount Sinai's emergency room with complaints of frequent urination and dehydration. A CT Scan revealed the extravasation or leaking of the contrast agent from the right ureter into the cul-de-sac. This extravasation was apparently the cause of urine leaking through a vaginal incision made during the August 18, 2014 laparoscopy and then out of the vagina. Plaintiff was ultimately admitted to Mount Sinai, and on September 8, 2014, Dr. Aaronson placed a

[4] As described by Dr. Aaronson at his deposition, the stent was a hollow tube with curved ends that, once inserted in the kidney and bladder, prevented the stent from slipping or being pulled out of either organ.

new stent into the right ureter, and also placed a new Foley catheter. Dr. Aaronson still believed that the ureter could heal itself, and thus continued with a conservative approach.

Dr. Aaronson removed the stent during a procedure conducted at Mount Sinai on October 23, 2014. During the procedure, Dr. Aaronson noted a possible stricture or narrowing of the ureter based on a retrograde pyelogram he performed on that day. Plaintiff was discharged from Mount Sinai following the procedure with directions to follow-up in 7 to 10 days. On October 26, 2014, plaintiff returned to Mount Sinai and was diagnosed with hydronephrosis secondary to stricture of the ureter and sepsis. On that day, Dr. Aaronson used a balloon to dilate the area of the stricture, and reinserted another stent. Plaintiff appeared at Dr. Aaronson's office for a follow-up visit on November 4, 2014, and various treatment options were discussed, but plaintiff did not return to him as a patient and was thereafter treated by doctors associated with another hospital. Plaintiff, in April 2015, underwent a surgery that involved the removal of the damaged portion of the ureter and the reimplantation of the undamaged portion of the ureter into the bladder.

It is in this factual context that the defendants' respective motions must be considered. With respect to the malpractice cause of action, "[i]n order to establish the liability of a professional health care provider for medical malpractice, a plaintiff must prove that the provider 'departed from accepted community standards of practice, and that such departure was a proximate cause of the plaintiff's injuries'" (*Schmitt v Medford Kidney Ctr.*, 121 AD3d 1088, 1088 [2d Dept 2014], quoting *DiGeronimo v Fuchs*, 101 AD3d 933, 936 [2d Dept

2012] [internal quotation marks omitted]; *see Hutchinson v New York City Health & Hosps. Corp.*, 172 AD3d 1037, 1039 [2d Dept 2019]). A defendant moving for summary judgment dismissing a medical malpractice action must make a prima facie showing either that there was no departure from accepted medical practice, or that any departure was not a proximate cause of the patient's injuries (*see Hutchinson*, 172 AD3d at 1039; *Williams v Bayley Seton Hosp.*, 112 AD3d 917, 918 [2d Dept 2013]; *Makinen v Torelli*, 106 AD3d 782, 783-784 [2d Dept 2013]). "Once the health care provider has made such a showing, the burden shifts to the plaintiff to demonstrate the existence of a triable issue of fact, but only as to the elements on which the defendant met the prima facie burden" (*Schmitt*, 121 AD3d at 1088; *see Hutchinson*, 172 AD3d at 1039; *Stukas v Streiter*, 83 AD3d 18, 30 [2d Dept 2011]).

In support of the summary judgment motion, Dr. Sarabanchong has submitted an affirmation from Dr. Theodore Goldman, M.D., a board certified gynecologist and obstetrician. Dr. Goldman asserts that, in view of the operative report and Dr. Sarabanchong's deposition testimony, Dr. Sarabanchong exercised proper care to visualize and protect the ureters during the procedure. Dr. Goldman notes, however, that injury to the ureters is a well known risk of the procedure, and, here, the field of dissection was close to the ureters (*see Henry v Duncan*, 169 AD3d 421, 421 [1st Dept 2019]).[5] Contrary to the allegations of plaintiff's bill of particulars and amended bill of particulars that Dr.

[5] Matthew P. Rutman, M.D., who is a board certified urologist, similarly asserts, in the affirmation submitted in support of Dr. Aaronson's motion, that an injury to the ureter is a known complication of the surgery performed by Dr. Sarabanchong, and is one which, more often than not, occurs in the absence of malpractice.

Sarabanchong was negligent in failing to place ureteral catheters prior to surgery in order to help identify the ureter intraoperatively, Dr. Goldman asserts that the consensus of the medical community does not support preoperative stent or catheter placement and that such a procedure has not been recommended by various medical bodies. Dr. Goldman further asserts that controlled studies do not document any difference in the injury rates during major gynecoligic surgery with and without prophylactic stenting. While not required based on the standard of care, Dr. Goldman notes that some surgeons use prophylactic stenting when patients have a history of severe endometriosis, pelvic abscess or cancer. Nevertheless, Dr. Goldman asserts that the use of the stent was not indicated here because plaintiff did not suffer from any of those conditions, and because the use of a stent does not reduce the risk of injury to the ureters. Finally, Dr. Goldman asserts that Dr. Sarabanchong properly deferred to Dr. Aaronson's decisions regarding the management of the ureter injury during Dr. Aaronson's consultation during the surgery, his consultation over the telephone near the end of the surgery, and with respect to the post surgical care of the injury.

Based on this affidavit, the deposition testimony in the record and the medical records, Dr. Sarabanchong has demonstrated his prima facie entitlement to summary judgment dismissing the medical malpractice cause of action based on the absence of any departures from accepted medical practice (*see Hutchinson*, 172 AD3d at 1039-1040; *Khosrova v Westerman*, 109 AD3d 965, 966 [2d Dept 2013]; *Mitchell v Lograno*, 108 AD3d 689, 692-

693 [2d Dept 2013]). This prima facie showing has shifted the burden to plaintiff to demonstrate the existence of a factual issue with respect to Dr. Sarabanchong's care.

In opposing the motion, plaintiff has submitted an affirmation from a board certified urologist.[6] Initially, Dr. Sarabanchong asserts that the affirmation from plaintiff's urologist may not be considered with respect to the care rendered by Dr. Sarabanchong because his or her specialty is urology, not obstetrics or gynecology. This court, however, finds that plaintiff's urologist has adequately explained his or her familiarity with laparoscopic surgeries performed in the area of the ureters, including surgeries involving hysterectomies, such that his or her affirmation may be considered despite the fact that plaintiff's expert is not a obstetrician/gynecologist (*see M.C. v Huntington Hosp.*, 175 AD3d 578, 580 [2d Dept 2019]; *Mezzone v Goetz*, 145 AD3d 573, 574 [1st Dept 2016], *lv dismissed* 29 NY3d 1074 [2017]; *Leavy v Merriam*, 133 AD3d 636, 637-638 [2d Dept 2015]; *Frank v Smith*, 127 AD3d 1301, 1303 [3d Dept 2015]; *Walsh v Brown*, 72 AD3d 806, 807 [2d Dept 2010]; *Ocasio-Gary v Lawrence Hosp.*, 69 AD3d 403, 404-405 [1st Dept 2010]; *Dykstra v Avalon Rest. Renovations, Inc.*, 60 AD3d 446, 446 [1st Dept 2009]; *Humphrey v Jewish Hosp. & Med. Ctr.*, 172 AD2d 494, 494 [2d Dept 1991]).

Nevertheless, the court concludes that the opinion by plaintiff's urologist that Dr. Sarabanchong was required to take the additional step of inserting a catheter into the ureter

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[6] Although the name and signature of plaintiff's urologist have been redacted from the affidavit attached to plaintiff's opposition papers, plaintiff has submitted a copy of the unredacted original to the court for in camera review (*see Stucchio v Bikvan*, 155 AD3d 666, 667 [2d Dept 2017]).

during the course of the surgery, or, having an intraoperative consultation with a urologist to perform the same is without probative value. In this respect, plaintiff's urologist fails to address Dr. Goldman's contention that the use of a stent or a catheter during the course of the surgery to identify the ureter does not reduce the risk of injury to the ureters and is not called for by the applicable standard of care (*see Iodice v Giordano*, 170 AD3d 971, 973 [2d Dept 2019]; *Tsitrin v New York Community Hosp.*, 154 AD3d 994, 996 [2d Dept 2017]; *DiLorenzo v Zaso*, 148 AD3d 1111, 1114 [2d Dept 2017]).

Plaintiff's urologist concedes that it was appropriate for Dr. Sarabanchong to call on Dr. Aaronson for a consultation during the procedure once Dr. Sarabanchong determined that there may have been a problem with the ureter, but asserts that Dr. Sarabanchong departed from accepted medical practice in failing to mention to Dr. Aaronson that the right ureter had been close to the operating field and that it may have suffered a thermal injury. This representation by plaintiff's urologist, however, misrepresents Dr. Sarabanchong's deposition testimony, in that Dr. Sarabanchong testified that he told Dr. Aaronson that he was concerned about a uterial injury, but could not recall if he had specifically mentioned the possiblity of a thermal injury. In any event, Dr. Aaronson testified at his deposition that, when he came in for the consultation, Dr. Sarabanchong told him that he suspected a possible thermal injury to the ureter. Dr. Sarabanchong thus provided Dr. Aaronson with all the information plaintiff's urologist believed was necessary for Dr. Aaronson to perform a proper evaluation.

Plaintiff's urologist finally opines that Dr. Sarabanchong departed from accepted medical practice in failing to ensure that Dr. Aaronson returned to the operating room after observing the catheter through the wall of the ureter, which is an observation consistent with a thermal injury. Dr. Aaronson, in his deposition testimony, emphasized that his telephone conversation with Dr. Sarabanchong, wherein Dr. Sarabanchong informed him that he (Dr. Sarabanchong) had observed a possible thermal injury, did not change Dr. Aaronson's plan for the management of plaintiff's injury. In asserting that Dr. Sarabanchong should have required that Dr. Aaronson return to the operating room, plaintiff's urologist fails to explain, in other than conclusory terms, why Dr. Sarabanchong could not rely on the plan of care chosen by Dr. Aaronson, a urologist specifically trained for treating ureter injuries, such as those sustained by plaintiff (*see Doe v Schwarzwald*, 142 AD3d 578, 579 [2d Dept 2016]; *Perez v Edwards*, 107 AD3d 565, 566 [1st Dept 2013], *lv denied* 22 NY3d 862 [2014]; *Dombroski v Samaritan Hosp.*, 47 AD3d 80, 84-86 [3d Dept 2007]; *Wasserman v Staten Is. Radiological Assoc.*, 2 AD3d 713, 714 [2d Dept 2003]). Accordingly, the affirmation of plaintiff's urologist fails to demonstrate the existence of factual issues with respect to Dr. Sarabanchong's care and, accordingly Dr. Sarabanchong's motion with respect to the medical malpractice cause of action is granted.

Dr. Artioukhina and Marina Artioukhina Medical P.C. are likewise entitled to summary judgment dismissing the medical malpractice claims as against them, in view of the dismissal of the action as against Dr. Sarabanchong since Dr. Artioukhina only acted as Dr.

Sarabanchong's assistant during the surgery, did not exercise any independent medical judgment, and did not handle any instruments (*Soto v Andaz*, 8 AD3d 470, 471 [2d Dept 2004]; *see Quille v New York City Health & Hosp. Corp.*, 152 AD3d 808, 809 [2d Dept 2017]; *Boston v Weissbart*, 62 AD3d 517, 518 [1st Dept 2009]).[7]

Turning to the medical malpractice claims as against Dr. Aaronson, Dr. Aaronson has submitted an affirmation from Matthew Rutman, M.D., a board certified urologist. Dr. Rutman asserts that during the initial consultation, Dr Aaronson performed appropriate tests relating to the function of the ureter, and, as these tests did not definitively demonstrate the nature of the injury, Dr. Aaronson appropriately elected to pursue a conservative course of treatment by leaving the catheter in the ureter. According to Dr. Rutman, Dr. Aaronson was not required to return to the operating room or alter his conservative treatment plan when Dr. Sarabanchong informed him of his observation of the catheter through the wall of the ureter. In this regard, Dr. Rutman asserts that the observation made by Dr. Sarabanchong was not definitive proof of a thermal injury and did not include any observation of a partial or complete transection of the ureter that would require surgical intervention. Dr. Rutman opines that Dr. Aaronson appropriately continued with the conservative treatment of relying on stent placement both following the surgery and upon the discovery of the fistula on

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[7] Plaintiff has not opposed the motion by Dr. Artioukhina and Marina Artioukhina Medical P.C. Although plaintiff has submitted a copy of a stipulation purporting to discontinue the action as against Dr. Artioukhina and Marina Artioukhina Medical P.C., the copy of the stipulation submitted was not signed by all the parties to the action and thus does not comply with the requirements of a voluntary discontinuance without a court order (*see* CPLR 3217 [a] [2]).

September 7, 2014. According to Dr. Rutman, progress was made through this treatment, as testing conducted on October 23, 2014 showed that the fistula had healed. Dr. Rutman asserts that the stricture that had developed was the result of scar tissue from the original injury, and was not caused by any of Dr. Aaronson's treatment regimen. Based on this affidavit, the deposition testimony in the record and the medical records, Dr. Aaronson has demonstrated his prima facie entitlement to summary judgment dismissing the medical malpractice cause of action based on the absence of any departures from accepted medical practice (*see Hutchinson*, 172 AD3d at 1039-1040; *Khosrova*, 109 AD3d at 966; *Mitchell*, 108 AD3d at 692-693).

In opposition, plaintiff's urologist asserts that Dr. Aaronson departed from accepted standards of care by failing, during his consultation, to perform additional testing, such as a ureteral catherter ureterogram or a visual inspection of the strictures at issue through open surgical dissection to assess the nature and extent of the injury to the ureter. Contrary to Dr. Rutman's opinion, plaintiff's urologist asserts that Dr. Sarabanchong's ability to visualize the ureter through the wall of the ureter was a red flag suggesting a thermal injury, and that Dr. Aaronson should have returned to the operating room at that time to further evaluate the injury. Plaintiff's urologist asserts that the standard of care required that a thermal injury be treated by surgical intervention, not conservative management, because a thermal injury, even if it does not result in a transection of the ureter, will cause the development of scar tissue as it heals that will result in the occlusion of the ureter and ultimately necessitate

surgery. According to plaintiff's urologist, the repair should have been conducted on August 18, 2014, or by August 21, 2014, which would have avoided the creation of the fistula, the stricture, infection, and other complications, including plaintiff's continuing complaints of flank pain, chronic interstitial cystitites and urinary urgency.

As plaintiff's urologist explains his or her opinions and points to facts in the medical record submitted to the court that support his or her assertions, the affirmation cannot be rejected as wholly conclusory, as defendant suggests, and this court finds that it is sufficient to demonstrate the existence of factual issues with respect to both liability and causation warranting denial of the motion with respect to Dr. Aaronson's liability (*see Neyman v Doshi Diagnostic Imaging Servs., P.C.*, 153 AD3d 538, 544-546 [2d Dept 2017]; *Omane v Sambaziotis*, 150 AD3d 1126, 1129 [2d Dept 2017]; *Leto v Feld*, 131 AD3d 590, 592 [2d Dept 2015]; *Polanco v Reed*, 105 AD3d 438, 441-442 [1st Dept 2013]; *Olgun v Cipolla*, 82 AD3d 1186, 1187 [2d Dept 2011]; *Bell v Ellis Hosp.*, 50 AD3d 1240, 1241-1242 [3d Dept 2008]). The conflicting opinions of the experts with respect to Dr. Aaronson's care thus present an issue of credibility that must be determined by a jury (*see Cummings v Brooklyn Hosp. Ctr.*, 147 AD3d 902, 904 [2d Dept 2017]; *Leto*, 131 AD3d at 592). Nevertheless, as Dr. Aaronson played no role in plaintiff's treatment before August 18, 2014 and plaintiff's urologist does not address whether Dr. Aaronson committed any departures after August 21,

2014, Dr. Aaronson is entitled to dismissal of the complaint to the extent that plaintiff alleges that he is liable for treatment rendered prior to and after those dates.[8]

With respect to plaintiff's lack of informed consent cause of action as against Dr. Sarabanchong, Dr. Artioukhina and Dr. Aaronson, these defendants have demonstrated their prima facie entitlement to dismissal of that cause of action through evidence that they obtained appropriate informed consent from plaintiff prior to performing the procedures at issue. (*see Schuck v Stony Brook Surgical Assoc.*, 140 AD3d 725, 727 [2d Dept 2016]; *Zapata v Buitriago*, 107 AD3d 977, 980 [2d Dept 2013]). Plaintiff, who did not address this issue in her opposition papers, has failed to demonstrate the existence of a factual issue warranting denial of the motions with respect to the lack of informed consent cause of action (*see Brady v Westchester County Healthcare Co.*, 78 AD3d 1097, 1099 [2d Dept 2010]).

Regarding the portion of Dr. Sarabanchong and Mount Sinai's motion addressed to Mount Sinai's liability, the court notes that, in moving for summary judgment, Mount Sinai was only required to address its vicarious liability for the actions of Dr. Sarabanchong, Dr. Artioukhina and Dr. Aaronson, as the only specific allegations of malpractice outlined in plaintiff's complaint, bill of particulars and amended bill of particulars relate to the care rendered by them (*see Schuck*, 140 AD3d at 726 [in moving for summary judgment, a

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[8] The court finds that Dr. Rutman's assertion that plaintiff's current complaints cannot be attributed to Dr. Aarsonson's treatment to be conclusory, and, in any event, the assertions of plaintiff's urologist that certain of plaintiff's current complaints were caused by the failure to perform a corrective surgery in August 2014 are sufficient to demonstrate the existence of a factual issue on this issue (*see Polanco*, 105 AD3d at 441-442).

defendant is only required to address and rebut the specific allegations of malpractice set forth in the plaintiff's complaint and bill of particulars]; *Bhim v Dourmashkin*, 123 AD3d 862, 865 [2d Dept 2014]; *Suits v Wyckoff Heights Med. Ctr.*, 84 AD3d 487, 489 [1st Dept 2011]).[9] As the action must be dismissed on the merits as against Dr. Sarabanchong and Dr. Artioukhna, Mount Sinai's liability turns solely on its potential liability for the care rendered by Dr. Aaronson (*see Shenoy v Kaleida Health*, 162 AD3d 1701, 1702 [4th Dept 2018]; *Smith v Watkins*, 145 AD3d 596, 597 [1st Dept 2016]; *see also Mitchell v Goncalves*, ___ AD3d ___, 2020 NY Slip Op 00268, *2 [2d Dept 2020]).

Mount Sinai argues that it may not be held liable for Dr. Aaronson's care because he was a private attending physician who was not employed by Mount Sinai. While the deposition testimony of Dr. Aaronson may be sufficient to establish that he was not an employee of Mount Sinai, his testimony does not otherwise demonstrate, as a matter of law, that he was not acting as an agent of the hospital for purposes of vicarious liability (*see Mitchell*, 2020 NY Slip Op 00268, *2; *see also Fuessel v Chin*, ___ AD3d ___, 2020 NY Slip Op 00404, *3 [2d Dept 2020]). Particularly relevant, in this respect, is the undisputed fact that plaintiff entered Mount Sinai for the purpose of the laproscopic surgery to be performed by Dr. Sarabanchong, a Mount Sinai employee. Plaintiff had no prior connection with Dr. Aaronson, and had no expectation that she would be treated by him. Dr. Aaronson

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[9] The court notes that plaintiff, in opposing the portion of the motion addressed to Mount Sinai's liability, makes no argument that Mount Sinai's staff committed any independent act of negligence relating to plaintiff's care.

only ended up being involved in plaintiff's care because he was the on-call attending urologist. Dr. Aaronson provided no testimony regarding any agreement he may have had with Mount Sinai regarding his on-call responsibilities, and Mount Sinai has failed to submit any contracts or agreements with Dr. Aaronson in this regard demonstrating that he was not under its control while acting in that role (*see Fuessel*, 2020 NY Slip Op 00404, *3; *Mitchell*, 2020 NY Slip Op 00268, *2; *Castro v Durban*, 161 AD3d 939, 942 [2d Dept 2018]; *Contreras v Adeyemi*, 102 AD3d 720, 722 [2d Dept 2013]).[10] As such, Mount Sinai has failed to demonstrate it prima facie entitlement to summary judgment dismissing the action as against it for Dr. Aaronson's actions and this portion of Dr. Sarabanchong and Mount Sinai's motion must be denied regardless of the sufficiency of plaintiff's opposition papers (*see Winegrad v New York Univ. Med. Ctr.*, 64 NY2d 851, 853 [1985]).

The caption is amended to read:

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[10] The facts may also demonstrate factual issues with respect to whether Mount Sinai may be held liable for Dr Aaronson's care under an ostensible or apparent agency theory even though she did not enter Mount Sinai through the emergency room given that plaintiff entered the hospital for purposes of treatment by one of its employees (*but see Palgano v Christakos*, 104 AD3d 501, 502 [1st Dept 2013]).

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LEVONIE THOMPSON-CASSIE and EVON CASSIE,

Plaintiffs,

- against -

Index No. 508316/16

PAULSCOTT AARONSON, M.D. and
MT. SINAI HOSPITAL OF QUEENS,

Defendants.

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This constitutes the decision, order and judgment of the court.

ENTER,

J. S. C.

HON. BERNARD J. GRAHAM

KINGS COUNTY CLERK
FILED
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