| **Pantaleon v Garber** |
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| 2020 NY Slip Op 31830(U) |
| June 12, 2020 |
| Supreme Court, Kings County |
| Docket Number: 501122/16 |
| Judge: Ellen M. Spodek |
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At an IAS Term, Part MMESP-6 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 12th day of June, 2020.

P R E S E N T:
HON. ELLEN M. SPODEK,

Justice.

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DAVID PANTALEON A/K/A DAVID PANTALEON FLORES,

Plaintiff,

-against-

ALETHEA GARBER, M.D., JARED BRAZG, M.D., THOMAS DELGUERICO, M.D., AARON WINNICK, M.D. AND MMC MEDICAL CENTER,

Defendants.

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Decision and Order

Index No.: 501122/16

Motion Seq. No. 2

The following e-filed papers read herein: NYSCEF Doc. No.

Notice of Motion/Cross Motion, Affirmation (Affidavit), and Exhibits Annexed 44, 45, 49[1]
Affirmation (Affidavit) in Opposition and Exhibits Annexed 76
Reply Affirmation (Affidavit) and Exhibits Annexed 89

[1] There appears to be duplicative defendants' attorney affirmations in the record.

Defendants Alethea Garber, M.D. (Dr. Garber), Jared Brazg, M.D. (Dr. Brazg), and Maimonides Medical Center (MMC) (collectively, defendants)[2] move, pursuant to CPLR 3212, for an order granting them summary judgment dismissing the action.

***Background***

On July 11, 2015, at 12:32 a.m., plaintiff David Pantaleon (plaintiff) presented himself to the MMC ER (ER) with complaints of abdominal pain. A triage nurse examined him at 1:34 a.m. At 4:08 a.m., Dr. Brazg, a resident physician at MMC, examined plaintiff. Dr. Brazg's examination discerned that the origin of plaintiff's abdominal pain was the right lower abdominal quadrant. Among other medical observations, Dr. Brazg concluded that plaintiff's abdomen was soft, non-distended, with suprapubic tenderness on palpation. Dr. Brazg further observed no McBurney point tenderness rebounding or guarding. Based upon his observations, Dr. Brazg ordered various diagnostic tests to be performed on plaintiff. The tests results revealed, among other information, an elevated white blood cell count, elevated neutrophils, elevated lactic acid, and elevated glucose. Dr. Brazg developed a differential diagnosis that plaintiff was experiencing either gastroenteritis, a urinary tract infection, gastritis, or constipation. Though not documented, Dr. Brazg testified during his deposition that appendicitis was considered, but the lack of McBurney point tenderness eliminated it as a likely diagnosis. At 4:36 a.m. Dr. Brazg noted his conclusion that plaintiff suffered from

[2] Pursuant to court ordered stipulations of discontinuance, plaintiff's action was discontinued as to Thomas Delguerico, M.D. and Aaron Winnick, M.D.

gastroenteritis and that he should be discharged with instructions to follow up with his primary healthcare provider.

Shortly thereafter at 5:05 a.m., Dr. Alethea, the attending physician, conducted an independent medical examination of plaintiff. Dr. Alethea noted that plaintiff was afebrile with stable vital signs, and that his abdomen was soft and non-tender. Upon her medical examination and review of the various test results, Dr. Alethea rendered a diagnosis of gastroenteritis. She then discharged plaintiff with the directives to follow up with his primary healthcare provider or return to the ER if necessary.

The following day, plaintiff sought the attention of his primary care physician, Dr. Sholomon. After examining plaintiff, Dr. Sholomon directed plaintiff to return to the ER for further treatment. Thereafter, plaintiff went back to MMC and was seen by non-party physicians in the ER, at which point he underwent further examinations and a CT scan. Plaintiff was diagnosed with acute appendicitis, ultimately requiring surgery and various other medical procedures.

Plaintiff subsequently commenced the instant action asserting defendants committed medical malpractice by, among other acts, failing to diagnose his appendicitis upon his presentation to the ER on July 11, 2015. Further, plaintiff alleges an additional cause of action sounding in negligent hiring and supervision as against MMC, and a cause of action for lack of informed consent against all defendants.[3] Plaintiff asserts that

[3] In their summary judgement motion, defendants seek, among other relief, the dismissal of plaintiff's cause of action against MMC sounding in negligent hiring and supervision. Plaintiff affirmatively asserts that he does not oppose this branch of defendants' motion. Thus, such relief is granted as unopposed.

as a consequence of defendants' professional negligence, plaintiff alleges he suffered, among other injuries, cholelithiasis and non-alcholic Steatohepatitis, lingering fatigue and abdominal pain. Defendants interposed individual answers with various affirmative defenses. Defendants now jointly move for an order granting summary judgment in their favor dismissing all causes of action.

***The Parties' Positions***

Defendants' principle position is that Dr. Brazg and Dr. Garber's treatment of plaintiff was in accordance with the accepted community standards of medical care, thus they are entitled to summary judgment dismissing the action. Defendants argue that plaintiff's symptoms aligned with a diagnosis of gastroenteritis, and therefore the treatment did not deviate from good practice. Additionally, defendants assert that during plaintiff's stay at the ER, his condition improved without the aid of medication, further supporting the diagnosis of gastroenteritis and plaintiff's discharge. Additionally, defendants contend that there was no need to inform plaintiff of the risks associated with appendicitis prior to his discharge as this was not the diagnosis he received. In support of their position, defendants proffered, among other evidence, the expert affidavits of Dr. Dan Wiener, a board-certified physician specializing in emergency medicine and Dr. Peter Geller, a licensed physician specializing in general surgery. Both experts attest that their medical opinions are based upon, among other things, their respective review of plaintiff's relevant medical records, the testimonies of the parties, and their medical degrees and work experience.

Relying on this expert evidence, defendants argue that Dr. Brazg's examination of plaintiff and determination that he suffered from gastroenteritis was appropriate considering the diagnostic test results and plaintiff's symptoms. Dr. Wiener opines that based upon the symptoms exhibited by plaintiff - suprapubic tenderness, nausea, and loose stool - Dr. Brazg's determination of gastroenteritis aligned with the observed symptoms. Dr. Wiener further opines that Dr. Brazg's finding of no McBurney point tenderness, an examination specifically designed to elicit pain associated with appendicitis, demonstrates that appendicitis was considered, but as the test elicited a negative result, there was no need to further investigate into appendicitis with a CT scan or a consultation with a surgeon. Additionally, he opines that the discharge was appropriate as plaintiff was instructed to follow up with his primary care physician or return to MMC if his symptoms worsened, as the medical records indicate his condition improved during his stay in the ER. Beyond asserting that Dr. Brazg did not deviate from accepted medical standards in his treatment of plaintiff, Dr. Wiener further attested that Dr. Brazg "was a resident on July 11 and his role as a resident was to examine the patient and report the findings to the supervising attending, who was Dr. Garber" (affirmation of Dr. Dan Wiener at 8, ¶ 25). Finally, Dr. Wiener states that there was no reason to apprise plaintiff of the risks associated with a ruptured appendix as plaintiff was not diagnosed with appendicitis.

Similarly, Dr. Wiener asserts that his review of the relevant evidence supports his conclusion that Dr. Garber did not deviate from the standards of care and practice in diagnosing plaintiff with gastroenteritis. He opines that based upon Dr. Garber's review

of the diagnostic tests and her physical examination of plaintiff (notably her findings of suprapubic tenderness, lack of abdominal tenderness, and plaintiff's afebrile status, along with the elevated white blood cell count) she appropriately diagnosed plaintiff with gastroenteritis. Further, Dr. Wiener opines that Dr. Garber's discharge of plaintiff without a surgical consultation or conducting a CT scan did not deviate from the standard of care as her findings led her to a diagnosis of gastroenteritis and a CT scan is not required in every case of diffuse abdominal pain. Thus, Dr. Wiener asserts that, while the diagnosis was ultimately incorrect, Dr. Garber's treatment and examination of plaintiff did not deviate from accepted standards of medical care. Additionally, Dr. Wiener opines that there was no need to warn plaintiff of risks associated with appendicitis as this was not Dr. Garber's diagnosis.

Dr. Geller concurs with Dr. Wiener, asserting that the various examinations and test results are consistent with a diagnosis of gastroenteritis. Dr. Geller also asserts that plaintiff's alleged injuries were not caused by defendants' failure to diagnose appendicitis. He opines that plaintiff presented himself on July 11, 2015 with either a perforated appendix or an infection, which would have necessitated the same course of treatment he received the following day. Thus, there was only a minor delay in the proper diagnosis and treatment of plaintiff and defendants' misdiagnosis did not alter the ultimate treatment plaintiff received. Additionally, Dr. Geller's review of plaintiff's subsequent medical records demonstrated to him that plaintiff's allegations of continuing abdominal pain, fatigue, and diagnoses of cholelithiasis and non-alcoholic Steatohepatitis were not caused by defendant's failure to diagnose appendicitis. Both he and Dr.

Wiener conclude that none of the alleged departures are a substantial factor in causing any of plaintiff's injuries.

Thus, defendants ultimate argument is that the causes of action asserted against Dr. Brazg must be dismissed principally because he did not deviate from the normal standards of care, and to the extent that it could be argued that he did deviate, such deviations are not the proximate cause of plaintiff's injuries; however, alternatively, they maintain that as Dr. Brazg was a resident physician at the time and exercised no independent control over plaintiff's medical treatment, precedent dictates that he is exempt from possible liability for medical malpractice. Turning to the claims asserted against Dr. Garber, defendants argue that her treatment was appropriate at all times, and regardless of any deviation, was not the proximate cause of plaintiff's alleged injuries. Defendants argue that all claims against MMC must also be dismissed as the only liability theory against it is pursuant to respondeat superior. Similarly, defendants argue that plaintiff's lack of informed consent cause of action must also be dismissed as there was no need to warn him of the risks associated with appendicitis.

In opposition, plaintiff's core position is that there are numerous questions of fact that prevent awarding defendants' accelerated judgment in their favor. Plaintiff argues that the injuries he suffered were caused by defendants' failure to render him professional medical care in accordance with accepted standards. In support of this position, he proffers, among other evidence, two expert affidavits.[5] Both experts attest that their

[5] Plaintiff's expert evidence is in the form of a redacted, signed, and notarized expert affidavit and a redacted, signed, but unnotarized expert affirmation. A court's refusal to consider redacted expert

medical opinions are based upon, among other things, their respective review of plaintiff's relevant medical records, the testimonies of the parties, the expert evidence proffered by defendants, and their medical degrees and work experience.

Plaintiff's ER expert asserts that defendants departed from good and accepted medical practices in, among other acts, failing to recognize plaintiff's appendicitis, failing to order an abdominal/pelvic CT scan, and paying inadequate attention to the laboratory results. Further, the ER expert opines that plaintiff's injuries were caused by defendants' failure to timely and properly diagnose appendicitis. The emergency expert attests that defendants' diagnosis of gastroenteritis was contrary to plaintiff's symptoms, asserting that "[g]astroenteritis is a disease typified by vomiting accompanied by diarrhea . . . Dr. Brazg documented that [plaintiff] had no vomiting or diarrhea . . . and under the [h]istory of [p]resent [i]llness, Dr. Brazg documented that [plaintiff] had only endorsed a single loose stool and had no vomiting" (aff of plaintiff's ER expert at 6). Beyond the lack of symptoms of gastroenteritis, plaintiff's ER expert opines that plaintiff presented with many indicators of appendicitis that defendants failed to identify and appropriately diagnose, specifically plaintiff's complaint of severe pain in his abdomen, abdominal tenderness, migratory pattern of pain, and the diagnostic tests displaying an elevated

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evidence in opposition of a motion for summary judgment is unwarranted in light of CPLR 3101 (d) (1) (i) (*see Vega v Mount Sinai-NYU Med. Ctr. & Health Sys.*, 13 AD3d 62, 63 [2d Dept 2004], *but cf. Capobianco v Marchese*, 125 AD3d 914, 916 [2d Dept 2015] [discussing unredacted and unsigned expert affidavits submitted in opposition to a motion for summary judgment]). Beyond this, defendants have not raised any issues of admissibility concerning plaintiff's proffered expert evidence and "a court should not examine the admissibility of evidence submitted in support of a motion for summary judgment unless the nonmoving party has specifically raised that issue in its opposition to the motion" (*Bank of N.Y. Mellon v Gordon*, 171 AD3d 197, 202 [2d Dept 2019], citing *Rosenblatt v St. George Health & Racquetball Assoc., LLC*, 119 AD3d 45, 55 [2d Dept 2014]). Thus, plaintiff's expert evidence shall be considered.

white blood cell count. Further, plaintiff's ER expert maintains that defendants deviated from accepted and good medical practice by failing to order a CT scan to further investigate plaintiff's illness. Plaintiff's ER expert also asserts that it was a deviation not to advise plaintiff of the risks associated with appendicitis prior to discharging him.

Plaintiff's surgical expert likewise opines that defendants deviated from good and accepted medical practice in their treatment of plaintiff, and that their deviations were substantial factors in causing plaintiff's appendix to rupture and form an abscess with adhesion and other injuries to plaintiff. Plaintiff's surgical expert specifically asserts that defendants' negligence caused plaintiff to suffer from a perforated appendix, infection, continuing severe diffuse pain, requiring multiple CT scans, increased risk of infection, and the need for a more difficult and delayed operation. Plaintiff's surgical expert asserts, contrary to Dr. Geller, that plaintiff did not present on July 11, 2015 with a perforated appendix or a phlegmon present. Plaintiff's surgical expert opines that the tests do not conclusively establish that there was perforation or phlegmon, and that Dr. Geller's assertions are wholly speculative. Additionally, he asserts that the lack of McBurney point tenderness is not necessary, nor sufficient, to rule out or diagnose appendicitis, thus lack of such a finding did not conclusively establish that plaintiff was not suffering from appendicitis. Further, plaintiff's surgical expert opines that "as a result of the initial failure to evaluate the symptoms of appendicitis, plaintiff has an increased risk of adhesions throughout the remainder of his life" (aff of plaintiff's surgical expert at 15).

While plaintiff argues that defendants failed to establish their prima facie case entitling them to summary judgment, his ultimate position is that his proffered expert evidence raises questions of fact precluding summary judgment. Additionally, plaintiff asserts, beyond the expert evidence, that certain factual assertions presented in plaintiff's arguments are contradicted by the various testimonies. Notably, plaintiff asserts that he never reported improvement in his pain levels prior to discharge. Further, plaintiff argues that defendants' contentions that their deviation was not the proximate cause of plaintiff's injuries are inappropriate for the court to determine on a motion for summary judgment as such an issue must be resolved by the trier of fact. Accordingly, plaintiff maintains that defendants' motion for summary judgment must be denied.

In reply, defendants principally contend plaintiff's expert affidavits are conclusory and are insufficient to raise triable issues of fact. Specifically addressing claims as against Dr. Brazg, defendants assert that plaintiff failed to rebut their prima facie case establishing that Dr. Brazg was a resident physician acting under the supervision of Dr. Garber, and thus cannot be held liable. Further, they argue that plaintiff's lack of informed consent cause of action must be dismissed as there was no procedure or act that violated plaintiff's physical integrity. Thus, defendants maintain that as they established their prima facie entitlement to judgment as a matter of law on their initial moving papers and plaintiff has failed to rebut this by raising a triable issue of fact, their motion must be granted.

***Discussion***

On a motion for summary judgment the court's function is issue finding, not issue determination (*see Trio Asbestos Removal Corp. v Gabriel & Sciacca Certified Pub. Accountants, LLP*, 164 AD3d 864, 865 [2d Dept 2018] [internal citations omitted]). "A party moving for summary judgment must demonstrate that 'the cause of action or defense shall be established sufficiently to warrant the court as a matter of law in directing judgment' in the moving party's favor" (*Jacobsen v New York City Health & Hosps. Corp.*, 22 NY3d 824, 833 [2014], quoting CPLR 3212 [b]). "[T]he proponent of a summary judgment motion must make a prima facie showing of entitlement to judgment as a matter of law, tendering sufficient evidence to demonstrate the absence of any material issues of fact" (*Alvarez v Prospect Hosp.*, 68 NY2d 320, 324 [1986] [internal citations omitted]). "Once this showing has been made, however, the burden shifts to the party opposing the motion for summary judgment to produce evidentiary proof in admissible form sufficient to establish the existence of material issues of fact which require a trial of the action" (*Id.*, citing *Zuckerman v City of New York*, 49 NY2d 557, 562 [1986]). In other words, "plaintiff 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])

"In determining a motion for summary judgment, the evidence must be viewed in the light most favorable to the nonmoving party, and all reasonable inferences must be resolved in favor of the nonmoving party" (*Santiago v Joyce*, 127 AD3d 954, 954 [2d Dept 2015] [internal citations omitted]). "To grant summary judgment it must clearly

appear that no material and triable issue of fact is presented" (*Sillman v Twentieth Century-Fox Film Corp.*, 3 NY2d 395, 404 [1957] [internal citation omitted]). Further, "[s]ummary judgment is a drastic remedy which should only be employed when there is no doubt as to the absence of triable issues" (*Stukas v Streiter*, 83 AD3d 18, 23 [2d Dept 2011] [internal citation omitted]; *see also Andre v Pomeroy*, 35 NY2d 361, 364 [1974]).

***Medical Malpractice***

Where a doctor is accused of medical malpractice, the "'doctor may be liable only if the doctor's treatment decisions do not reflect his or her own best judgment, or fall short of the generally accepted standard of care'" (*Feteha v Scheinman*, 169 AD3d 871, 873 [2d Dept 2019], quoting *Nestorowich v Ricotta*, 97 NY2d 393, 399 [2002]). "To prevail on a motion for summary judgment in a medical malpractice action, a defendant must make a prima facie showing either that there was no departure from the accepted community standards of medical care, or that his or her acts were not a proximate cause of the plaintiff's injuries" (*Pinnock v Mercy Med. Ctr.*, 180 AD3d 1088, 1090 [2d Dept 2020] [internal citations omitted]). Critically, "a doctor is not liable in negligence merely because a treatment, which the doctor as a matter of professional judgment elected to pursue, proves ineffective or a diagnosis proves inaccurate. Not every instance of failed treatment or diagnosis may be attributed to a doctor's failure to exercise due care" (*Nestorowich*, 97 NY2d at 398, citing *Schrempf v State of New York*, 66 NY2d 289, 295 [1985]; *see also generally Lacqua v Silich*, 141 AD3d 690 [2d Dept 2016]). A defendant doctor must proffer expert evidence to establish that she/he did not deviate from accepted standards of medical care, or that her/his deviation was not the proximate

cause of plaintiff's injuries (*see generally Grasso v Nassau County*, — AD3d —, 2020 NY Slip Op 01329 [2020]; *M.C. v Huntington Hosp.*, 175 AD3d 578 [2d Dept 2019]; *Hernandez v Nwaishienyi*, 148 AD3d 684 [2d Dept 2017]; *McCarthy v N. Westchester Hosp.*, 139 AD3d 825 [2d Dept 2016]).

"[A] plaintiff, in opposition to a defendant physician's summary judgment motion, must submit evidentiary facts or materials to rebut the prima facie showing by the defendant physician that he was not negligent in treating plaintiff so as to demonstrate the existence of a triable issue of fact" (*Alvarez*, 68 NY2d at 324). "General and conclusory allegations that are unsupported by competent evidence are insufficient to defeat a motion for summary judgment" (*Messeroux v MMC Med. Ctr.*, 181 AD3d 583 [2d Dept 2020] [internal quotation marks and citations omitted]; *see also DiMitri v Monsouri*, 302 AD2d 420, 421 [2d Dept 2003]). To satisfy its burden rebutting defendant's prima facie showing, a plaintiff must submit expert testimony (*see Ahmed v NY City Health & Hosps. Corp.*, 84 AD3d 709, 711 [2d Dept 2011]; *see also Thompson v Orner*, 36 AD3d 791, 792 [2d Dept 2007]).

Expert evidence offered in rebuttal of defendant's prima facie showing must demonstrate beyond a deviation of the accepted medical standards, but also that there is a "nexus between the alleged malpractice and the [alleged] injur[ies]" (*Bertini v Columbia Presbyt. Med. Ctr.*, 279 AD2d 492, 493 [2d Dept 2001]; *see also Adams v Pilarte*, 152 AD3d 97, 106 [1st Dept 2017]). "Where the expert's ultimate assertions are speculative or unsupported by any evidentiary foundation, however, the opinion should be given no probative force and is insufficient to withstand summary judgment" (*Diaz v Downtown*

*Hospital*, 99 NY2d 542, 544 [2002]). "In order not to be considered speculative or conclusory, expert opinions in opposition should address specific assertions made by the movant's experts, setting forth an explanation of the reasoning and relying on specifically cited evidence in the record" (*Schwartz v Partridge*, 179 AD3d 963, 964 [2d Dept 2020] [internal quotation marks and citations omitted]).

Where a medical malpractice action involves a physician within his residency acting under the supervision of an attending physician, the inquiry requires further examination. "A resident who assists a doctor during a medical procedure, and who does not exercise any independent medical judgment, cannot be held liable for malpractice so long as the doctor's directions did not so greatly deviate from normal practice that the resident should be held liable for failing to intervene" (*Tsocanos v Zaidman*, 180 AD3d 841, 841 [2d Dept 2020] [internal quotation marks and citations omitted]; *see also Macancela v Wyckoff Hgts. Med. Ctr.*, 176 AD3d 795, 797 [2d Dept 2019]). A defendant resident physician must demonstrate that he did not perform "any specific, independent act on [his] part [which] proximately caused the injured plaintiff's injuries" (*Nasima v Dolen*, 149 AD3d 759, 760 [2d Dept 2017], citing *Crawford v Sorkin*, 41 AD3d 278, 280 [1st Dept 2007]; *Cook v Reisner*, 295 AD2d 466, 467 [2d Dept 2002]) and that "the diagnosis and treatment plan implemented and continued under the supervision of the attending physicians did not include orders so clearly contraindicated by normal practice that ordinary prudence required inquiry into the correctness of the orders" (*France v Packy*, 121 AD3d 836, 837 [2d Dept 2014], citing *Costello v Kirmani*,

54 AD3d 656, 657 [2d Dept 2008]; *see also Cynamon v Mount Sinai Hosp.*, 163 AD3d 923, 925 [2d Dept 2018]).

Additionally, where a plaintiff seeks liability against a hospital for negligent treatment received by physicians, "[a]s a general matter, under the doctrine of respondeat superior, a hospital may be held vicariously liable for the negligence or malpractice of its employees acting within the scope of employment, but not for negligent treatment provided by an independent physician, as when the physician is retained by the patient" (*Cynamon*, 163 AD3d at 924 [internal quotation marks and citations omitted]). However, there is an exception to this rule "where a patient comes to the ER seeking treatment from the hospital and not from a particular physician of the patient's choosing" (*Galluccio v Grossman*, 161 AD3d 1049, 1052 [2d Dept 2018] [internal quotation marks and citations omitted]). Thus, to be entitled to summary judgment, a defendant hospital must either demonstrate that the physicians alleged of malpractice are independent contractors or that plaintiff did not seek treatment from the hospital generally, but rather a particular physician of his choosing (*see id.*; *Sampson v Contillo*, 55 AD3d 588 [2d Dept 2008])

Ultimately however, where there is competent and competing expert evidence presented to the court, summary judgment is inappropriate (*see Joyner v Middletown Med., P.C.*, — AD3d —, 2020 NY Slip Op 02626 [2d Dept 2020]; *Castillo v Surasi*, 181 AD3d 786 [2d Dept 2020]; *Colombini v Westchester County Healthcare Corp.*, 24 AD3d 712, 716 [2d Dept 2005], citing *McDougald v Garber*, 73 NY2d 246, 255 [1989]).

Addressing plaintiff's claim of medical malpractice as against Dr. Brazg, defendants established their prima facie entitlement to summary judgment. Dr. Brazg served as a resident physician under the supervision of Dr. Garber on July 11, 2015 (*see* affirmation of Dr. Dan Wiener at 2, ¶ 2; Dr. Brazg deposition tr at 72; Dr. Garber deposition tr at 14-15; defendants' exhibit N at 23). Dr. Garber specifically testified to her role as attending physician: "I follow cases with the residents. Residents would usually see a patient preliminarily and I follow up and see the patient myself, too, and we discuss it and discuss the management of the patient" (Dr. Garber deposition tr at 14-15). While the record is clear that Dr. Brazg was involved in the diagnosis of gastroenteritis (*see id.*; *see generally* defendants' exhibit N; Dr. Brazg deposition tr at 59), the record is equally clear that Dr. Garber ultimately rendered the diagnosis after consultation with Dr. Brazg and was the physician with authority to discharge the plaintiff (*see* Dr. Garber deposition tr at 48, 60; *see also generally* defendants' exhibit N [throughout the medical records Dr. Garber is identified as plaintiff's "physician" and "care provider" while Dr. Brazg is identified as "attending physician"]).

Additionally, as aforementioned, Dr. Wiener, defendants' ER expert, specifically attests that "[a]s to Dr. Brazg, he was a resident on July 11 and his role as a resident was to examine the patient and report the findings to the supervising attending, who was Dr. Garber" (affirmation of Dr. Dan Wiener at 8, ¶ 25). Further, both Dr. Wiener and Dr. Geller opine that Dr. Garber's treatment of plaintiff did not deviate from good and accepted medical practice. Thus, defendants established their prima facie showing that Dr. Brazg, as a resident physician under the supervision of Dr. Garber, is entitled to

summary judgment dismissing the medical malpractice cause of action (*see generally Tsocanos*, 180 AD3d at 841; *Macancela*, 176 AD3d at 797; *Nasima*, 149 AD3d at 760; *Cook*, 295 AD2d at 467; *Cynamon*, 163 AD3d at 925).

In response, plaintiff failed to raise a triable issue of fact defeating Dr. Brazg's prima facie showing. Specifically, the plaintiff's experts fail to address whether Dr. Brazg exercised independent medical judgment (*see Nasima*, 149 AD3d at 760, *but cf. Macancela*, 176 AD3d at 798 [wherein plaintiff's medical expert raised a triable issue of fact as to whether resident doctor exercised independent medical judgment or provided independent care respective of attending physician]). Further, even though plaintiff's experts opine that Dr. Garber deviated from good and standard practice, their affidavits are insufficient to raise questions of fact as to whether Dr. Garber's alleged deviations were "so clearly contraindicated by normal practice that ordinary prudence required inquiry into the correctness of the orders" on the part of Dr. Brazg (*France*, 121 AD3d at 837) or "so greatly deviate[d] from normal practice that the resident should be held liable for failing to intervene" (*Tsocanos*, 180 AD3d at 841).

Turning to Dr. Garber, she established her prima facie entitlement to judgment as a matter of law by demonstrating that she did not depart from the accepted community standards of medical care when treating plaintiff, and regardless of whether there were deviations, her acts were not a proximate cause of the plaintiff's injuries (*Pinnock*, 180 AD3d at 1090). Dr. Wiener's expert affidavit addresses the specific acts of alleged negligence constituting the malpractice as enumerated in plaintiff's bill of particulars (*see generally* defendants' exhibit E; *see also Drago v King*, 283 AD2d 603, 603-604 [2d

Dept 2001]). Specifically, Dr. Wiener concludes based upon his medical expertise and a review of plaintiff's medical records, that Dr. Garber rendered good and adequate care to plaintiff. He opines that based upon the medical records, while ultimately a misdiagnosis, Dr. Garber's determination that plaintiff suffered gastroenteritis was appropriate considering the symptoms and test results. Beyond this, he asserts that Dr. Garber did not deviate from accepted standards in deciding not to perform a CT scan or have a surgical consultation regarding plaintiff's condition, as not every instance of abdominal pain requires a CT scan and the medical records purport that plaintiff's well-being had improved during his time in the ER (*see* affirmation of Dr. Dan Wiener at 9-10, ¶¶ 27-28).

Similarly, Dr. Geller demonstrated that Dr. Garber's deviations were not a substantial factor in causing plaintiff's alleged injuries. Dr. Geller specifically opined that based upon his review of plaintiff's medical records, that Dr. Garber's failure to diagnose plaintiff's appendicitis did not cause his alleged injuries as plaintiff presented himself to the ER with a perforated appendix and/or an infection present. Dr. Geller provides that given the condition plaintiff was in, the course of treatment he received would have been the same as he received the following day, and that the delay in treatment was not a factor in causing plaintiff's alleged injuries of cholelithiasis and non-alcoholic Steatohepatitis, lingering fatigue and abdominal pain (*see* affirmation of Dr. Peter Geller at 9-11, ¶¶ 33-38). Accordingly, Dr. Garber established her prima facie entitlement to judgment as a matter of law dismissing the medical malpractice cause of

action (*see generally Pinnock*, 180 AD3d at 1090; *M.C. v Huntington Hosp.*, 175 AD3d at 579-580; *McCarthy*, 139 A.D.3d at 826-827).

In rebuttal, plaintiff raised triable issues of material fact defeating Dr. Garber's prima facie showing of judgment as a matter of law by proffering competent and conflicting expert evidence asserting that Dr. Garber deviated from good and accepted medical practice in her treatment of plaintiff and that such deviations were the proximate cause of plaintiff's injuries (*see Keane v Dayani*, 178 AD3d 797, 798 [2d Dept 2019] [where parties adduce conflicting medical expert opinions summary judgment is inappropriate]). Contrary to defendants' assertions, plaintiff's experts' affidavits are not conclusory or insufficient to raise material questions of fact. Plaintiff's ER expert and surgical expert opine and provide specific assertions rebutting the opinions made by defendants' experts "setting forth an explanation of the reasoning and relying on specifically cited evidence in the record" (*Schwartz*, 179 AD3d at 964). Plaintiff's ER expert identifies specific acts performed by Dr. Garber which constitute departures of good and ordinary medical care, notably misinterpreting laboratory reports, failing to conduct a CT scan, and failing to observe signs of appendicitis (aff of plaintiff's ER expert at 7-8). Plaintiff's surgical expert maintains that Dr. Garber's misdiagnosis of gastroenteritis ultimately delayed appropriate treatment, leading to the rupture of his appendix, the presence of an infection, necessitating a delayed surgery and causing plaintiff's alleged injuries (affirmation of plaintiff's surgical expert at 12-15). Accordingly, defendants' motion to the extent it seeks dismissal of the medical malpractice action as against Dr. Garber is denied (*see generally Mackauer v Parikh*, 148

AD3d 873 [2d Dept 2017] [defendant medical providers' motion for summary judgment was properly denied where after the defendants established their prima facie entitlement to judgment as a matter of law, plaintiff raised a triable issue of fact as to whether defendants negligently failed to diagnose him with appendicitis]).

As defendants' motion is denied to as to Dr. Garber, the motion must likewise be denied as to MMC, as plaintiff seeks to inculpate MMC based upon the theory of respondeat superior. Further, defendants present no evidence demonstrating that Dr. Garber is not an employee of MMC (*Cynamon*, 163 AD3d at 924), nor evidence that plaintiff sought treatment of a specific physician rather than general treatment at its ER (*Galluccio*, 161 AD3d at 1052; *Sampson*, 55 AD3d at 589-590). Accordingly, defendants' motion is denied to the extent it seeks dismissal of plaintiff's medical malpractice action as against MMC.

***Lack of Informed Consent***

"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" (*Godel v Goldstein*, 155 AD3d 939, 941 [2d Dept 2017] [internal quotation marks and citations omitted]).

> "A cause of action premised on a lack of informed consent is meant to redress a '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" (*Walker v St. Vincent Catholic Med. Ctrs.*, 114

> AD3d 669, 670 [2d Dept 2014] [internal quotation marks and citations omitted]).

"'[A] failure to diagnose cannot be the basis of a cause of action for lack of informed consent unless associated with a diagnostic procedure that involves invasion or disruption of the integrity of the body'" (*Dixon v Puma*, 2017 NY Slip Op 30405[U] [Sup Ct, Kings County 2017], quoting *Janeczko v Russell*, 46 AD3d 324, 325 [1st Dept 2007]).

Accordingly,

> "[t]o establish a cause of action to recover damages based on lack of informed consent, a plaintiff must prove (1) that the person providing the professional treatment failed to disclose alternatives thereto and failed to inform the patient of reasonably foreseeable risks associated with the treatment, and the alternatives, that a reasonable medical practitioner would have disclosed in the same circumstances, (2) that a reasonably prudent patient in the same position would not have undergone the treatment if he or she had been fully informed, and (3) that the lack of informed consent is a proximate cause of the injury" (*Gilmore v Mihail*, 174 AD3d 686, 688 [2d Dept 2019]).

Critically, the medical professional must have conducted an actual procedure (*see generally Gilmore*, 174 AD3d at 688; *Figueroa-Burgos v Bieniewicz*, 135 AD3d 810, 811-812 [2d Dept 2016]; *Trabal v Queens Surgi-Center*, 8 AD3d 555, 557 [2d Dept 2004]). Additionally, "'the causal connection between a doctor's failure to perform his [or her] duty to inform and a patient's right to recover exists *only when it can be shown objectively that a reasonably prudent person would have decided against the procedures actually performed*'" (*Trabal*, 8 AD3d at 557, quoting *Dries v Gregor*, 72 AD2d 231 [4th Dept 1980] [emphasis added]).

Here, defendants have established their prima facie entitlement to judgment, as a matter of law, dismissing plaintiff's lack of informed consent claim. Plaintiff's allegations forming the basis of such claim are that defendants failed to advise him of the risks associated with appendicitis prior to discharge (*see generally* defendants' exhibit E 10-12 [plaintiff's bill of particulars]). The proffered evidence presented by defendants demonstrates that Dr. Garber, Dr. Brazg, and MMC never performed any actual procedures on plaintiff which he alleges invaded his physical integrity (*see Gilmore*, 174 AD3d at 688; *Figueroa-Burgos*, 135 AD3d at 811-812; *Trabal*, 8 AD3d at 557; *see also* affirmation of Dr. Dan Wiener at 10, ¶ 29). In response, plaintiff failed to raise a triable issue of fact. None of the proffered evidence demonstrates that there was a specific "diagnostic procedure that involve[d] [an] invasion or disruption of the integrity of [his] body" (*Dixon*, 2017 NY Slip Op 30405[U] [Sup Ct, Kings County 2017] [internal quotation marks and citation omitted]). Rather, plaintiff's argument is that defendants, by failing to disclose every potential alternative diagnosis, failed to acquire informed consent of plaintiff prior to his discharge. Holding doctors to such requirements to prevent liability for lack of informed consent is untenable as every potential action for medical malpractice based upon a misdiagnosis would thus become an additional action for lack of informed consent, and would require doctors to disclose a myriad of alternative diagnoses which may or may not be causing plaintiff's ailments.

To the extent not specifically addressed herein, the parties remaining contentions and arguments were considered and found to be without merit and/or moot. Accordingly, it is

**ORDERED** that defendants' motion is granted to the extent plaintiff's first cause of action (medical malpractice) is dismissed as against Dr. Brazg; and it is further,

**ORDERED** that defendants' motion is granted to the extent plaintiff's second cause of action (lack of informed consent) is dismissed as against all defendants; and it is further,

**ORDERED** that defendants' motion is granted to the extent that plaintiff's third and fourth causes of action (sounding in negligent hiring and supervision) are dismissed as against MMC; and it is further,

**ORDERED** that defendants' motion is denied in all other respects.

This constitutes the decision and order of the court.

ENTER

Ellen Spodek

J. S. C.