SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NASSAU

PRESENT: HON. ANTONIO I. BRANDVEEN,
Supreme Court Justice

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DOUGLAS HELKOWSKI,

Plaintiff,

TRIAL / IAS PART 22
NASSAU COUNTY

INDEX NO.: 604159/2015

Motion Seq. No.: 06, 08, 09, and 10

- against-

SHIRLEY GOODMAN, M.D., NORTH SHORE LIJ MEDICAL GROUP, JILLIAN SCAMBIA, D.O., DANIEL MCCALLY, M.D., H. AHMED, M.D. (SAID NAME INTENDED TO REPRESENT THE PHYSICIAN WHO CONSULTED AND RENDERED MEDICAL CARE TO PLAINTIFF ON MAY 30, 2014, JUNE 3, 2014, AND JUNE 13, 2014 AT NASSAU HEALTH CARE CORPORATION), ORVILLE MCLENAN, M.D., "JOHN/JANE DOE, R.N." (SAID NAME BEING FICTITIOUS BUT INTENDED TO REPRESENT THE REGISTERED NURSE WHO PROVIDED MEDICAL CARE TO PLAINTIFF ON JUNE 6, 2014 AND JUNE 13, 2014 AT NASSAU HEALTH CARE CORPORATION), "JOHN/JANE DOE, M.D." (SAID NAME BEING FICTITIOUS BUT INTENDED TO REPRESENT THAT PHYSICIANS WHO PROVIDED MEDICAL CARE TO PLAINTIFF ON JUNE 6, 2014 AT NASSAU HEALTH CARE CORPORATION), NASSAU HEALTH CARE CORPORATION A/K/A NUHEALTH CORPORATION D/B/A NASSAU UNIVERSITY MEDICAL CENTER, MUHAMMAD HAMID, M.D., AND WINTHROP UNIVERSITY HOSPITAL,

Defendants.

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Upon the foregoing papers, the motion (seq. 006) by defendants Jillian Scambia, D.O. and

Nassau Health Care Corporation s/h/a Nassau Health Care Corporation a/k/a NUHealth Corporation d/b/a Nassau University Medical Center for an order, pursuant to CPLR 3212, seeking summary judgment dismissal of the plaintiff's complaint, the motion (seq. 008) by defendant, Orville McLenan, M.D., for an order, granting summary judgment dismissal of the plaintiff's complaint, and the motion (seq. 009) by defendant Winthrop University Hospital, for an order granting summary judgment dismissal of the plaintiff's complaint, and the late filed motion (seq. 10) by defendants Shirley Goodman, M.D., North Shore LIJ Medical Group, and Haris Ahmed, M.D., s/h/a H. Ahmed, M.D., (collectively referred as "defendants Goodman," are consolidated for disposition and granted to the limited extent stated below.

The facts underlying this medical malpractice case are as follows:

Plaintiff, Douglas Helkowski ("Helkowski"), was forty-six years of age in 2014 when the alleged malpractice herein occurred. He was divorced and living with his parents. Plaintiff had a history of anxiety, depression and opiate dependence, and had been hospitalized at the defendant Nassau Health Care Corporation s/h/a Nassau Health Care Corporation a/k/a NUHealth Corporation d/b/a Nassau University Medical Center (herein referred to as "NUMC") Detox Program from July 22, 2013 through August 19, 2013. While there, he was prescribed Trazodone, a medication used in the treatment of depression and sleep disorder.

Following his discharge from the NUMC Detox Program, plaintiff's primary care physician, defendant, Shirley Goodman, M.D. ("Dr. Goodman"), continued the plaintiff on Trazodone, for use as an anti-depressant as well as a sleep aid. It is undisputed on this record that one of the possible side effects of Trazodone is priapism – a prolonged and painful erection of the penis.

On or about May 27, 2014, plaintiff took Trazodone at night as prescribed, somewhere

between 10:00pm and 1:00am. When he woke up on May 28, 2014, he had a semi-erection. The same morning, he had his monthly visit with Dr. Goodman. Plaintiff testified that, prior to this incident, there was "only one time" a few months prior that he noticed a semi-erection; however, at the time, plaintiff did not know what had caused it nor associated it with Trazodone. On this prior occasion, the semi-erection had lasted only approximately two hours.

Notably, although plaintiff had had an appointment with Dr. Goodman, and despite having woken up with an erection, plaintiff did not mention the erection to Dr. Goodman as he expected it to resolve like the prior experience.

At her oral examination before trial, Dr. Goodman testified that, following her examination of the plaintiff on May 28, 2014, she, among other things, kept the plaintiff's Trazodone prescription the same.

Plaintiff testified that when he went home that day, the erection had not gone away. He stated that, the following day, on May 29, 2014, the erection continued and became painful. At approximately 5:00 pm, he presented to the Emergency Room (ER) at NUMC. At his oral examination before trial, plaintiff testified that, by this time, his penis had been erect from May 28, 2014 at 8:00/9:00am through May 29, 2014 at 6:00 pm, when he presented to the ER – i.e., approximately 33 hours.

In the ER, plaintiff was seen by defendant Jillian Scambia, D.O. ("Dr. Scambia"), a first-year surgical intern, who, following an examination which revealed an erect penis, tender to palpation, and accounting for plaintiff's use of Trazadone, diagnosed him with a priapism – specifically, a low flow priapism, or ischemic priapism. [1]

[1] Dr. Scambia defined priapism and an erection as lasting more than 4 hours. She stated that the treatment for ischemic priapism is time sensitive and if it is not treated within a certain time frame, the patient could have, among other things, a loss of sexual function. Dr. Scambia testified that the treatment for an ischemic priapism included irrigation – which instills a diluted Phenylephrine solution in an attempt to

Dr. Scambia testified that in 2013-2014, she was a first-year transitional rotating intern at NUMC and was rotating through General Surgery on May 28, 2014. In this capacity, her duties included caring for patients, which would encompass procedures, such as irrigation of priapisms. Notably, Dr. Scambia testified that given her status as a first-year intern, any treatment rendered by her was done under the supervision of an attending physician. Indeed, Dr. Scambia testified that, following an examination of the plaintiff, she contacted the attending urologist on call, defendant, Daniel McCally, M.D. ("Dr. McCally") and advised him of plaintiff's history, physical examination findings and assessment. She testified that, as the attending urologist, Dr. McCally was responsible for supervising her evaluation of urology patients and that she performed all treatment as per his plan and instructions. Ultimately, Dr. McCally agreed with her assessment of the plaintiff and instructed her that treatment was necessary to detumesce the penis. She stated that he instructed her on how to perform a penile aspiration.

Dr. Scambia entered a procedure note in the plaintiff's NUMC chart, which described what was done in accordance with Dr. McCally's instructions. Specifically, Dr. Scambia noted that she used a 21-gauge needle to access the corpora cavernosum and aspirated 5cc-s of dark red blood, which she did not consider to be therapeutic to treat the plaintiff's ischemic priapism. Thereafter, she injected the diluted Phenylephrine solution at 5-10 minute intervals, as instructed by Dr. McCally. She noted that although the plaintiff reported slight improvement following this procedure, the penis remained erect. Dr. Scambia contacted Dr. McCally for further instructions on how to proceed. Dr. McCally instructed Dr. Scambia to attempt the detumescence procedure again. Dr. Scambia performed this second procedure on May 30, 2014 at 12:30 a.m., in the same

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detumesce the penis (the process of subsiding from a state of tension, swelling, or [especially] sexual arousal) – and aspiration – by which old blood is evacuated from the corpora cavernosum of the penis – followed by injection of Phenylephrine. She explained that this process can be repeated and, if unsuccessful, can be followed by surgery.

manner as she did on the first attempt.

During the second procedure, 70cc-s of dark blood was aspirated, and the Phenylephrine solution was administered. Dr. Scambia contacted Dr. McCally to advise him that the plaintiff's pain had improved, but that he was still tender at the base of the penis. Dr. Scambia testified that she was then instructed to admit the plaintiff.

Dr. Scambia testified that she then notified Dr. McCally as well as defendant H. Ahmed, M.D. ("Dr. Ahmed"), the Senior Urology resident, of the plaintiff's admission.

Notably, Dr. Scambia did not render any further treatment to the plaintiff. Nor did she have any further discussion with Dr. McCally about the plaintiff.[2]

At his deposition, plaintiff admits that Dr. Scambia told him about the procedure to treat the prolonged erection, including a needle to manually remove blood from the penis. Plaintiff also acknowledged signing a Consent to this procedure (Motion [Seq. 008], Ex. H [Plaintiff's Deposition, August 1, 2016], p. 89).

At his oral examination before trial, Dr. Daniel McCally testified that in his role as the attending physician, his duties included coordinating the education of residents, who are physicians in post-graduate training, which, in 2014, included defendants Jillian Scambia, D.O. and H. Ahmed, M.D. Dr. McCally admitted that, in 2014, Drs. Scambia and Ahmed would be under his supervision.

Notably, Dr. McCally also testified that a resident physician should have contact with the attending urologist in order to perform the aspiration and irrigation procedures.[3] Furthermore, he

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[2] However, Dr. Scambia testified that on June 2, 2014, following the plaintiff's shunt surgery, *infra*, she had a conversation with the plaintiff's parents, who were concerned with the prescription for narcotic pain medication in light of the plaintiff's history of drug abuse.

[3] Dr. McCally also corroborated Dr. Scambia's testimony as to defining an ischemic priapism, defining a prolonged erection, the complications associated with ischemic priapism, explaining the aspiration and irrigation procedures, and the like. Dr. McCally also confirmed that the aspiration and irrigation

stated that, in this case, it was his decision to allow Dr. Scambia to perform the detumescence procedures on the plaintiff.

Indeed, he testified that he agreed with Dr. Scambia's assessment that the plaintiff had a Trazodone induced priapism, and although he did not recall the discussions he had with Dr. Scambia, he testified that it was his custom and practice to tell the residents how to perform the aspiration and irrigation procedures, including the injection of the diluted Phenylephrine. He explained that he would have instructed Dr. Scambia to use a large bore needle and indicated that a 21-gauge butterfly needle was enough. He also testified that it was not uncommon for a patient with ischemic priapism to require more than one detumescence procedure. Dr. McCally confirmed that although there was reported improvement after the second detumescence procedure, he ordered that the plaintiff be admitted as he still had and erection and pain.

Dr. McCally testified that, following the plaintiff's admission, in the early morning of May 30, Dr. Ahmed, a senior urology resident also under his supervision, attempted a third detumescence procedure on the plaintiff.[4]

Dr. Ahmed testified at his oral examination before trial that, in 2014, he was a second-year resident at NUMC doing his first year of training in urology. He confirmed that he was supervised by the Urology attending physicians including Dr. McCally and defendant Orville McLenan, M.D. ("Dr. McLenan"). Like Dr. Scambia, Dr. Ahmed also corroborated Dr. Scambia and Dr. McCally's sworn testimony as to defining an ischemic priapism, its treatment, explaining the irrigation and

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procedures can be repeated several times in an attempt to treat the ischemic priapism and, further, that if these attempts fail, a shunt procedure is indicated, to allow blood to escape from the corpora cavernosa.

[4] Notably, Dr. McCally actually, for the first time, saw the plaintiff at the NUMC Urology Clinic on June 13, 2014, following the plaintiff's shunt surgery, *infra*. This clinic visit included a check for signs of infection, including redness, tenderness along with a toxic appearance. The note indicated that he was doing better, but still had pain.

aspiration procedures, and the like.

Dr. Ahmed testified that he first saw the plaintiff on May 30, 2014. He stated that Dr. Scambia advised him of plaintiff's presentation overnight and her two prior detumescence procedures, which she indicated had provided some improvement in the plaintiff's pain, but that the result was short-lived.

Dr. Ahmed indicated that it was necessary to get the attending physician's – i.e., Dr. McCally – approval prior to any treatment which would include any additional treatment that he would be called upon to render. Nevertheless, Dr. Ahmed testified that the attending physician approved the third attempt at detumescence and that if this was not successful, the plaintiff would require surgery. Accordingly, Dr. Ahmed performed a bedside penile detumescence procedure following which procedure, plaintiff was discharged home (on May 30, 2014).

Notably, Dr. Ahmed testified that he did not recall examining the patient nor did he have any recollection as to whether plaintiff's penis was still erect or detested at the time of discharge. There is no pre-discharge examination note form him. However, the plaintiff testified that it was Dr. Ahmed who discharged him on May 30, 2014.

The discharge summary was co-signed by both Drs. McCally and Ahmed.

Nevertheless, Dr. Ahmed testified that it was the attending physician, Dr. McCally, who made the decision to discharge the plaintiff home following the third detumescence procedure.[5]

Ultimately, plaintiff was discharged (following the third detumescence procedure) on May 30, 2014 at 2:45pm with Percocet for pain control and Augmentin (antibiotic) to be taken every 12 hours. Plaintiff was also instructed to follow up with the urology clinic on Monday June 2, 2014

[5] Dr. Ahmed testified that he next saw the plaintiff at the NUMC Urology Clinic on June 13, 2014. His note from this date indicates that the plaintiff was status post shunt procedure -- which had been performed on June 1 – and that the plaintiff was doing well despite his complaints of pain and burning on urination.

at 2:00pm. Plaintiff's parents drove him home from the hospital.

The next day, on June 1, 2014, plaintiff's parents drove the plaintiff back to the ER at NUMC because, plaintiff testified, "the erection had never gone away to a point where it felt comfortable at all." Plaintiff testified that he was still in pain, his genitals were so swollen and painful that he could not sit, stand, sleep or lay down. Plaintiff was admitted to the hospital at approximately 5:50 AM on June 1, 2014 where he was seen by the then attending urologist, defendant Orville McLenan, M.D. ("Dr. McClenan") at approximately 6:30AM.

On that morning, June 1, 2014, Dr. McClenan examined the plaintiff and confirmed that he had priapism. Anticipating the need for a surgical procedure, Dr. McClenan spoke with the plaintiff about the risks, benefits and alternatives of a shunt procedure. The plaintiff signed an informed consent at 7:00 a.m. on June 1, 2014, witnessed by K. Gordon and Dr. McClenan. Dr. McClenan also spoke with the plaintiff's mother and father about the procedure and informed them that their son had priapism for over 30 hours, which could result in impotence.

Plaintiff was taken to the operating room where priapism was confirmed by Dr. McClenan. Dr. McClenan attempted to treat the patient conservatively by aspirating blood from the penis, but this was again not successful. Plaintiff then underwent the shunting procedure. The entire operation took from 7:10 a.m. to 8:03 a.m. A shunt was created by making a stab incision through the glan into the corpora cavernosa twice on the left and twice on the right. Blood was drained which eventually resolved the tumescence of the priapism. A dressing was applied, anesthesia was terminated, and the patient was sent to the recovery room. Thereafter he was admitted to the hospital.

Following the surgery, plaintiff testified that he was in "excruciating pain." He testified that the pain had not gone down during this second admission. However, plaintiff understood,

based on his conversations with the medical staff, that his sexual function would be fine after the procedure.

On June 3, 2014 at approximately 9:00AM, Dr. Scambia examined the patient and noted "swelling present, erythema and ecchymosis of the scrotum and suprapubic region". Dr. Scambia also documented that the patient complained of "intermittent penile pain plus frequent small volume voids". During this second admission, plaintiff also noticed that there was some blistering on the penis.

The plaintiff remained in the hospital until he was discharged on June 3, 2014 with instructions to return to the NUMC Clinic for follow up care every Friday.

Notably, Dr. McLenan did not see the patient during his post-operative course or care at the hospital. Indeed, Dr. McLenan had no further contact with this patient. His only date of treatment was June 1, 2014 when he performed the shunting procedure.

Following his discharge, when the plaintiff got home, he was still in tremendous pain which continued to the time he returned to the Clinic at NUMC three days later on June 6, 2014.

On June 6, plaintiff presented to his scheduled clinic visit with sudden and sharp pain on his groin. The pain score reported was a 10 out of 10. It was also noted that, among other things, he had swollen glands. At the time of his presentation to the clinic, his penis was "inflamed, just red, throbbing, three times, four times the width it should be" (Exhibit 5, p. 120). A nurse had to hold him up in the waiting room because he could not sit or stand. Plaintiff complained of excruciating pain and that his condition "wasn't getting any better" (Id at pp. 566, 570). He was told by the examining physician that he had to deal with the pain since it was a painful surgery (Id. at pp. 121,568, 570, 914). In the end, despite his complaints of pain and an infection, the plaintiff was found to be progressing reasonably well. He was instructed to come back for follow-up visit

in a week (his Friday visits).

One week later, on June 13, 2014, plaintiff presented to the clinic as instructed, still in pain. Plaintiff was seen by Dr. Ahmed during this visit. By this second clinic visit, plaintiff's symptoms had worsened – notably, his swelling was worse, his pain had increased, and he reported painful urination. On this visit, Dr. Ahmed noted residual fibrosis and edema present and that pain remained an issue. Notably, during the second visit, plaintiff testified that at this visit, he reported that he had an infection – he stated that he reported that he felt fatigued, feverish, with chills, burning sensation in the penis, sweating, lightheadedness, and having flu-like symptoms. According to the plaintiff, despite his complaints, Dr. Ahmed was dismissive and stated that this was normal, that he was "just at a plateau now", that he would get better and "just go home and take more pain medication and you'll be fine" (Exhibit 5, pp. 124-125, 573, 575-576; Exhibit 6, pp. 109-110, 275; Exhibit 7, pp. 96, 116). Ultimately, plaintiff was found to be recovering comfortably. Dr. Ahmed prescribed pain medicines. Dr. Ahmed did not prescribe any antibiotics despite the plaintiff's complaints about a suspected infection. Plaintiff was instructed to follow up with the clinic in a month.

Plaintiff did not leave the house from June 14 to June 18 due to his pain. However, since his condition was not improving, and despite Dr. Ahmed's assurances otherwise, on June 19, plaintiff sought medical attention elsewhere – namely, with non-party, Dr. Marc A. Schumer, M.D. ("Dr. Schumer"), a urologist.

On June 19, during the consultation with Dr. Schumer, plaintiff made similar complaints as those made at the clinic, including that he was in excruciating pain and that he felt he had an infection. Dr. Schumer noted severe pain associated with swelling, bruising, and penile pain. Dr. Schumer also noticed that the plaintiff was experiencing fatigue, headache, bruising, itching and a

rash, hypertension, nausea and vomiting, joint pain and muscle pain, dizziness and weakness. After evaluating the plaintiff, Dr. Schumer determined that the had a "Chronic – Possible infection" (Exhibit 17). Dr. Schumer told him to go straight to defendant, Winthrop University Hospital ("Winthrop") as the penis was grossly infected.

On the evening of June 19, as instructed by Dr. Schumer, plaintiff was driven by his parents to the ER at Winthrop Hospital whereupon, at 3:32 PM, he presented with complaints of pain to penis, swelling and purulent drainage. Plaintiff was triaged at 3:51PM. Fluids were started at around 5:17PM and he was evaluated by non-party Dr. George as well as the urology attending physician/surgeon, non-party, Dr. Mellinger.

Dr. Mellinger examined the plaintiff's genitalia and agreed with Dr. Schumer that he had an infection of the penis. Dr. Mellinger admitted the plaintiff to treat his infection. Specifically, plaintiff was admitted to the medicine floor at approximately 11:04PM under the services of the late defendant Muhammad Hamid, M.D. ("Dr. Hamid") with a diagnosis of penile cellulitis/penile abscess and anemia.[6] It was further noted that plaintiff had sepsis secondary to penile cellulitis that was present on admission.

During the course of the Winthrop admission, the plaintiff had lab work done which demonstrated an elevated white blood cell count. Plaintiff also underwent a CT scan which demonstrated a collection at the base of the penis. Various consultations were also requested by Dr. Hamid including hematology, infectious disease, urology, pain management, and psychiatry. According to the urology consultation performed on June 19, 2014, plaintiff's history included three attempts of corporal aspiration and irrigation that failed to reduce the priapism and subsequent winter shunt, after which the patient had persistent pain and discomfort requiring

[6] Dr. Hamid died and the named defendant in his stead is "Rafia Hamid, as temporary administratrix of the Estate of Muhammad Hamid, M.D., deceased.

narcotic medication. Plaintiff reported pain at the time of the consultation and the physical examination revealed marked tenderness and the edema to the penile shaft. Blood cultures were obtained and the laboratory studies revealed an elevated white count, hemoglobin of 7.4, and hematocrit 22.5. The impression was findings suggestive of cellulitis and infection. At such time, the plaintiff was treated with an antibiotic coverage as well as pain management.

Eventually, on June 23, 2014, Dr. Mellinger performed a surgery which involved an incision and drainage of the abscess. In this surgery, Dr. Mellinger resected a large portion of necrotic tissue.

Following the surgery Dr. Mellinger advised plaintiff that the area where he had the surgery was infected and that it was the worst infection he had ever seen and that there was sepsis in his system. Dr. Mellinger had to cut chunks of it out along the base of the penis.

Plaintiff was placed on multiple antibiotics and pain medications following the surgery. As of June 29, 2014, the plaintiff was being administered multiple antibiotics for his penile abscess. On or about June 30, 2014, the plaintiff complained of numbness and tingling to his bilateral fingers and toes and neurology was consulted. On July 1, 2014, the neurology consult noted that the patient was managed for pain with various medications and that the bilateral numbness and paresthesia were most likely secondary to the combination of some of these medications. It was also noted, during this admission, that plaintiff's mental state was altered and that he reported that the pain had started to spread to the rest of his body, paralysis was setting in and that he had difficulty breathing.

Consequently, on July 2, 2014, the patient underwent electromyogram studies with evidenced sensory motor polyneuropathy that suggested Guillain-Barré Syndrome ("GBS"). The plaintiff was then transferred to the medical care intensive unit for observation. Notably, plaintiff

did not have a prior history of GBS prior to being admitted to Winthrop Hospital.

On or about July 7, 2014, once he was cleared from ICU level of care, plaintiff was transferred to back Dr. Hamid's service who advised him that the infection in his penis had led to a systematic infection and GBS.

Plaintiff remained at Winthrop from June 19, 2014 through August 2, 2014. During his stay, although he was admitted to Dr. Hamid's service, he was followed by Dr. Mellinger.

Plaintiff was discharged from Winthrop to a rehabilitation facility on August 2, 2014. Plaintiff's main diagnosis was Methicillin susceptible staphylococcus aureus septicemia, along with acute infective polyneuritis/GBS, inflammatory disorder of penis, iron-deficiency anemia, sepsis, disturbance of skin sensation, hyperkalemia, thrombocytopenia, myoclonus, chronic pain, constipation, hyperpotassemia, thrombocythemia, and phictitis and thrombophlebitis of superficial veins of upper extremities.

In bringing this complaint, plaintiff claims that the defendants herein, *inter alia*, failed to properly treat and manage his ischemic priapism, failed to perform adequate and timely detumescence procedures, failed to perform a shunting procedure in a timely fashion, failed to adequately supervise physicians in training, caused a delay in treatment of such condition, failed to render adequate post-operative care, failed to perform adequate evaluations and diagnostic testing, failed to timely diagnose and treat plaintiff's subsequent penile infection during his various presentations to defendant NUMC's emergency room and clinics, and failed to timely treat plaintiff's cellulitis and provide adequate antibiotic therapy, not only departing from good and accepted practices in the medical field, but also their own policies and procedures and national accreditation guidelines.

It is the plaintiff's contention that the departures from the standard of care committed by

the defendants herein with regards to the treatment and management of plaintiff's priapism and the ensuing infection, proximately caused and contributed to plaintiff's neurological condition, including his Guillian-Barre Syndrome and/or critical care neuropathy.

The law is clear. "In order to establish the liability of a physician for medical malpractice, a plaintiff must prove that the physician deviated or departed from accepted community standards of practice, and that such departure was a proximate cause of the plaintiff's injuries" (*Stukas v. Streiter*, 83 AD3d 18, 23 [2nd Dept. 2011]). Thus, in moving for summary judgment, a physician defendant must make a *prima facie* showing that there was no departure from good and accepted medical practice or that the plaintiff was not injured thereby (*Id.* at 24; *see Alvarez v. Prospect Hosp.*, 68 NY2d 320, 324 [1986]; *Tsitrin v. New York Community Hosp.*, 154 AD3d 994, 995 [2nd Dept. 2017]; *Lesniak v. Stockholm Obstetrics & Gynecological Servs., P.C.*, 132 AD3d 959, 959 [2nd Dept. 2015]). Once this showing has been made, the burden shifts to the plaintiff to rebut the defendant's *prima facie* showing with evidentiary facts or materials so as to demonstrate the existence of a triable issue of fact (*Alvarez v. Prospect Hosp.*, *supra* at 324; *Stukas v. Streiter*, *supra* at 30).

"Summary judgment is not appropriate in a medical malpractice action where the parties adduce conflicting medical expert opinions" (*Feinberg v. Feit*, 23 AD3d 517, 519 [2nd Dept. 2005]; *Simpson v. Edghill*, 169 AD3d 737, 738 [2nd Dept. 2019]), since conflicting expert opinions raise credibility issues which are to be resolved by the factfinder (*Guctas v. Pessolano*, 132 AD3d 632, 633 [2nd Dept. 2015]). However, "[g]eneral allegations of medical malpractice, merely conclusory and unsupported by competent evidence tending to establish the essential elements of medical malpractice, are insufficient to defeat [a] defendant physician's summary judgment motion" (*Alvarez v. Prospect Hosp.*, *supra* at 325; *Lowe v. Japal*, 170 AD3d 701, 702 [2nd Dept. 2019];

Smith v. Mollica, 158 AD3d 656, 658 [2nd Dept. 2018]).

" '[I]n general, a hospital may not be held vicariously liable for the malpractice of a private attending physician who is not an employee (citations omitted)' " (*Dupree v Westchester County Health Care Corp.*, 164 AD3d 1211, 1213 [2nd Dept 2018], *quoting Toth v Bloshinsky*, 39 AD3d 848, 850 [2nd Dept. 2007]). "Therefore, when hospital employees, such as resident physicians and nurses, have participated in the treatment of a patient, the hospital may not be held vicariously liable for resulting injuries where the hospital employees have merely carried out the private attending physician's orders (citations omitted)" (*Dupree v Westchester County Health Care Corp.*, *supra* at 1213). "These rules shielding a hospital from liability do not apply when: (1) 'the staff follows orders despite knowing "that the doctor's orders are so clearly contraindicated by normal practice that ordinary prudence requires inquiry into the correctness of the orders" ' (*Id.*, *quoting Doria v Benisch*, 130 AD3d 777, 777-778 [2nd Dept. 2015], *quoting Toth v Community Hosp. at Glen Cove*, 22 NY2d 255, 265 n. 3 [1968]); (2) the hospital's employees have committed independent acts of negligence; or (3) the words or conduct of the hospital give rise to the appearance and belief that the physician possesses the authority to act on behalf of the hospital (citations omitted)" (*Dupree v Westchester County Health Care Corp.*, *supra* at 1213). " '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" ' " (*Id., quoting Muslim v Horizon Med. Group, P.C.*, 118 AD3d 681, 683 [2nd Dept. 2014], *quoting Alvarado v Beth Israel Med. Ctr.*, 78 AD3d 873, 875 [2nd Dept. 2010]) and that an 'exception to the general rule [does] not apply' " (*Dupree v Westchester County Health Care Corp.*, *supra* at 1213, *quoting Rizzo v Staten Is. Univ. Hosp.*, 29 AD3d 668, 668-669 [2nd Dept. 2006]).

Thus, "[w]hen supervised medical personnel are not exercising their independent medical judgment, they cannot be held liable for medical malpractice unless the directions from the supervising superior or doctor so greatly deviates from normal medical practice that they should be held liable for failing to intervene" (*Bellafiore v. Ricotta*, 83 AD3d 632, 633 [2nd Dept. 2011]; *see Zhuzhingo v. Milligan*, 121 AD3d 1103, 1106 [2nd Dept. 2014]).

Moreover, although " '[a]s a general rule, a hospital is not vicariously liable for the malpractice of a private attending physician who is not its employee' " (*Galluccio v. Grossman*, 161 AD3d 1049, 1052 [2nd Dept. 2018], *quoting Padula v. Bucalo*, 266 AD2d 524, 524 [2nd Dept. 1999]; *Sampson v. Contillo*, 55 AD3d 588, 589 [2nd Dept. 2008]), a hospital may nevertheless be held vicariously liable for the acts of independent physicians where a patient enters the hospital through the emergency room seeking treatment from the hospital and not from a particular physician of the patient's choosing (*Galluccio v. Grossman*, *supra* at 1052; *Salvatore v. Winthrop Univ. Med. Ctr.*, 36 AD3d 887, 888 [2nd Dept. 2007]; *Ryan v. New York City Health & Hosps. Corp.*, 220 AD2d 734, 736 [2nd Dept. 1995]). "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' " (*Muslim v. Horizon Med. Group, P.C.*, 118 AD3d 681, 683 [2nd Dept. 2014], *quoting Alvarado v. Beth Israel Med. Ctr.*, 78 AD3d 873, 875 [2nd Dept. 2010]), "and that 'the exception to the general rule did not apply' " (*Muslim v. Horizon Med. Group, P.C.*, *supra* at 683, *quoting Rizzo v. Staten Is. Univ. Hosp.*, 29 AD3d 668, 668–669 [2nd Dept. 2006]).

As to the defendant's burden in seeking summary judgment dismissal of the plaintiff's claim of lack of informed consent, this Court begins by noting that lack of informed consent is a distinct cause of action which requires proof of facts not contemplated by an action based merely

on allegations of negligence (*Kleinman v. North Shore Univ. Hosp.*, 148 AD3d 693, 694 [2nd Dept. 2017] [internal quotation marks and brackets omitted]). "A cause of action predicated 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" (*Id.* [internal quotation marks omitted]; see Public Health Law § 2805–d[1]; *Figueroa–Burgos v. Bieniewicz*, 135 AD3d 810 [2nd Dept. 2016]; *Tsimbler v. Fell*, 123 AD3d 1009, 1010 [2nd Dept. 2014]; *Walker v. Saint Vincent Catholic Med. Ctrs.*, 114 AD3d 669, 670 [2nd Dept. 2014]). Thus, to establish a cause of action to recover damages for malpractice 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 (*see Figueroa–Burgos v. Bieniewicz*, *supra* at 811; *Tsimbler v. Fell*, *supra* at 1010; *Walker v. Saint Vincent Catholic Med. Ctrs.*, *supra* at 670).

The principles of law pertaining to a claim of negligent hiring, supervision and retention, "[g]enerally, where an employee is acting within the scope of his or her employment, the employer is liable for the employee's negligence under a theory of *respondeat superior* and no claim may proceed against the employer for negligent hiring, retention, supervision or training" (*Talavera v. Arbit*, 18 AD3d 738, 738 [2nd Dept. 2005]; *see Quiroz v. Zottola*, 96 AD3d 1035, 1037 [2nd Dept. 2012]). A cause of action for negligent hiring is based upon the defendant's status as an employer.

Such a claim requires the employer to answer for a tort committed by an employee against a third person "when the employer has either hired or retained the employee with knowledge of the employee's propensity for the sort of behavior which caused the injured party's harm" (*Kirkman by Kirkman v. Astoria General Hosp.*, 204 AD2d 401, 403 [2nd Dept. 1994]; *see Carnegie v. J.P. Phillips*, 28 AD3d 599, 600 [2nd Dept. 2006]; *Mataxas v. North Shore Univ. Hosp.*, 211 AD2d 762 [2nd Dept. 1995]). "The employer's negligence lies in his having placed the employee in a position to cause foreseeable harm, harm which would most probably have been spared the injured party had the employer taken reasonable care in making decisions respecting the hiring and retention of his employees" (*Detone v. Bullit Courier Serv.*, 140 AD2d 278, 279 [1st Dept. 1988]). Thus, a negligent hiring claim does not require the existence of any particular relationship between the plaintiff and the defendant employer (*see Rodriguez v. United Transp. Co.*, 246 AD2d 178, 180 [1st Dept. 1998]). Rather, the defendant is responsible for the harm its negligently hired employee causes to any third party.

The Court will now address each motion herein separately, applying the aforesaid principles to the facts presented.

Sequence 009

As against defendant Winthrop, plaintiff alleges, *inter alia*, that during his presentation at Winthrop with penile cellulitis and an eventual diagnosis of an abscess, he received medication which caused GBS and/or critical care neuropathy. Plaintiff also asserts that Winthrop is vicariously liable for the actions of Drs. Mellinger and Hamid. Additionally, plaintiff claims that the hospital is negligent in hiring, retention, and supervision of its staff. Plaintiff also alleges that the defendant neither provided nor obtained his informed consent for the surgical procedures performed by Dr. Mellinger.

Upon the instant motion, defendant Winthrop University Hospital, seeks summary judgment dismissal of the plaintiff's complaint as asserted against it including claims of medical malpractice, lack of informed consent and vicarious liability in their entirety.

Notably, although the plaintiff has advanced claims against defendant Winthrop, *supra*, he does not oppose said defendant's motion for summary judgment [Seq. 009]. Indeed, counsel for plaintiff, in his "Affirmation of No Opposition" dated September 18, 2019, explicitly asserts the following:

> ***
> 2. I respectfully submit this Affirmation to state that Plaintiff is not opposing the Motion for Summary Judgment of defendant WINTHROP UNIVERSITY HOSPITAL ("WINTHROP"), in light of its role in the care of treatment of Plaintiff post-priapism and after the cellulitis and infection had developed, which necessitated the administration of medication, and thus, is not addressing the remaining allegations made by defendant WINTHROP in the instant motion in their entirety.
> ***

Despite the foregoing, the movant is not relieved of its obligation to first establish a *prima facie* case of entitlement to the relief requested (*Zecca v Riccardelli*, 293 AD2d 31, 34 [2nd Dept. 2002]). Indeed, despite the fact that Winthrop's motion is unopposed by the plaintiff herein, this Court remains obligated to first determine whether the movant has established its *prima facie* entitlement to judgment as a matter of law. " failure to make such *prima facie* showing requires a denial of the motion, regardless of the sufficiency of the opposing papers (*Alvarez v. Prospect Hosp.*, *supra* at 324; *Winegrad v. New York Univ. Med. Center*, 64 NY2d 851, 853 [1985]) – or in this case, the lack thereof.

Here, in support of its motion for summary judgment, Winthrop submits and relies upon, *inter alia*, the expert affirmation of Prashant Malhotra, M.D., a physician Board Certified in Internal Medicine with a subspecialty of Infectious Disease.

In his sworn affirmation, Dr. Malhotra, based upon his "review[] of…the records of Winthrop University Hospital from June 19, 2014 to August 2, 2014; plaintiff's Verified Bill of Particulars; the records of Dr. Goodman; the records of Nassau University Medical Center; the records of Dr. Schumer; the records of Dr. Mellinger; the deposition transcripts of Douglas Helkowski; the deposition transcript of Dr. Goodman; the deposition transcript of Dr. Scambia; the deposition transcript of Dr. McCally; the deposition transcript of Dr. Ahmed; the deposition transcript of Dr. McClenan; and the deposition transcript of P.A. Pinto on behalf of Winthrop University Hospital" (Malhotra Aff., ¶ 5), opines, to a reasonable degree of medical certainty, in pertinent part, as follows:

> ***
> 33. The Winthrop University Hospital records do demonstrate care within the confines of good and accepted medical practice and do not substantiate the allegation of failure to train the staff.
>
> 34. In summary, it is my opinion to a reasonable degree of medical certainty that the care and treatment rendered by the hospital staff and those individuals that plaintiff alleges the hospital is vicariously liable, for were all in accordance with good and accepted medical practice. There is no documented medical evidence to support the alleged claim that his antimicrobials contributed to Guillain-Barre. The various medications prescribed to Mr. Helkowski during the Winthrop University Hospital admission did not cause or contribute to the development of Guillain-Barre Syndrome. Further, the records reflect ample evidence of discussion with the patient about all of his procedures, the medications being given and allowing the patient to verbalize his opinions.
>
> 35. Further, there were no acts or omissions on the part of any of the health care providers who cared for Mr. Helkowski during the June through August of 2014 Winthrop University Hospital admission that caused injury or damage to Mr. Helkowski.
> ***

(Malhotra Aff., ¶¶33-35).

This Court finds that defendant Winthrop has established its *prima facie* entitlement to

judgment as a matter of law (*see generally*, *Bacalan v. St. Vincents Catholic Medical Centers of New York*, 179 AD3d 989 [2nd Dept. 2020]).

Under these circumstances, and there being no opposition to the defendant's application, this Court grants Winthrop's instant motion for summary judgment dismissal of the plaintiff's complaint as asserted against it (*see generally*, *Pagano v. Cohen*, 164 AD3d 516 [2nd Dept. 2018]; *Prunty v. Pastula*, 171 AD3d 1110 [2nd Dept. 2019]).

The complaint against Winthrop University Hospital is dismissed.

Sequence 008

As against defendant, Orville McLenan, M.D., the plaintiff claims, *inter alia*, that Dr. McLenan was negligent in his care and treatment of the plaintiff from May 29, 2014 to June 13, 2014. Plaintiff also claims that Dr. McLenan was negligent in the management of the plaintiff's priapism, that he failed to properly treat the priapism as an emergency, and that he negligently performed medical and surgical procedures to treat the plaintiff's priapism. Additionally, plaintiff claims that Dr. McLenan improperly discharged the plaintiff on June 3, 2014 despite his complaints of penile pain. Finally, plaintiff claims that Dr. McLenan also failed to prescribe adequate antibiotic coverage for plaintiff's infection following the procedure.

In support of his motion for summary judgment dismissal, Dr. McLenan submits and relies upon, *inter alia*, the expert affirmation of Gary H. Weiss, M.D., Ph.D, a medical physician licensed to practice in the State of New York, Board Certified in Urology and presently an Attending Urologist at both North Shore University Hospital and Long Island Jewish Medical Center.

Based upon his review of, *inter alia*, the Bill of Particulars and the medical records of Douglas Helkowski from NUMC, depositions taken in this action including the seven days of

testimony of the plaintiff, the deposition testimony of Dr. McLenan as well as the other parties' depositions, Dr. Weiss, opines, in pertinent part, as follows:

> ***
> 11. Based upon the system set up by [NUMC], Dr. McLenan did not see this patient again at any time, either during this June 1 admission or at either of the clinic visits on June 6 and June 13, 2014. His only treatment of this patient was the shunting procedure on June 1, 2014.
>
> 12. It is apparent from a review of the records and deposition testimony that Dr. McLenan's care and treatment of this patient was at all times well within the acceptable standard of care in the community. The decision to do a shunting procedure was correct and indicated. The performance of the procedure was successful. Two hundred fifteen milliliters of blood were removed and the priapism relieved. This patient was given appropriate antibiotic coverage with intravenous Ancef IV piggyback every twelve hours until the time of his discharge. The urologist who saw him on the day of discharge, June 3, 2014 noted that he would be sent home with antibiotics. This antibiotic coverage given to the patient was well within the standard of care. Thereafter, Dr. McLenan had no further contact with this patient after the emergency shunting procedure.
>
> 13. It is therefore my opinion, with a reasonable degree of medical certainty that Dr. McLenan's care and treatment of this patient was at all times well within the standard of care of urologists.
> ***

(Weiss Aff., ¶¶11-13).

This Court finds that the defendant, Dr. McLenan has established his *prima facie* entitlement to judgment as a matter of law that he neither departed from good and accepted medical practice in his care and treatment of the plaintiff herein nor was any such alleged departure the proximate cause of plaintiff's injuries (*see Sukhraj v. New York City Health & Hosps. Corp.*, 106 AD.3d 809 [2nd Dept. 2013]; *Swanson v. Raju*, 95 AD3d 1105, 1106 [2nd Dept. 2012]; *Stukas v. Streiter*, *supra* at 24; *compare, Pullman v. Silverman*, 28 NY3d 1060, 1062 [2016]; *Gentile v Malihan*, 179 AD3d 902 [2nd Dept. 2020]).

In opposition, the plaintiff submits "a combined Opposition to the Motions of the three moving defendants, NUMC, DR. SCAMBIA and DR. MCLENAN" (Osuna Aff. In Opp., ¶4).

Indeed, the plaintiff's counsel frequently refers to them collectively as "the defendants NUMC", *infra*. Although this Court recognizes that each defendant is entitled to a particularization of his or her alleged departures, this Court will nevertheless consider the plaintiff's "combined opposition" insofar as they apply to the motions advanced by Dr. McLenan (Sequence 008) as well as by Dr. Scambia and NUMC (Sequence 006), *infra*.

In his opposition, plaintiff relies upon, *inter alia*, an expert affirmation of a physician licensed to practice medicine in the States of Massachusetts and New Hampshire and is Board Certified by the American Board of Urology, and the expert affirmation of a physician licensed to practice medicine in the State of Pennsylvania and Board Certified in Internal Medicine and Infectious Disease.

The Court notes that "[i]t is sufficient if the expert attests to familiarity with either the standard of care in the locality or to a minimum standard applicable locally, statewide, or nationally (*see McCullough v. University of Rochester Strong Mem. Hosp.,* 17 A.D.3d 1063; *Hoagland v. Kamp,* 155 A.D.2d 148, 150; *Payant v. Imobersteg,* 256 A.D.2d 702, 705)" *(* M.C. *v. Huntington Hosp.*, 175 A.D.3d 578, 581[2nd Dept. 2019). The affirmation of the plaintiff's expert sufficiently identified, and assessed, the defendants' conduct against the relevant standard of care.

Plaintiff's Urology expert, opines, in pertinent part, as follows:

***

63. It is undisputed that in the instant case, Plaintiff sustained an ischemic priapism as a result of taking Trazodone, which is a drug known to cause priapism***. Priapism is a persistent erection that continues for hours that is not associated with sexual stimulation. Patients presenting with priapism need to be emergently evaluated to determine if the same is ischemic or non-ischemic as time is of the essence to treat the former.

64. Ischemic priapism is a low flow prolonged erection resulting from intracavernosal pressure, and involves decreased arterial flow, blood stagnation, hypoxia, and

acidosis manifesting as a prolonged, rigid, and painful erection, tender to palpitation, which is considered a urologic emergency***. If the patient is experiencing ischemic priapism, then adequate interventions need to be implemented as early as possible to increase the opportunity of a good prognosis and recovery and reduce the likelihood of penile damage and erectile disfunction***. In contrast, a nonischemic priapism it involves a prolonged non-painful erection that may be partially rigid and is not a medical emergency as most of the time it resolves spontaneously***.

65. The objective in managing a patient with ischemic priapism is for the penis to return to a flaccid (achieve detumescence) and a nonpainful state and preserve erectile function. The initial treatment for this type of priapism is aspiration of the cavernosa, followed by irrigation and injection of phenylephrine***. If the patient is not responsive to such treatment then the performance of a distal shunt, such as a Winter, Al-Ghorab or Ebbehoj, is indicated***. If the aforementioned shunt is not effective, then a proximal shunt may be subsequently indicated.

66. It is my opinion, within a reasonable degree of medical certainty that Defendants failed to properly treat and manage Plaintiff s ischemic priapism during his presentations to the emergency room, hospitalizations, and clinical visits at defendant NUMC. At the time of his first presentation to the emergency room, Plaintiff was experiencing a painful erection for approximately 6 hours, following a non-painful semi-erection the day prior. There is no dispute that Dr. Scambia's first and second attempts of aspiration and infusion were unsuccessful.

67. Dr. Scambia saw the patient around 8:00pm and performance the first attempt to detumesce the penis through aspiration and irrigation procedure around 9:00 pm, which lasted for approximately 20 to 40 minutes, and proved unsuccessful. At around 12:30 am, she performed a second attempt that was similarly ineffective. It is my opinion, within a reasonable degree of medical certainty, that Dr. Scambia departed from the standard of care and failed to properly perform the detumescence procedures. During the first and second attempt, Dr. Scambia used a 21-gauge needle, which was an ineffective needle size for Plaintiff's condition as it was not likely to aspirate enough blood for the procedure to be effective***. During the first detumescence procedure, Dr. Scambia only aspirated 5cc, which is an inadequate amount of blood for aspiration***. It was a departure to use this size of needle to treat Plaintiffs priapism in light of his medical history and presenting conditions.

68. Additionally, there was an infiltration of 3 cc in the subcutaneous tissue of the 8cc of phenylephrine that was purportedly administered, which indicated that the needle either become dislodged out of the corpora cavernosa in the subcutaneous issue or it was not inserted in the right location initially, and thus, Dr. Scambia failed to infuse an adequate amount of phenylephrine of at least 10cc***. Therefore, the amount of phenylephrine injected for treatment was also inadequate.

69. Moreover, the second attempt was performed at approximately 12:30 am using the same sized needle. After the first procedure, the penis became fully erect shortly thereafter and thus, there was a further delay in holding treatment to the Plaintiff for longer than necessary.

70. Defendant's expert, Dr. Frederick Gulmi, incorrectly advances, that Dr. Scambia's lack of inexperience did not contribute to Plaintiffs injuries***. Dr. Scambia was not aware of the duration of time she should have been attempting to treat ischemic priapism with aspiration, irrigation, and infusion, nor the maximum does of Phenylephrine that a patient with ischemic priapism should have received***. As a result of Dr. Scambia's inadequate treatment and technique, there was a further delay in treatment and the opportunity of a better prognosis for Plaintiff.

71. It is my opinion that Dr. Scambia, as a resident, failed to recognize her limitations and inexperience and seek assistance in treating a patient with ischemic priapism that, according to her note, had become painful for the last 6 hours and thus prompt and adequate treatment was of an urgent nature. For instance, according to defendant Dr. McCally, Dr. Scambia did not discuss that she aspirated only 5cc during the first attempt nor recalls whether she advised if she had experience or not***. Defendant Dr. Scambia should have advised the attending Dr. McCally, that she had never performed a detumescence procedure to treat priapism prior to the performance of the same.

72. Based on the two failed detumescence procedures performed by a PGY-1 resident, it should have been clear that the Plaintiff needed, at a minimum, for an aspiration and irrigation procedure to be performed by an experienced physician to manage his ischemic priapism, or if the same was also unsuccessful, to promptly perform a distal shunt. Thus, it is my opinion, within a reasonable degree of medical certainty that it was a departure from the standard of care to not have an attending physician examine the patient and/or directly supervise the resident on the evening of May 29, 2014 or shortly after 1:00 am on May 30, 2014. Nonetheless, a third detumescence procedure was performed by a PGY-2 resident after 6:30 to 7:00 am without the supervision of an attending, which was also unsuccessful.

73. Furthermore, according to Dr. Scambia there were no other physicians or more senior residents or interns on call who were covering the emergency room the evening of May 29, 2014**. She only consulted with Dr. McCally over the phone***. Thus, it is my opinion, within a reasonable degree of medical certainty, that it was a departure from the standard of care for defendant NUMC to not have sufficient and adequate personnel to directly supervise defendant Dr. Scambia, a first-year resident.

74. After Dr. Scambia's two detumescence procedures failed, she admitted Plaintiff to a hospital at approximately 1:00 am on May 30, 2014. However, no further interventions were commenced until after 6:30 am or 7:00 am when Dr. Ahmed started his shift and performed the third detumescence procedure sometime

thereafter, as there was no attending or more senior resident on site to evaluate the patient. Therefore, from the time he was admitted to the hospital there was an additional delay of at least 5 to 6 hours.

75. Furthermore, defendant Dr. McCally, the attending urologist, was not in the Hospital that evening of May 29, 2014 nor examined Plaintiff after he was admitted under his service on May 30, 2014***. It is my opinion, within a reasonable degree of medical certainty, that defendant Dr. McCally deviated from the standard of care by failing to directly examine, evaluate, and timely perform any necessary procedures on Plaintiff despite being aware of at least two prior unsuccessful detumescence procedures***. After two unsuccessful detumescence procedures, Plaintiff's condition had become more severe and emergent, which warranted the physical presence of an attending physician to oversee his care.

76. Within a reasonable degree of medical certainty, it is my opinion, that Plaintiff was improperly discharged on May 30, 2014, as it is more likely than not that Plaintiff's was still erect and consequently his priapism had not resolved at the time of his discharge. According to the Plaintiff he returned to the emergency room at NUMC as "the erection had never gone away to a point where it felt comfortable at all"***. As noted by Dr. McCally, a patient needs to stay in the hospital until the detumescence is achieved, "the patient says he doesn't have pain" and "if there is any question, the patient stays in the hospital" for "observation or perhaps a further treatment"***. Resolution of priapism can be verified by measurement of cavernous blood gases or blood flow measurement by color doppler ultrasonography. None of these methods were utilized during the admissions of May 30, 2014, June 1, 2014, or during the clinic visits of June 6, 2014 and June 13, 2014. Therefore, it was a deviation from the standard of care to fail to properly evaluate and assess whether Plaintiff's priapism had fully resolved prior to discharging him for the hospital in light of his persistent complaints.

77. It is also my opinion that defendant NUMC had insufficient personnel and lack of adequate supervision for the residents under their sponsorship and training. Based on my review of the NUMC medical records and defendants' testimony, it is evident that an attending did not examine Plaintiff prior to his discharge. Dr. Scambia prepared the discharge summary, which was only co-signed by Dr. McCally without seeing the patient***. Dr. Ahmed discharged Plaintiff home, however, there are no notations in the chart prepared by him describing the procedure he performed, the effectiveness of the same, or the results of his purported examination prior to discharge***. It is further my opinion that it was a departure from good and accepted medical practices to discharge Plaintiff without him being properly evaluated and examined by an attending physician. Thus, as the admitting physician, defendant Dr. McCally deviated from the standard of care by failing to be present to the hospital to evaluate and treat the patient, or directly supervise the residents, on the evening of May 29, 2014 and during his subsequent hospital admission and discharge on May 30, 2014. Defendant Dr. McCally should have come in to the hospital to evaluate whether the two detumescence procedures

performed by Dr. Scambia had failed because they were performed incorrectly or because they would be ineffective, indicating the need for a more invasive procedure such as Winter or Ebbehoj shunt. However, Plaintiff was not seen by an attending physician during his stay at the hospital.

78. As a result of the untimely discharge, it is my opinion, within a reasonable degree of medical certainty, that it was a departure from the standard of care to delay the shunt procedure until June 1, 2014, if the three attempts of aspiration, irrigation, and infusion procedures were unsuccessful. If the patient did not respond to the initial treatment rendered, surgical intervention was indicated to resolve his priapism. It is very likely that if an attending had properly performed the detumescence procedure on the night of May 29, 2014 or, at least on the early morning of May 30, 2014, and such attempt(s) were unsuccessful then a distal shunt procedure would have been performed at least two days prior to the actual day of the shunting on June 1, 2014, which would have resulted in less damage to the penis and would had increased the likelihood of a better prognosis to Plaintiff in particular because the duration of his full and painful erection had only been approximately occurring for 6 hours at the time of his first presentation to the hospital***.

79. On June 1, 2014 at approximately 7:34 am, Dr. McLenan performed a shunting procedure, which is erroneously described as a "Winter Shunt." Based on the operative note, Dr. McLenan actually performed an Ebbehoj shunt, since he utilized a scalpel blade in lieu of a biopsy needle to perform the procedure. It is my opinion within a reasonable degree of medical certainty that the distal shunt procedure was unnecessary delayed, which was a departure from the standard of care. Every hour that treatment is delayed, the likelihood of a bad prognosis increases. At the time of discharge on May 30, 2014, approximately 20 additional hours had elapsed. Thus, from the time Plaintiff initially presented to NUMC at approximately 5:00 am, and the time the distal shunt was performed on June 1, 2014 at approximately 7:00 am, there was a delay of approximately 60 hours.

80. It is also my opinion within a reasonable degree of medical certainty that defendant Dr. McLenan departed from the standard of care by failing to render proper post-operative treatment. Admittedly, Dr. McLenan did not examine the patient during his post-operative course in the hospital in order to determine if the shunt procedure was successful or not nor during the follow-ups at the urology clinic despite performing the distal shunt procedure on June 1, 2014***. He did not author a discharge summary and just signed the one prepared by the resident***. It is my opinion, within a reasonable degree of medical certainty, that Dr. McLenan's care and treatment did not end at the conclusion of the performance of the distal shunt. The standard of care indicated for Dr. McLenan to further evaluate the patient and ensure that the distal shunt had fully resolved the priapism, or if such was not the case, perform other surgical interventions or refer the patient to another urologist who was able to perform the same.

81. It is my opinion within a reasonable degree of medical certainty, that based on my

review of the medical records, including the Winthrop Hospital records, that the abscess was not just in the skin of the issue of the penis but also in the corpora cavernosa, as these erectile bodies had collected purulent material as noted by the incision and drainage procedure report of June 23, 2014.

82. Based on the above, it is probable that Plaintiff's erection had not fully resolved after the shunt procedure. Priapism is caused by blood that gets trapped inside the erectile body or corpora cavernosa. During his hospitalizations and follow-up clinic visits, Plaintiff's penis was significantly swollen and extremely painful. According to the Winthrop incision and drainage of the penile abscess' report, in addition to the subcutaneous tissue, the corpora cavernosa contained purulent drainage and necrotic tissue, indicating a severe infection. If the priapism had resolved and therefore, the blood was circulating out of the corpora bodies, then the chance of the same being filled with purulent material would be very low. Consequently, it is plausible that the corpora cavernosa still contained trapped blood after the shunting procedure, was left stagnant for an extended period, which caused or contributed to Plaintiff's persistent extreme pain and swelling, became infected, and caused purulent drainage to accumulate in the erectile tissue. Furthermore, Plaintiff also developed a fistula to the urethra, which indicated that he sustained a destructive and severe infection.

83. Subsequent to his discharge from the hospital, defendant NUMC had additional opportunities to properly treat Plaintiff when he presented on two occasions to the clinic for follow-up as instructed with persistent complaints of pain, swelling, and dysuria, which were indicted of of possible cellulitis that ultimately developed into a penile cavernosal abscess, sepsis, and the ensuing complications.

84. It is father my opinion, within a reasonable degree of medical certainty, that the physicians who evaluated and treated Plaintiff at the clinic, including defendants Dr. Ahmed and Dr. McCally, also failed to properly manage his priapism post-operatively during the two clinic presentations. During the clinic presentations, despite Plaintiff's persistent complaints, no adequate work-up was performed to rule out any infections or unresolved ischemic priapism. It is possible that the signs, symptoms, and complaints presented by Plaintiff on June 13, 2014, were indicative of an unresolved erection or cellulitis and more than likely developing corporal abscess formation. Defendants Dr. Ahmed and Dr. McCally could have order cavernosal blood gas, color doppler ultrasonography, imaging studies, or to admit the patient to the hospital, to assess or rule out a persistent priapism with or without coexisting infection. Moreover, had these defendants properly evaluated and treated the infection that was highly likely present and apparent at least at the time of second clinic presentation, the early management of the same, through IV antibiotics, would have prevented the development of an infection of such severity, and would have more likely than not, prevented the ensuing complications suffered by the patient, including the penile cavernosal abscess, sepsis, and his neurological disorders.

85. I will further defer to Plaintiff's expert in Infectious Disease to opine on the

standards of care as to the diagnosis and treatment of the cellulitis and any departures from the standards of care by the aforementioned defendants regarding the same.

86. Defendants NUMC further departed from the standard of care in failing to maintain proper and adequate documentation of the medical staff's examinations, assessments, and interventions performed during the patient's hospitalizations and clinic visits. For instance, Dr. Ahmed was not able to conclude, based on his review of the chart, how well the overnight irrigations worked or the degree of relief experienced by the patient, if any***. Dr. Ahmed further conceded that it was good and accepted urology practice to prepare a report of the procedure performed***. Furthermore, there is nothing in the records that memorialize or reference discussions between Dr. Ahmed and the attending urologist***.

87. Also, it is my opinion that the residents, including Dr. Ahmed and Dr. Scambia, were not properly supervised at the hospital and clinics, by defendant NUMC and the attendings under its supervision, such as Dr. McCally. Particularly, Dr. Scambia, as a PGY-1 resident, required direct supervision, during which a supervising physician, such as an attending or more senior resident, is physically present with the resident and the patient, or at, a minimum, necessitated indirect supervision with direct supervision immediately available, where the supervising physician is physically within the hospital and immediately available to assist the resident.

88. Furthermore, defendant NUMC, through Dr. Scambia, Dr. Ahmed, Dr. McCally, and Dr. McLenan, failed in adequately informing Plaintiff of the foreseeable risks, benefits, and alternatives of the proposed treatment or the procedure. Based on a review of the medical records and deposition testimony, is not clear that Defendants NUMC properly explained the full risks and benefits of the available procedures and timing of the same to treat his priapism, such as an earlier distal shunt instead of three unsuccessful detumescence procedures, the type of shunt, and properly communicating what each procedure entailed and likelihood of success.

89. Defendant's expert, Frederick Gulmi, M.D., allegations that Plaintiff had an erection for at least 30 hours duration and thus had already experienced significant tissue damage which prevented the effectiveness of the nonsurgical attempts to resolve the priapism is against the medical literature, and contradicted by defendants' own testimony and medical records***. Regardless of the timing of the presentation of the patient with ischemic priapism, the standard of care requires to act quickly and manage his priapism as early as possible. No diagnostic studies performed at NUMC to determine the extent of Plaintiff's penile tissue damages despite the various opportunities to do so. The patient's own history supported only a partial erection the previous day, and a full and painful erection for 6 hours. Thus, there is no basis to conclude that at the time of his presentation to the ER on May 29, 2014, Plaintiff had already significant tissue damage and destruction and erectile dysfunction during his first admission as purported by defendant's expert ***.

90. Although the treatment of this condition is time sensitive, Plaintiff's erection had become painful approximately 6 hours prior to his presentation to NUMC. Even though it is reported that he experienced the priapism for 30 hours, only 6 hours

prior was the penis fully erect and painful. Thus, at such time, the likelihood of recovery without sustaining permanent penile damage was considerably greater***. For instance, Dr. McCally testified that "studies have shown if you go beyond 72 hours, that you are almost guaranteed or it is a very high risk that the patient will not be able to develop spontaneous erection subsequently"***.

91. If, as advanced by defendant's expert, the patient's penis had already been damaged, which prevented the successful aspiration and insertion of Phenylophrine solution from being therapeutic, then had an attending physician determined that a properly performed procedure was unsuccessful on 5/29, he should have proceed directly to perform distal shunt procedure instead of performing two additional attempts of detumescence procedures and discharging Plaintiff on May 30, 2014 without surgical intervention ***. Furthermore, if Plaintiff's chance of recovery and ability to gain erectile function were so slim at the time the shunt procedure was performed, then the next step would have been to perform an immediate penile prosthesis or refer him to another hospital to perform any indicated procedures. Nonetheless no further interventions were performed after the performance of the distal shunt on June 1, 2014. Plaintiff was discharged home on June 3, 2014 and was assured during his two subsequent clinic visits that, despite his documented persistent complaints of severe pain of 10 out of 10, dysuria, and penile swelling, this was normal and was instructed to follow-up in a month after the June 13, 2014 visit.

92. Furthermore, Defendants' expert does not account for the delay caused by Defendants NUMC in treatment between the subsequent second and third aspiration and irrigation procedures and from the time of discharge until the distal shunt was eventually performed on June 1, 2014. As indicated by Dr. Gulmi, when an erection last more than 4 hours "prompt medical attention is needed to avoid the potential for serious injury, including destruction of tissue in the penis, penile fibrosis, and erectile dysfunction" and "the longer the erection last beyond 4 hours the more likely those issues inherent in the disease process will arise"***. However, this does not imply that if the erection lasts more than 4 hours that permanent damage will result, and a positive outcome can still result even in erections lasting more than 24-30 hours***.

93. Regardless of the duration of the erection at the time of the emergency room presentation on May 29, 2014, Defendants NUMC failed to provide adequate care and treatment in handling Plaintiff's priapism. Thus, even assuming that the patient had a poor prognosis during his initial emergency room visit at the NUMC, defendants were required to provide him with proper treatment and urgent interventions within the standard of care and avoid further delays in treatment, which they failed to do so.

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(Plaintiff's Urology Expert Affirmation)

Similarly, the plaintiff's Internal Medicine and Infectious Disease expert, opines, in pertinent part, as follows:

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6. I have reviewed the pertinent materials in this action, including the medical records from defendants Shirley Goodman, M.D., Nassau University Medical Center, Winthrop University Hospital, Bill of Particulars and Supplemental Bill of Particulars, the various depositions held in this case, including plaintiff, defendants, and non-party witness, photographs, and defendants Jillian Scambia, D.O., Orville McLenan, M.D., Nassau University Medical Center, and Muhammad Hamid, M.D.'s Expert Affidavits in support of their respective motions for summary judgment.

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Opinion

61. Based upon my professional knowledge, education, training and experience as a Board Certified physician in Internal Medicine and Infectious Disease, including knowledge of the accepted standards of medical practice and care and guidelines applicable in 2013, 2014, and presently, as well as my review of the above mentioned medical records and materials, it is my opinion with a reasonable degree of medical certainty that defendant NUMC, acting through it agents, employees, and/or independent contracts under its supervision, including Jillian Scambia, DO, Daniel McCally, M.D., Haris Ahmed, M.D., and Orville McLenan, M.D. (hereinafter "Defendants NUMC") departed from the standard of care in the medical community by failing to render adequate post-operative care, falling to perform adequate evaluations and diagnostic testing, and failing to timely treat Plaintiff's cellulitis and provide adequate antibiotic therapy, which proximately caused and contributed to Plaintiff's injuries, including his penile cavernosal abscess, sepsis, staphylococcus aureus septicemia, chronic pain, neuropathy, neurological impairments, penile trauma and tissue damage, erectile dysfunction, among other related injuries, substantially reduced the likelihood of a good outcome and diminished his chance for full recovery.

62. I will defer to plaintiff's expert in Urology to opine on the standards of care in the field of Urology and as to the departures from the standards of care by the aforementioned defendants.

63. It is my opinion, within a reasonable degree of medical certainty, that based on Plaintiff s sign, symptoms and complaints presented on June 6, 2014 and June 13, 2014, including his persistent excruciating pain, swelling in the glans and shaft, and dysuria, Defendants NUMC should have been concerned about a potential infection at such times. It is my opinion, within a reasonable degree of medical certainty, that Defendants NUMC should have treated the patient with indicated antibiotics in light of his persistent complaints of extreme pain and worsening condition.

64. Following his admission of June 1, 2014 and the performance of a distal shunt, Plaintiff was discharge on June 3, 2014, with complaints of excruciating penile pain. Dr. McLenan did not see the patient during his postoperative course in the hospital or during the clinic follow ups. Plaintiff's photographs dated June 2, 2014 of his genitalia, depict the head of the penis with a blister or drop of visible fluid,

that could be indicative of potential drainage. Plaintiff was instructed to follow up at the urology clinic on June 6, 2014.

65. Based on Plaintiff's hospital course at NUMC and the interventions performed to manage his priapism, it is foreseeable that infections could result from different kinds of bacteria around the surgical wounds, which can progress and result in bad outcomes if untreated, such as necrotizing infections of the genitalia. The anatomical location of the groin area has the potential for infections with anaerobic bacteria, staphylococcus, streptococcus, and gram-negative rods.

66. On June 6, 2014, Plaintiff presented to defendant NUMC's clinic with complaints of sharp pain on his groin of 10/10, swollen glands, and dysuria or painful urination. According to the patient, at such time his penis was red, inflamed, and throbbing. Furthermore, the photographs of the patient's penis dated June 6, 2014, depict a penile head that is macerated, red, swollen and with scabbing, which would be consistent with a possible infection. Plaintiff complained that his condition was not getting better and the medical records note only mild improvement as to the penile pain. There are no vital signs taken or documented during this clinical visit. According to the records, he was still on amoxicillin on such visit. However, according to his parents, by such time he had finished the prescribed amoxicillin. The patient was instructed to come back for follow-up in a week***.

67. On June 13, 2014, the patient presented to the clinic as instructed. Dr. Ahmed and Dr. McCally treated and purportedly examined him during this visit. Plaintiff again reported constant and sharp pain in his penis of 10 out of 10. Per Dr. Ahmed's documents that the pain still remained an issue and he also reported burning pain on urination. Plaintiff also noted residual fibrosis and edema, According to Plaintiff the patient medications were not helping and the swelling and the pain had increased since the first clinic visit. Plaintiff also complained that he felt fatigued, feverish, chills, burning sensation in the penis, sweating, having flu-like symptoms, clamminess, lightheaded and believed there was something wrong with his body. Plaintiff's mother was able to observe some discharge coming from his penis on this visit. However, according to the patient and his family, such complaints were dismissed. No vital signs, including his temperature, were documented during this visit. Per the clinic note, pain control was to be continued with dilaudid/ketoral. There is no mention of the prescription or administration of any antibiotics. The patient was instructed to follow up in a month. It is my opinion, within a reasonable degree of medical certainty, that Defendant NUMC, through the actions or inactions of defendant Dr. McCally and Dr. Ahmed, failed to properly intervene and treat Plaintiff's infection on June 13, 2014.

68. Upon review of the photographs dated June 16, 2014, his penis looks significantly more swollen and in a worse condition compared to the photographs of June 6, 2014. Based on the progression of the appearance of the penis between the June 6, 2014 and the June 16, 2014 photographs, it is very likely that the penis closely resembled the appearance of the latter on June 13, 2014. Based on the reported

complaints, consistent with the likely appearance of the penis on June 13, 2014, it is my opinion, with a reasonable degree of medical certainty, that the photographs of the penis depict cellulitis, for which an adequate work-up was required and the prompt initiation of adequate intravenous antibiotics, such as Vancomycin.

69. Although he was discharged with oral antibiotics after the hospitalizations, he was not on antibiotics at the time of the clinic visits. At the minimum, there is no dispute that the patient was not on any antibiotics nor prescribed the same at the time of the clinic visit of June 13, 2014***. Even assuming he was still on amoxicillin/Augmentin on June 13, 2014, such oral antibiotic would have been ineffective to treat the type of infection that the patient sustained, which ultimately developed into a penile cavernosal abscess and resulted in sepsis and multiple other complications. The indicated treatment would be to admit him to the hospital to receive IV antibiotics such as vancomycin and piperacillin/tazobactam.

70. It is my opinion within a reasonable degree of medical certainty, that at least on June 13, 2014, it is probable that Plaintiff had an infection at such time. Around the time Plaintiff was admitted to Winthrop Hospital on June 19, 2019, he was diagnosed with sepsis secondary to penile cellulitis, penile abscess, staphylococcus aureus septicemia, and anemia. Staphylococcus aureus is a bacterial component of the skin flora that is known to cause abscesses. A penile abscess is a urologic condition that commonly presents with localized penile swelling and painful erections.

71. It is my opinion, within a reasonable degree of medical certainty, that at the latest at the time of the clinic visit of June 13, 2014, if not sooner, there was a clear need for imaging studies, such as ultrasound, computed tomography (CT), or magnetic resonance imaging (MRI), and/or laboratory studies, to evaluate Plaintiff's penile area in light of his persistent and worsening complaints of penile swelling, dysuria, and pain, that still existed twelve days after the surgery. It is also my opinion that on such visit Plaintiff needed to assessed and treated for cellulitis. However, defendant NUMC, through Dr. McCally and Dr. Ahmed, departed from the standard of care by failing to properly evaluate the patient, which would more likely than not lead to an earlier diagnosis and treatment Plaintiff's penile cellulitis and the rendering of indicated treatment, such as admitting him to the hospital to receive IV antibiotic therapy, such as vancomycin, which would have also covered the staphylococcus aureus bacteria and gram negative bacteria.

72. Furthermore, it is my opinion, within a reasonable degree of medical certainty, that Plaintiff' s severe infection and neurological disorders that were diagnosed and/or developed at Winthrop Hospital could have been probably avoided if earlier treatment with IV antibiotic therapy had been administered a week earlier. By the time Plaintiff was admitted to Winthrop Hospital, he was septic, with low blood pressure and elevated WBCs, febrile, and his inflammation markers were at high levels, which would have likely not occurred if Plaintiff had been treated with IV antibiotics in a hospital setting at the latest on or around June 13, 2014.

73. Defendants NUMC, through Dr. McCally and Dr. Ahmed, on behalf of defendant NUMC, had the opportunity to deliver adequate care and treatment to Plaintiff's cellulites at such time, which would have resulted in earlier treatment and would have more likely than not resulted in a less severe infection before the formation of the penile cavernosal abscess, which ultimately required surgical intervention, and would have likely prevented Plaintiff's subsequent neurological complications and impairments. Therefore, it is my opinion, that defendants Dr. McCally and Dr. Ahmed, departed from the acceptable standards of care in the medical field by failing to admit the patient to a hospital to administer adequate antibiotic therapy in IV form to deal with the progression of the cellulitis, which ultimately was a substantial and/or contributing factor in causing Plaintiff's neurological impairments.

74. Defendants NUMC failed to consider and evaluate Plaintiff's persistent complaints, including penile swelling, painful urination, and overall extreme pain in the penile shaft and glands, and failed to perform adequate evaluations and diagnostic testing to rule out any potential complications from his priapism and ensuing interventions, such as a possible infection.

75. It is also my opinion, that early management of Plaintiff's cellulitis, would have very likely prevented the development of the abscess and sepsis. It is further my opinion, within a reasonable degree of medical certainty, that the severity of the infection contributed to the neurological implications that transpired at Winthrop Hospital and his diagnosis of OBS.

76. Furthermore, at the time of the June 13, 2014 clinic presentation, defendant NUMC, further departed from the standard of care by failing to properly follow-up on Plaintiff's condition in light of his signs, symptoms, and complaints. Defendants Dr. Ahmed and/or Dr. McCally advised the patient to return in a month for a follow-up appointment. It is my opinion, within a reasonable degree of medical certainty, that based on the aforementioned sign, symptoms, complaints, including persistent swelling, pain, dysuria, sweating, chills, clamminess, lightheadedness, fatigue, drainage, and other complaints, consistent with likely appearance of his penile shaft and glans on June 13, 2014, it was a departure from the standard of care to schedule a follow-up a month after this clinic visit. Defendants should have followed up more closely with the patient and, if they did not intend to admit him for the hospital, instructed him to come back to the clinic or the hospital for further evaluation and follow-up within a few days thereafter.

77. Plaintiff remained under Defendants NUMC care post-operatively and up until the time he presented to Winthrop Hospital on June 19, 2014 and sought and was supposed to receive adequate care and treatment at defendant NUMC's hospital and clinics. He was following Defendants NUMC's instructions, presented for follow-up appointments and treatment as indicated, and relied on the assurances from the medical providers at NUMC that his progression was normal and that he should not

be concerned about his persistent complaints.

78. It is also possible, if the priapism had not fully resolved following the shunt procedure on June 1, 2014, that blood could have remained trapped in the corpora cavernosa and affect the circulation of blood through the penis, which would affected the ability of the body to prevent infection and could have led to the purulent drainage collection and necrotic tissue observed during the incision and drainage of June 23, 2014. Regardless, if adequate work-up and evaluations would have been performed post-operatively, if such was the case, the same could have been properly treated and resolved with indicated interventions.

79. Defendants NUMC further departed from the standard of care in failing to maintain proper and adequate documentation of the medical staff's examination and assessment during the patient's hospitalizations and clinic visits, to enable proper observation and monitoring of Plaintiff s condition.

80. Therefore, it is my opinion, within a reasonable degree of medical certainty that the departures from the standard of care of Defendants NUMC and the failure to timely diagnose and treat Plaintiffs cellulitis, was the proximate and contributary cause of Plaintiff's severe infection, penile cavernosal abscess, sepsis, neurological impairments, and the ensuing necessary surgical and medical interventions, complications, and injuries arising from the same.

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(Plaintiff's Infectious Disease Expert).

This Court finds that plaintiff has failed to present any admissible evidence warranting a trial on the issue plaintiff's lack of informed consent claim as asserted against Dr. McLenan. The plaintiff failed to offer any evidence to challenge the otherwise undisputed testimony and documentary proof on this record that establishes that Dr. McLenan spoke with the plaintiff in the holding area prior to the surgery, and that the consent form itself bears the plaintiff's signature along with that of a witness. In any event, neither of plaintiff's experts offers any proof to challenge the movant Dr. McLenan's claim that, notwithstanding all of the above, the procedure performed by Dr. McLenan was an emergency and pursuant to Public Health Law Section 2805-d(2), consent was not needed.

However, the plaintiff has met his burden of raising a triable issue of fact in opposition to

Dr. McLenan's prima facie showing of entitlement to summary judgment, i.e., whether Dr. McLenan's post-operative course of treatment, beginning on June 1, 2014, departed from accepted standards of medical practice (*see, Gentile v. Malihan, supra).*

Sequence 006

As against defendants Jillian Scambia, D.O., and NUMC, plaintiff alleges that said defendants, *inter alia*, were negligent in the treatment of his priapism; that they negligently performed detumescence procedures to treat the priapism; negligently performed penile injections and aspirations and without plaintiff's informed consent; and failed to recognize and treat a penile infection. In addition, plaintiff alleges that these defendants were negligent in the hiring, retention and/or supervision of physicians who were incompetent. As a result of the alleged negligence, plaintiff has alleged injuries including erectile dysfunction and penile disfigurement.

In support of their motion, defendants Dr. Scambia and NUMC, submit and rely upon, *inter alia*, the expert affirmation of Frederick Gulmi, M.D., a physician licensed to practice in the State of New York and Board Certified in the field of Urology.

In his affirmation, Dr. Gulmi attests that following his review of, *inter alia*, the pleadings, Bill of Particulars/Supplemental Bill of Particulars, medical and hospital records along with all of the deposition testimony taken in this case as well as photographs, it is his opinion, with a reasonable degree of medical certainty that "the treatment rendered by these defendants (including the hospital staff and employees), was within the standard of good and accepted medical practice and that the treatment rendered was not a proximate cause of plaintiff's alleged injuries" (Gulmi Aff., ¶2). Specifically, Dr. Gulmi, opines, in pertinent part, as follows:

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3. … The treatment at issue took place during two admissions at NUMC (May 29-30, 2014 and June 1-3, 2014) and two outpatient Urology Clinic visits on June 6 and 13, 2014.

4. It is my opinion, with a reasonable degree of medical certainty, which is detailed below, that all of the treatment rendered by the movant/defendants (including the hospital staff) herein was in accordance with good and accepted medical practice; that the plaintiff was sufficiently advised of the risks and complications of the proposed procedure and gave his informed consent. It is also my opinion, with a reasonable degree of medical certainty, that the treatment rendered by the movant/defendants herein did not proximately cause any of the plaintiffs alleged injuries.

5. It is also my opinion, with a reasonable degree of medical certainty, that defendant JILLIAN SCAMBIA, D.O., as a first-year medical intern, exercised no independent medical judgment in the care and treatment rendered to the plaintiff and at all times acted under the direction and supervision of the Attending Urologist, warranting dismissal of the case as against her.

6. As detailed below, it is my opinion, with a reasonable degree of medical certainty, that when plaintiff first presented to NUMC on May 29, 2014, he had an erection of at least 30 hours duration and had already experienced significant tissue damage which prevented the effectiveness of the nonsurgical attempts to resolve the priapism. The oxygen-deprived blood that had accumulated in the penis caused significant damage to the surrounding tissues resulting in penile fibrosis preventing an effective penile detumescence. There was nothing Dr. Scambia or NUMC did or did not do during the treatment of the plaintiff that caused the failure of the aspiration procedure or the need for the shunt surgery. It is also my opinion, with a reasonable degree of medical certainty, that the plaintiff was given the appropriate antibiotics following his admissions to assist in the prevention of infection and further there were no signs or symptoms of an infection through the last date of treatment at NUMC on June 13, 2014.

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OPINION

17. It is my opinion, with a reasonable degree of medical certainty, that there were no departures from good and accepted medical practice with regard to the treatment rendered by Dr. Scambia and NUMC (or its staff/employees) and that the treatment rendered by these defendants was not the proximate cause of the plaintiff's alleged injuries. (When reference is made to treatment at NUMC, this refers to treatment rendered at NUMC and by staff/employees. Also, the opinions expressed herein are all made with a reasonable degree of medical certainty and are supported by the certified medical records, sworn testimony and my knowledge and experience with the diagnosis, evaluation and treatment of priapism.).

18. Plaintiff presented to NUMC on May 29, 2014, complaining of an erection of 30+hours duration. This medical condition, known as priapism, is defined as a persistent penile erection, continuing beyond four hours duration, in the absence of sexual desire. Priapism can be caused by an underlying medical condition (such as

sickle cell anemia, lupus) or a reaction to a medication (such as antidepressants). Plaintiff was correctly diagnosed with ischemic priapism ("low flow"), which is the result of blood not leaving the penis, presenting with symptoms characterized by a painful erection. ischemic priapism can be caused by medications, including Trazodone, which plaintiff had taken. As there is no allegation that plaintiff was misdiagnosed or that the diagnosis of ischemic priapism was in error, I will not discuss the other types of priapism. When an erection lasts longer than 4 hours, prompt medical attention is needed to avoid the potential for serious injury, including destruction of tissue in the penis, penile fibrosis and erectile dysfunction. The longer the erection lasts beyond 4 hours the more likely these issues inherent in the disease process will arise.

19. As a first year intern, Dr. Scambia worked under the direction of the Attending physician, who in this case, was urologist, Dr. McCally. She appropriately and timely advised Dr. McCally of her findings, which were correct and accurate, and properly sought the attending's guidance and instruction with regard to the plan of care. Dr. McCally formulated the treatment plan, which included the least invasive means to attempt detumescence (return to flaccid state) which was the appropriate and correct first step to treat ischemic priapism. Dr. Scambia thoroughly and properly discussed the diagnosis and treatment with the plaintiff in order to obtain his informed consent. She also performed the aspiration procedure in accordance with the instructions provided and with good and accepted medical care and with reasonable success for a patient with such long standing ischemic priapism.

20. Ischemic priapism requires prompt medical treatment to afford the patient the greatest opportunity to preserve sexual function. The diagnosis of ischemic priapism is associated with significant complications, including erectile tissue necrosis (death), sloughing, infection and fibrosis as well as erectile dysfunction. The goal of treatment is to eliminate the erection (detumescence), restore normal blood flow and to preserve erectile function. Without any treatment, the patient will certainly lose the ability to achieve spontaneous erections. A delay in seeking treatment for ischemic priapism results in deoxygenation of the blood within the corpora cavernosum and increases acidity of the blood thus increasing the likelihood of permanent and irreversible damage to the sensitive tissues within the penis, resulting in varying degrees of erectile dysfunction. The injury to the tissues and resultant erectile dysfunction occurs because the blood trapped in the penis does not have oxygen, and, therefore, the surrounding tissues become hypoxic and the longer this condition exists, the greater the likelihood of permanent damage and erectile dysfunction. Tissue damage can begin at 4-6 hours after the onset of the erection. Priapism lasting 24 hours or longer will result in tissue necrosis (death) and fibrosis (scarring), leading to erectile dysfunction. When plaintiff first presented to NUMC with an erection of 30+ hours, his prognosis was poor and he had already demonstrated tissue damage and likely some degree of erectile dysfunction.

21. The standard of care to treat ischemic priapism involves a step-by-step process with

the least invasive means to detumesce the penis attempted first. This includes an aspiration procedure, which is a combination of draining the accumulated blood from the penis, followed by the injection of medication. Aspiration removes the viscous, hypoxic blood, while injection of sympathomimetic medication (such as phenylephrine) constricts or tightens the blood vessels that carry blood into the penis, allowing the vessels that carry blood out of the penis to open, resulting in an increased outflow from the penis. A diluted solution of Phenylephrine is the preferred drug as it is effective and has limited cardiovascular side effects. A 21 gauge or larger needle is inserted at the base of the penis and into the corpus cavernosum to aspirate blood and to inject the diluted phenylephrine solution. The phenylephrine is diluted with normal saline, with small injections (1-3mi) made every 3-5 minutes for approximately one hour. During the injections, close observation is necessary for any cardiovascular side effects, such as hypertension, headache, bradycardia, tachycardia, palpitations and cardiac arrhythmia. This procedure may be repeated as necessary in order to resolve the priapism without surgery. If this treatment is not successful, the priapism is unremitting and the patient has significant penile pain then, the next step includes surgery to create a shunt between the trapped blood in the corpora cavernosum and the corpora spongiesum in the glans penis to re-route blood flow so that blood can exit the corpora cavernosum restoring oxygenated blood to the penis.

22. Often times, multiple aspirations are necessary in an attempt to detumesce a priapic penis. The failure to achieve detumescence with aspiration/medication is not indicative of any negligence on the part of the physician. The most common reason that nonsurgical intervention is unsuccessful is due to the duration of the erection and the resultant tissue damage preventing the medication from being absorbed in order to be therapeutic. Also, with an extended priapism the retained blood in the penis clots making it difficult to aspirate, regardless of the size of the needle used. With extended duration ischemic priapism, ischemia and acidosis have set in, which impairs the tissues absorption response to the injections and results in fibrosis of the corpora cavernosum. With an ischemic priapism of extended duration, of longer than 24 hours, response to aspiration becomes increasingly unlikely, although standard of care dictates that this is the first step in the treatment of ischemic priapism.

23. Even a single prolonged erection can cause pathologic changes within the tissues of the penis. Physiological changes begin at 4 hours, with edema/swelling; followed by cellular damage at 24 hours, at which time varying degrees of erectile dysfunction can be expected. The hypoxia and acidosis (lack of oxygen) seen in the priapic penis at even 4 hours can result in irreversible dysfunction of the smooth muscle, which controls erectile function. A priapism lasting longer than 24 hours is usually associated with a severe degree of erectile dysfunction and the prognosis is worse with an erection lasting longer than 24 hours. Plaintiff first presented to NUMC with an erection lasting at least 30 hours (33 hours based upon his testimony), supporting the conclusion that he had already sustained significant tissue damage and likely erectile dysfunction.

24. It is my opinion, with a reasonable degree of medical certainty, that when plaintiff first presented to NUMC, he already had significant tissue damage and destruction, which prevented the Phenylephrine solution from being therapeutic. This tissue damage was the reason the noninvasive attempts at detumescence were not effective. There was nothing Dr. Scambia did or did not do during these procedures which resulted in the failure to detumesce plaintiff's priapic penis. Dr. Scambia's use of a 21-guage needle was within the accepted standard of medical care and did not have any effect on the outcome of the procedure or plaintiff's prognosis. The use of a 21-gauge needle is within the good and accepted standard of care. There is no greater likelihood of complication (such as the failure to detumesce) associated with the use of a 21-gauge needle as opposed to a larger needle, such as a 14-16 gauge needle. The use of a 21-gauge needle did not cause the need for additional procedures nor did it cause the need for the shunt. The records and testimony document that aspiration was not successful with the use of a larger bore needle, such as 14-16 gauge needle, used by Dr. McLenan on June 1 or Dr. Ahmed on May 30.

25. Further, Dr. Scambia's note indicating that approximately 3ccs of the phenylephrine solution was not absorbed (remained in the subcutaneous tissue) did not have any effect on the outcome of the procedure or plaintiff's prognosis or course. It is my opinion, with a reasonable degree of medical certainty, that the minute amount of medication that was not absorbed did not have any effect on his treatment or outcome, nor did it cause any injury to the plaintiff or change his prognosis. As indicated above, the aspiration was not successful due to the duration of plaintiff's erection and the resultant tissue damage that prevented the absorption of the medication.

26. It is my Opinion, with a reasonable degree of medical certainty, that Dr. Scambia's status as a medical intern, did not cause the failure of the aspiration procedures. She was a medical doctor and was familiar with the treatment of priapism and had observed the aspiration procedure during her training. Further, two more senior physicians (2nd year resident, Dr. Ahmed and Attending Physician, Dr. McLenan) had attempted to detumesce with aspiration and were not successful (which as noted above was due to the duration of the erection which caused tissue damage and failure to absorb the medication). It is my opinion, with a reasonable degree of medical certainty, that the aspiration procedure was a minimally invasive, nonsurgical technique to attempt detumescence of the priapic penis and did not require the presence of the Attending Physician, who remained available for consultation by the medical intern, This nonsurgical procedure is routinely performed in ERs without the presence of an Attending physician. Further, patients are instructed with the self-injection of phenylephrine to treat priapism, without the presence of a urologist. It is my opinion, with a reasonable degree of medical certainty, that it was appropriate for Dr. Scambia, as a first year medical intern, to perform the bedside aspiration procedure without the presence of a senior physician and further, that her status as a medical intern, in no way compromised or had any

effect on the outcome of the procedure.

27. It is also my opinion, with a reasonable degree of medical certainty, that there is no merit to plaintiff's claim that Dr. Scambia and NUMC (staff/employees) failed to diagnose a penile infection. There were no indications of the presence of an infection from the first treatment at NUMC (on May 29, 2014) through the last date plaintiff treated at NUMC, on June 13, 2014. During the hospitalizations and at each discharge from NUMC, the plaintiff was given the appropriate antibiotics (Augmentin) and the appropriate dose (875-mg tablet), which is sufficient and indicated to assist with the prevention of a broad-spectrum of bacterial infections. This choice of this antibiotic was correct and would act to kill any bacteria present as well as prevent any bacterial infection from developing. The records indicate that the plaintiff's white blood count, an indication of infection, was normal as of June 3, 2014, after the last admission for the insertion of the shunt. (White blood count on 6/3/14 at 7:54am: 8.94K, with normal range 4.50-11k/mm) Further, infection is a well-known and common risk of any procedure and is not evidence of any malpractice. The plaintiff concedes that he had no symptoms that would indicate the presence of infection through June 6, 2014, and further concedes that he did not contact anyone at NUMC between June 6-13, 2014, with any complaints related to an infection. Further, at the June 13, 2014 Clinic visit, there were no findings that would indicate the presence of an infection and plaintiff did not seek any medical attention for six days after the last clinic visit. He did not call the Urology Clinic or any other medical provider with complaints indicating an infection from June 13-19, 2014. Further, when plaintiff presented to Dr. Schumer on June 19, 2014, he had no fever and no discharge and there were no findings to confirm an infection. On presentation to Winthrop University Hospital on June 19, 2014, plaintiff reported first experiencing fever/chills four days before admission, which would have been on June 15th, after the last treatment at NUMC. Infections can develop at any time and symptoms will be expected between 1-3 days. The symptoms associated with infection include fever, purulent discharge from the wound, redness around wound, swelling, and hot skin near the wound. The plaintiff did not exhibit any signs of infection through his last visit at NUMC on June 13, 2014. Further, the Winthrop records (June 19, 2014) document no fever, no discharge, and no swelling. Based upon the testimony and records, it is my opinion, with a reasonable degree of medical certainty, that plaintiff did not have an infection as of the last date of treatment at NUMC on June 13, 2014.

28. Moreover, it is my opinion, with a reasonable degree of medical certainty, that there is no evidence that the staff or employees of NUMC were negligent in the care provided to the plaintiff. There was no evidence whatsoever to suggest that any employees/staff were incompetent or failed to perform any orders directed by the private attending physicians. As indicated above, there is no merit to the claim that Dr. Scambia was not qualified to perform the nonsurgical procedure in an attempt to detumesce the priapism. The records and testimony document that she had training and experience in the evaluation and treatment of priapism and that she was under the supervision of an experienced private Attending Urologist (Dr.

McCally). The plaintiff's claim that the nonsurgical intervention was not successful due to the alleged lack of skill on the part of Dr. Scambia is completely erroneous. The procedures were performed correctly and the reason they were not successful was because plaintiff delayed medical treatment for over 30 hours, resulting in permanent damage to the tissues in his penis, which prevented the absorption of the phenylephrine solution. The hypoxic tissues and local acidic environment created by the prolonged priapism prevented the medication from effectively allowing an increased flow of oxygenated blood into the penis and the deoxygenated blood out of the penis. There is nothing to suggest Dr. Scambia improperly performed the procedures as even more experienced physicians attempted nonsurgical detumescence, which were also unsuccessful in resolving plaintiff's priapism.

Informed consent

29. It is further my opinion, with a reasonable degree of medical certainty, that all of the procedures performed at NUMC were done with plaintiff's informed consent. Ischemic priapism requires treatment, beginning with the least invasive measures to remove the accumulated blood and inject vasoconstrictor medications in an attempt to restore normal blood flow to the penis and to preserve sexual function. There was no alternative initial treatment for the plaintiff's ischemic priapism. If the plaintiff did not have any treatment at all, he would be in significant and intractable pain and would certainly lose penile function.

30. There are risks and possible complications associated with aspiration and injection, which include bleeding/hematoma, infection as well as the need for additional, more invasive treatment, if detumescence is not achieved. With any surgery, including the procedures at issue, there is always the possibility that the goal will not be achieved, caused by factors unrelated to the manner in which the procedure was performed. A known and accepted complication associated with aspiration and injection of medications is that it will not restore normal blood flow to the penis, requiring the need for surgical intervention, with the creation of a shunt. The risks/complications associated with a shunt include those associated with all surgeries, including bleeding and infection, failure of the procedure resulting in a prolonged priapism and also the possibility of irreversible erectile dysfunction. The plaintiff was made aware of the risks and potential complications as well as the need for treatment to address the priapism.

31. The plaintiff consented to all of the procedures at issue, acknowledging this at his deposition. Plaintiff acknowledged being told that more than one attempt at detumescence would be made using the needles. He acknowledged his understanding of each of the procedures and issued his written consent for each. He was appropriately and thoroughly advised of the need for treatment and the potential risks and complications of the procedures, which allowed him to make an informed decision about whether to proceed with the treatment. Dr. Scambia properly and correctly discussed the procedure and advised that this procedure was necessary to attempt to restore normal blood to the penis while attempting to

preserve sexual function. A reasonable patient, in plaintiffs position, would not refuse this conservative attempt to restore blood flow to the penis, in an effort to preserve sexual function. If plaintiff refused this treatment, he would certainly lose erectile function.

32. It is my opinion, with a reasonable degree of medical certainty, that plaintiff was sufficiently informed of the need for treatment and the potential for risks/complications to allow him to make an informed decision regarding whether to proceed with the procedures. He acknowledged his understanding and signed a consent to undergo the procedures.

CONCLUSION

33. It is my opinion, with a reasonable degree of medical certainty, that the reason detumescence with aspiration and medication was not effective was because plaintiff delayed treatment for his erection for over 30 hours. At the time he first presented to NUMC, he had already sustained significant tissue destruction, which prevented absorption of the medications to have its desired effect to allow for increased blood flow out of the penis. There was nothing Dr. Scambia or NUMC did or did not do during these detumescence attempts that caused the procedures to fail. The tissue damage caused the need for surgical intervention to treat the priapism. It is also my opinion, with a reasonable degree of medical certainty, that there was no evidence of any infection up through the last date of treatment at NUMC on June 13, 2014, which is supported by the NUMC records, deposition testimony and the records of plaintiff's subsequent medical care providers. It is my opinion, with a reasonable degree of medical certainty, that the treatment rendered by Dr. Scambia and NUMC did not proximately cause plaintiff's alleged injuries, which were all caused by plaintiff's failure to seek medical attention for his prolonged erection for 30+ hours. This delay in seeking medical attention resulted in permanent and significant tissue damage which caused his alleged erectile dysfunction.

34. Based upon the foregoing, it is my opinion, with a reasonable degree of medical certainty, that the care and treatment rendered to the plaintiff by Dr. Scambia and the staff and employees of NUMC, to the plaintiff was within good and accepted medical practice and was not the proximate cause of the injuries alleged. Further, based upon my review of all the relevant materials in this case, it is my opinion, with a reasonable degree of medical certainty, that there are no independent viable claims that exist against the hospital staff relative to the care and treatment rendered to him at NUMC.

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(Gulmi Affirmation)

Based on the foregoing, this Court finds that defendants having addressed and rebutted the

specific allegations of "malpractice" as set forth in the plaintiff's bill of particulars (*see generally, Bacalan v. St. Vincents Catholic Medical Centers of New York*, *supra*), have met their *prima facie* burden of establishing entitlement to judgment as a matter of law.

Accordingly, the burden shifts to the plaintiff to raise a triable issue of fact (*Gentile v Malihan*, *supra*).

The Court finds, after affording the non-movant plaintiff the benefit of every favorable inference (*Dockery v. Sprecher*, 68 AD3d 1043 [2nd Dept. 2009]), that plaintiff's opposition and supporting proof, including the plaintiff's experts' affirmations, raise triable issues of fact about the propriety of the medical care and treatment rendered by NUMC and its agents, employees and staff, *including, but not limited to*, whether defendants NUMC and Dr. Scambia departed from accepted standards of medical and urological practice in failing to properly treat plaintiff's erection for many hours, and if so, whether that departure was a proximate cause of plaintiff's injuries (see, *Gentile v Malihan*, *supra*). The Court further finds with respect to Dr. Scambia, who was a first-year medical resident at NUMC in 2014 when the plaintiff first presented to the emergency room of NUMC and had never performed the detumenscene procedure on plaintiff's penis she was directed to carry out, that the plaintiff's experts raised

triable issues of fact as to whether Dr. Scambia had a responsibility to exercise independent medical judgment under the factual circumstances which existed at the time the plaintiff was treated by her in the emergency room, whether she deviated from good and accepted medical practice in failing to exercise independent medical judgment, whether the attending urologist's directions over the telephone deviated from normal practice, whether she was obligated to intervene in the attending physician's treatment of the plaintiff, and whether these deviations, if any are found to have occurred, were a proximate cause of the plaintiff's injuries

(see Macancela v. Wyckoff Heights Med. Ctr., 176 A.D.3d 795, 797–98 [2nd Dept. 2019]; *see Also Jagenburg v. Chen–Stiebel,* 165 A.D.3d 1239, 1240; *Hofsiss v. Goodman,* 128 A.D.3d 898, 899; cf. Tsocanos v. Zaidman, 180 AD3d 841 [2nd Dept. 2020]). A jury should resolve the credibility of the parties and the differing opinions of the expert witnesses (*see, Barbuto v Winthrop Univ. Hosp.*, 305 AD2d 623 [2nd Dept. 2003]; *see also Stoves v City of New York*, 293 AD2d 666 [2nd Dept. 2002]; *Halkias v Otolaryngology-Facial Plastic Surgery Assoc.*, 282 AD2d 650 [2nd Dept. 2001]).

Sequence 010

Defendants Goodman move for an order *inter alia* permitting them to file a late, by fifteen days, motion for summary judgment dismissing the complaint against them, and if permitted, to grant summary judgment in favor of these defendants. The application must be denied in view of the Court of Appeals strict application of the timing requirements set forth CPLR 3212 (a) in *Brill v. City of New York,* 2 NY3d 368 [2004]. Furthermore, the movants have not demonstrated good cause for their late filing. Even assuming *arguendo* that the movants demonstrated good cause for their late request, defendants Goodman did not make a *prima facie* showing *inter alia* that they did not deviate from accepted standards of medical practice with respect to plaintiff's priapism, and his subsequent infection (*see, Pullman v. Silverman,* 28 NY3d 1060, 1062).

Accordingly, for the reasons stated above, (1) the motion (seq. 006) by defendants Jillian Scambia, D.O. and Nassau Health Care Corporation s/h/a Nassau Health Care Corporation a/k/a NUHealth Corporation d/b/a Nassau University Medical Center, for an order, pursuant to CPLR 3212, granting summary judgment in their favor and dismissing plaintiff's complaint against them, is DENIED in its entirety;

(2) the motion (seq. 008) by defendant Orville McLenan, M.D., for an order granting summary judgment in his favor is GRANTED only to the extent that the complaint asserts a lack of informed consent claim against him, and in all other respects is DENIED;

(3) the motion (seq. 009) by defendant Winthrop University Hospital for an order granting summary judgment dismissing plaintiff's complaint is GRANTED;

(4) the motion by defendants Shirley Goodman, M.D., North Shore LIJ Medical Group, And Haris Ahmed, M.D. s/h/a H. Ahmed, M.D., for an order permitting them leave to file a late motion for summary judgment, is DENIED in its entirety.

Any applications not specifically addressed are denied.

The foregoing constitutes the decision and order of this Court.

Dated: May 14, 2020

HON. ANTONIO I. BRANDVEEN, J.S.C.

NOT FINAL DISPOSITION