Davis v Alarcon
2022 NY Slip Op 30740(U)
March 7, 2022
Supreme Court, New York County
Docket Number: Index No. 805042/2017
Judge: John J. Kelley

SUPREME COURT OF THE STATE OF NEW YORK
NEW YORK COUNTY

PRESENT: HON. JOHN J. KELLEY **PART** 56M

Justice

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MICHAEL DAVIS and ALYSSA DAVIS,

Plaintiffs,

- v -

GABRIEL ALARCON, D.O., COLUMBIA MEMORIAL FAMILY CARE-VALATIE, THE COLUMBIA MEMORIAL HOSPITAL, LISA GALATI, M.D., STEVEN PARNES, M.D., UNIVERSITY EAR NOSE & THROAT OF NORTHEASTERN NEW YORK, LLP, MICHAEL KORTBUS, M.D., HUDSON ENT, P.C., TODD DOYLE, M.D., NEW YORK ONCOLOGY HEMATOLOGY, P.C., ALBANY MEDICAL CENTER HOSPITAL, and MEMORIAL HOSPITAL FOR THE TREATMENT OF CANCER AND ALLIED DISEASES,

Defendants.

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INDEX NO. 805042/2017

MOTION DATE 11/15/2021

MOTION SEQ. NO. 008

DECISION + ORDER ON MOTION

The following e-filed documents, listed by NYSCEF document number (Motion 008) 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 337, 342, 347, 352, 354, 355, 356, 357, 358, 359, 360, 361, 362, 364, 365, 369, 374, 378, 379, 380

were read on this motion to/for JUDGMENT - SUMMARY.

In this action to recover damages for medical malpractice based upon departures from good and accepted medical practice and lack of informed consent, the defendants Todd Doyle, M.D., and New York Oncology Hematology, P.C. (NYOH), together move pursuant to CPLR 3212 for summary judgment dismissing the complaint insofar as asserted against them. The plaintiffs oppose the motion. The motion is granted to the extent that the movants are awarded summary judgment dismissing the claims premised on failure to obtain fully informed consent and departures from good practice based on the alleged insufficiency of the dosage and frequency of radiation therapy that was employed to treat laryngeal cancer. The motion is otherwise denied, as there are triable issues of fact as to whether the movants departed from good and accepted practice in failing to appreciate the nature, extent, and consequences of the

bacterial infection that the plaintiff Michael Davis (hereinafter the patient) sustained in the course of such treatments, in failing to consult with other specialists in connection with the infection, in failing to recognize that the cancer was more aggressive than presumed, and in failing to treat the patient more aggressively via a partial laryngectomy. There are also triable issues of fact as to whether these departures caused or contributed to the recurrence of the patient's cancer and his need for a total laryngectomy, as well as subsequent chemotherapy and further radiation treatments.

On May 11, 2015, the patient, who was then 40 years of age, presented to internist Gabriel B. Alarcon, D.O., at Columbia Memorial Family Care with complaints of hoarseness since the previous winter. Alarcon referred plaintiff to Michael Kortbus, M.D., an otolaryngologist (that is, an ear, nose, throat [ENT] physician), who examined the patient on May 20, 2015 at Hudson ENT, P.C. The patient reiterated his complaints of slight throat soreness since January 2015, as well as slight pressure in his ears and snoring. Kortbus performed a flexible fiberoptic laryngoscopy, which identified a large fungating mass comprising the entire left vocal cord, and advised the patient of the need for a direct microlaryngoscopy (DML) with biopsy. Kortbus performed the DML with tumor stripping at The Columbia Memorial Hospital, which revealed the existence of left glottic squamous cell carcinoma. On June 1, 2015, the patient returned to Kortbus's office, denying the existence of any symptoms. Kortbus referred plaintiff to Lisa Galati, M.D., a surgical oncologist, and recommended that the patient undergo a positron emission tomography (PET) scan and consult with a gastroenterologist.

On June 8, 2015, the patient underwent at PET scan at Columbia Memorial Hospital, the results of which raised concerns that the patient was exhibiting a neoplastic process in the left anterior aspect of the larynx with nodularity. On June 26, 2015, the plaintiff presented to Galati at the ENT department of Albany Medical Center Hospital (AMCH) for evaluation for possible surgical intervention. A flexible nasopharyngolaryngoscope (FNPLS) revealed that the larynx had a fungating mass along the entire length of the left vocal cord, with equal movement of the

arytenoids. Galati diagnosed a T2N0M0 carcinoma of the larynx, and noted the presence of headache, insomnia, difficulty swallowing, hoarseness, and sinus complaints. She discussed the treatment option of laryngeal preservation surgery with the patient, but recommended radiation therapy instead to preserve the vocal cords. She thus referred the plaintiff to Doyle, a radiation oncologist, who saw the patient at his practice, NYOH, later that day for a radiation oncology consultation. Doyle recommended definitive radiation therapy alone.

Between July 2015 and August 2015, the patient underwent a course of radiation treatment. The patient followed up with Doyle and Galati after completion of the radiation therapy. Thus, on October 16, 2015, the patient had a follow-up visit with Galati. On a scope examination of his larynx, Galati identified a very deep ulceration running the length of the left vocal cord. Galati recommended a thorough examination under anesthesia with jet ventilation and a biopsy of any ulceration. She scheduled the examination for November 17, 2015.

On November 12, 2015, only five days prior to the scheduled examination and biopsy, the patient presented to AMCH's ENT department for an emergency visit, and was seen by Steven Parnes, M.D., who reviewed the patient's medical history, both as reported by the patient and as contained in the AMCH medical chart. During this visit, the patient complained of left ear pain for two days, and expressed concern about a recurrence of his cancer despite his prior radiation therapy. His voice was very hoarse, and his family reported many secretions from the nose and sinuses. On examination, the patient evinced a click caused by left-side temporomandibular joint dysfunction (TMJ), and a little inflamed erythema on the neck, but no obvious masses. A hypopharyngeal exam revealed edema of the arytenoids and the aryepiglottic folds. Parnes noted that could not see the left vocal cord, and that there was not much movement on the left side. He further noted that the patient:

> "is having a biopsy by Dr. Galati for problems with his left vocal cord. He has a vocal cord cancer that [Doyle] treated with radiation and there is concern it may

> be recurrence. His voice is very hoarse, which has been for quite a while and also family says he is having a lot of secretions from his nose and sinuses."

Parnes himself did not treat the patient's cancer.

Parnes explained at his deposition that there was no reason to send the plaintiff to the hospital for evaluation at this visit because he did not observe any issues or acute distress that would necessitate a hospitalization, such as airway issues, bleeding, or infections. Parnes advised the patient to increase his intake of fluids, avoid caffeine, use Mucinex and nasal sprays to help his symptoms, and to self-treat for TMJ with heat, analgesics, soft diet, and a bite block. Parnes also told the patient to go ahead with the biopsy scheduled for November 17, 2015. On that later date, the patient was admitted to AMCH for a microdirect laryngoscopy and biopsy of the left vocal cord lesion. Galati performed that procedure on that date. She noted that, intra-operatively, an irregular white, exophytic lesion was seen to be nearly replacing the left true vocal cord, with extension into the subglottis. Pathology of the left vocal cord revealed a recurrence of invasive squamous cell carcinoma that was moderately differentiated.

After having been referred to Memorial Sloan Kettering Cancer Center in November 2015, the plaintiff underwent a total laryngectomy with radical neck dissection at that hospital on December 16, 2015.

In their initial bill of particulars as to Doyle, the plaintiffs objected to any request that they elucidate what conduct constituted a departure from good practice, asserting that those requests improperly sought expert opinions. In their first supplemental bill of particulars, the plaintiffs alleged that, due to Doyle's negligence, the patient suffered from invasive squamous cell carcinoma of the throat, laryngeal edema, and vocal cord lesions, and was compelled to undergo a total laryngectomy and thyroidectomy, with concomitant bilateral neck dissections, bilateral tracheo-esophageal groove dissections, free flap reconstruction, rectus abdominus myocutaneous free tissue transfer, and pharyngoesophageal repair with skin island of rectus

abdominus flap. They claimed that the patient required a tracheostomy, and was left with surgical scarring from all of the procedures.

In their fourth supplemental bill of particulars, the plaintiffs alleged that Doyle either examined, tested, or treated the patient with radiation therapy on at least 50 separate dates between June 26, 2015 and March 11, 2016. They asserted that Doyle failed properly to care for the patient's tumor and abscesses during that period of time. They further asserted that Doyle failed to advise the patient of the proper protocol for radiation treatment and failed to obtain his fully informed consent to the procedures that he ultimately performed. The plaintiffs further alleged that Doyle failed properly to diagnose the patient's cancer and engaged in an inordinate delay before commencing treatment. They also claimed that Doyle failed properly to treat the patient's cancer and abscesses, inasmuch as he administered improper dosages of radiation for an incorrect period of time and prescribed incorrect medications. The plaintiffs asserted that the radiotherapy administered by Doyle was insufficiently aggressive, that the procedures that were performed were contraindicated, and that Doyle should have consulted with and retained other specialists to treat the patient, and failed to provide proper post-therapeutic care and treatment. In their amended bill of particulars, the plaintiffs alleged that Doyle was further negligent in failing immediately to admit the patient into the hospital November 12, 2015 and failing to arrange for consultations with radiation oncologists and surgeons on that date as well. The plaintiffs effectively alleged that, had Doyle treated the patient's cancer in a more timely and aggressive fashion, the patient would not have suffered a recurrence of his cancer after the radiation therapy, and would not have had to undergo a laryngectomy and thyroidectomy.

In support of his motion, the movants submitted the pleadings, the plaintiffs' several bills of particulars, relevant medical records, and the expert affirmation of their retained radiation oncologist Jay Bosworth, M.D., who is board certified in that subspecialty of radiology. Dr. Bosworth noted that the patient presented to Doyle on June 26, 2015, at which time Doyle

examined him, performed a nasopharyngolaryngoscopy, and concluded that the patient's laryngeal cancer was a Stage II cancer. Based on Dr. Bosworth's review of the records and deposition transcripts, he reported that Doyle had a lengthy discussion with the patient regarding the risks and benefits of definitive radiation therapy treatment. As Dr. Bosworth explained it, In view of the stage of cancer, and the guidelines suggested by the National Comprehensive Cancer Network (NCCN), Doyle recommended definitive radiation therapy, provided the patient with a comparison of surgical intervention versus radiation therapy, and elaborated how radiation therapy is just as efficient as surgery, albeit without the same significant risks. According to Dr. Bosworth's review of the records, later that same date, the patient executed an "informed consent" form and, on June 30, 2015, sat through an educational course on radiation treatment that provided information on what to expect, side-effects, how a patient should care himself, and the like. The patient was sent home with educational material, including a pamphlet from National Cancer Institute entitled "Radiation Therapy and You," that, in Dr. Bosworth's view, laid out everything regarding radiation treatment, including risks and probabilities of success.

As Dr. Bosworth explained it, Doyle thereafter conducted several CT Simulation exams, the purpose of which was to identify the precise location and size of the tumor, giving Doyle the precise target for the radiation, and ensuring that the entire tumor was being treated. Dr. Bosworth continued that

> "Doyle initiated radiation treatment of 7000 cGy (centigray radiation units) in 200 cGy per day fractions. . . .
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> "Throughout treatment, Dr. Doyle conducted portal tests and dosimetry exams on a weekly basis. The portal tests can help ascertain that the tumor is not enlarging and that the correct area is being treated. Dosimetry reviews by the physicist make sure the correct amount of radiation is being delivered.
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> "Dr. Doyle first administered radiation treatment on July 9, 2015. The final treatment was on August 26, 2015. Plaintiff received 35 treatments in 48 days.
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> "On July 10, 2015, plaintiff complained of an infection at the site of the tumor.

> Dr. Doyle prescribed Levaquin and referred plaintiff to Dr. Galati. Dr. Galati drained purulent material from the infection site on this same date. Purulence is essentially pus and is symptomatic of an infection. Dr. Doyle had a phone discussion with Dr. Galati on this day regarding the infection. . . . During this call they both came to the conclusion that radiation treatment should proceed as scheduled and there was no reason to stop the radiation. On July 11, 2015, there was a second draining at Albany Medical Center (AMC).
>
> "On July 13, 2015, Dr. Doyle examined the patient for any remaining infection. Upon examination, he noted no significant fluctuance. The lack of fluctuance is indicative [of] no, or very little, pus remaining. He noticed an Erythema which is superficial reddening of the skin due to irritation. This is very normal during radiation treatment and is generally indicative of the treatment working. When radiation treatment was given on July 13, the infection had been treated for several days and appeared to be under control."

Dr. Bosworth's reading of the records indicated that an August 7, 2015 examination revealed that the tumor had decreased in size by 60-70%, and that the radiation treatment was completed on August 26, 2015.

As Dr. Bosworth recounted it, the patient was expected to follow up regularly with Dr. Galati, who would be expected to examine the patient using direct laryngoscopy, a course of examination that Dr. Bosworth described as "usual and customary." He opined that, inasmuch as Doyle was a radiation oncologist, he did not possess the same training and expertise as an ENT surgeon who focuses on cancer and, as such, it was more appropriate for someone like Galati to provide acute care and regular follow-up examinations.

Dr. Bosworth asserted that the records reflected that, on August 28, 2015, September 20, 2015, and September 21, 2015, the patient called NYOH regarding acute side effects, and was told that he should call Galati or go to the hospital within the hour. In fact, on September 11, 2015, Galati examined the plaintiff's neck and did not find any signs of infection. According to Dr. Bosworth, as only two weeks had lapsed since the conclusion of radiation therapy, it was too soon to tell whether the patient's cancer had been cured, as radiation causes changes in the cells that could continue to destroy cancer cells for several months. Dr. Bosworth explained that, as such, the treatment actually persists in attacking the cancer for about six or more weeks after the conclusion of treatment. He opined that, in light of that fact, whether the tumor was

extant on September 11, 2015, could have been irrelevant, as the cancer could still recur or be cured.

On September 29, 2015, plaintiff saw Doyle. As Dr. Bosworth interpreted the records, the patient's infection had nearly healed by this time, there was no definitive evidence of a tumor, and his neck evinced no lymphadenopathy, which could have led to a possible finding of disease of the lymph nodes. This was the last time that Doyle saw the plaintiff.

Dr. Bosworth recited the patient's medical history subsequent to his last visit with Doyle, including Galati's biopsy and her diagnosis of recurrent cancer, and noted that, once accepted as a patient by Memorial Sloan Kettering Cancer Center, the patient underwent a total laryngectomy and reconstructive surgery on December 16, 2015, with intermittent leakage until May 13, 2016 from the tube that had been placed in his trachea. Dr. Bosworth further noted that, on March 4, 2016, the patient began additional radiation therapy, along with chemotherapy at the same time. As he explained it,

> "This is because if the cancer cells survived the radiation treatment cycle, they are most likely radiation resistant. Additionally, another course of radiation to the same area could cause significant damage to normal cells if they have been previously irradiated. The cells have been damaged and are unable to receive radiation twice. However, in this situation there may have been persistent cancer after the second surgery at Memorial Sloan Kettering. In addition, the reason plaintiff was able to receive radiation following the surgery is because the larynx was removed, and the reconstructive surgery placed new skin from a different area of his body at the treatment area. This new skin had not been treated with radiation prior. Therefore, radiation could be utilized again."

Dr. Bosworth further provided an explanation as to the benefits of chemotherapy subsequent to the laryngectomy, noting that the patient's cancer had increased in severity and had by then become a Stage III cancer, as revealed on a PET scan, and that Stage III and IV cancer is, in fact, treated with radiation treatment and chemotherapy. He further reported that the patient underwent his post-surgery radiation therapy from March 2016 through April 2016, with treatment continuing despite the discharge of purulent material through May 2016. As Dr. Bosworth also reported, as of December 22, 2016, when the patient saw his oncologist at

Memorial Sloan Kettering, the patient was doing well, that in 2017 the patient received a speaking valve permitting him to speak despite the absence of a larynx, and that, as of 2021, the patient was cancer free, and was able to speak, eat, and drink normally.

Dr. Bosworth opined that, when the patient was examined by and treated with Doyle in 2015, Doyle, in accordance with the American Joint Committee on Cancer's (AJCC) diagnosis guidelines, properly diagnosed the patient's cancer as Stage II, based on the size of the tumor, the absence of lymph system involvement, and the absence of metastatic cancer. He asserted that both Doyle and Galati performed the proper diagnostic testing, employing a laryngoscopy, PET scans, and an FNLPS, which revealed movement in the vocal cord. As Dr. Bosworth explained it, Stage III cancer is an appropriate diagnosis only if the vocal cord's movement is completely restricted, the tumor has grown outside the larynx, or there is lymph node involvement or the cancer has metastasized.

According to Dr. Bosworth, Doyle's treatment was within the appropriate standard of care, as squamous cell skin cancer with a tumor diameter greater than two centimeters can be treated with definitive radiation therapy, which he described as "the standard treatment." Although he opined that surgery was also an alternative to radiation therapy, only one or the other, and not both, would have been appropriate as of 2015, but that surgery entailed more risks than radiation. Dr. Bosworth explained that, had the patient elected to undergo surgery at that point, it would have entailed a partial or total laryngectomy. Moreover, he asserted that chemotherapy is generally reserved for patients who have already received radiation treatment and cannot receive radiation again, patients who cannot tolerate surgery, and patients over the age of 60, none of which applied to the patient here.

Dr. Bosworth also concluded that the dosage of radiation administered to the patient met the standard of care, which he described as a total of 6000-7000 cGy, as set forth in NCCN guidelines. Inasmuch as Doyle administered 7000 cGy of radiation in doses of 200 cGy over the course of approximately seven weeks, Dr. Bosworth further concluded that the course of

treatment met the standard of care. Similarly, Dr. Bosworth opined that Doyle's administration of 200 cGy doses to plaintiff in 35 treatments over the course of 48 days met the standard of care for the frequency and duration of treatments, in accordance with NCCN guidelines. For the same reason, Dr. Bosworth asserted that Doyle did not perform any contraindicated procedures. Moreover, Dr. Bosworth additionally opined that, based on the patient's medical history, and the timing of his presentation of symptoms, his examinations and testing, and the commencement of treatment, Doyle and NYOH appropriately and timely referred and consulted with other doctors, as necessary, as they responded at "the moment a possible issue presented itself," and regularly sent updates and records to other relevant providers.

In connection with the infection that the patient contracted while under Doyle's care, Dr. Bosworth opined that Doyle correctly and appropriately treated it by prescribing antibiotics; Dr. Bosworth also concluded that Doyle correctly and appropriately proceeded with the radiation therapy treatments notwithstanding the presence of the infection, as he checked for the signs fluctuance, which would have indicated a buildup of pus underneath the treatment area, and confirmed that there was no fluctuance.

Dr. Bosworth also averred that Doyle obtained fully informed consent to the radiation therapy procedure from the patient.

The movants' expert further concluded that none of the movants' conduct or actions caused or contributed to any injuries claimed by the patient, as he would have had to undergo the laryngectomy and reconstructive surgery in any event. As he explained it,

> "[r]adiation therapy and any cancer treatment, for that matter, is not a guarantee. Despite it being 90% effective, there is a possibility that it will not eliminate the cancer or that the cancer will recur.
>
> *****
>
> "Plaintiff's cancer recurring is indicative of his cancer being radiation resistant. Both his treating providers at Memorial Sloan Kettering, Dr. Ganly and Dr. Gelblum, confirmed this. As such, they treated with surgery, radiation therapy, and adjuvant therapy.

> "Currently, and at the time of plaintiff's treatment with Dr. Doyle, it is not possible to identify whether squamous cell cancer of the larynx is radiation resistant prior to treatment. Radiation resistant cancer of the larynx can only be identified when either tumor is not responding to radiation throughout treatment or the cancer recurs. Dr. Doyle took scans of plaintiff's tumor on a weekly basis throughout treatment. Additionally, on August 7, 2015, Dr, Galati noted that the tumor shrunk 60-70 percent. As such, it was impossible to know whether plaintiff s cancer was radiation resistant prior [to] the completion of radiation treatment.
>
> "As plaintiff's cancer was radiation resistant no matter what he would have needed a laryngectomy. Chemotherapy alone for this is not within the standard of care for treatment of squamous cell cancer of the larynx. Additionally, no definitive radiation treatment plan alone can combat radiation resistant cancer. The only solution is surgery.
>
> "Further, plaintiff would have required radiation after surgery regardless. This is because, following surgery, radiation is generally recommended. As there is concern of some cancer cells remaining, a radiation treatment plan is recommended in order to ensure all of the cancer cells are removed.
>
> "As such, there was nothing that Dr. Doyle could have done at the time. There was no way of knowing whether plaintiff's cancer is radiation resistant."

In opposition, the plaintiffs relied upon the same pleadings, bills of particulars, deposition transcripts, and medical records as did the movants, and also submitted the expert affirmation of a board-certified otolaryngologist/head and neck surgeon. He opined that the movants departed from good and accepted medical practice because, "[f]undamentally, [they] failed to appreciate the significance of the infection in Mr. Davis's neck on July 10, 2015." According to the plaintiffs' expert, Doyle "failed to obtain an appropriate cytology analysis of the aspirated fluid obtained by Dr. Galati on July 10, 2015, and failed to refer Mr. Davis for further evaluation. As a result, Dr. Doyle was not able to ascertain an accurate diagnosis of Mr. Davis. and refer him for more appropriate treatment."

As the plaintiffs' expert explained it,

> "appropriate testing of the aspirated fluid would have indicated a more aggressive cancer than Dr. Kortbus had previously diagnosed, indicating the need for more aggressive treatment. In addition, this presentation required further evaluation of the patient, including another laryngoscopy under general anesthesia, to afford a thorough examination of Mr. Davis' larynx. This additional work-up would, in my opinion, have confirmed that Mr. Davis was suffering a more aggressive cancer than originally understood. It is also my opinion with a reasonable degree of medical certainty that the more aggressive treatment would

> have been a partial laryngectomy with dissection of the lymph nodes, followed by a course of radiation. Such treatment would have given Mr. Davis a substantial opportunity to preserve his voice box, while still curing his throat cancer. Instead, Mr. Davis underwent inadequate radiation treatment by Dr. Doyle, which led to the persistence of his throat cancer, thereafter requiring a total laryngectomy at Memorial Hospital for Cancer and Allied Diseases (hereinafter MSK) on December 16, 2015 by Dr. Ganly. The total laryngectomy, of course, required the removal of the entire voice box, and Mr. Davis now lives with a stoma in his neck, and because he cannot speak, must attempt to communicate with a tracheoesophageal prosthesis."

The plaintiffs' expert further noted that, although Doyle consulted with Galati with respect to the infection, prescribed antibiotics, and agreed with her that radiation therapy should proceed as planned, the movants' expert never opined as to what the standard of care is concerning evaluation of the fluid aspirated by Galati, or the need for further evaluation in the circumstances presented by the patient.

The plaintiffs' expert concluded that Doyle's failure to order a cytology evaluation of the aspirated fluid and further to assess the source of the infection, or make a referral for additional evaluation, was a departure from good medical practice by, and led to the failure to make a more accurate diagnosis and pursue more aggressive and appropriate treatment, which therefore was a proximate cause of the patient's subsequent injuries, including the loss of his voice box.

It is well settled that the movant on a summary judgment motion "must make a prima facie showing of entitlement to judgment as a matter of law, tendering sufficient evidence to eliminate any material issues of fact from the case" (*Winegrad v New York Univ. Med. Ctr.*, 64 NY2d 851, 853 [1985] [citations omitted]). The motion must be supported by evidence in admissible form (*see Zuckerman v City of New York*, 49 NY2d 557, 562 [1980]), as well as the pleadings and other proof such as affidavits, depositions, and written admissions (*see* CPLR 3212). The facts must be viewed in the light most favorable to the non-moving party (*see Vega v Restani Constr. Corp.*, 18 NY3d 499, 503 [2012]). In other words, "[i]n determining whether summary judgment is appropriate, the motion court should draw all reasonable inferences in

favor of the nonmoving party and should not pass on issues of credibility" (*Garcia v J.C. Duggan, Inc.*, 180 AD2d 579, 580 [1st Dept 1992]). Once the movant meets his or her burden, it is incumbent upon the non-moving party to establish the existence of material issues of fact (*see Vega v Restani Constr. Corp.*, 18 NY3d at 503). A movant's failure to make a prima facie showing requires denial of the motion, regardless of the sufficiency of the opposing papers (*see id.*; *Medina v Fischer Mills Condo Assn.*, 181 AD3d 448, 449 [1st Dept 2020]).

"The drastic remedy of summary judgment, which deprives a party of his [or her] day in court, should not be granted where there is any doubt as to the existence of triable issues or the issue is even 'arguable'" (*De Paris v Women's Natl. Republican Club, Inc.*, 148 AD3d 401, 403-404 [1st Dept 2017]; *see Bronx-Lebanon Hosp. Ctr. v Mount Eden Ctr.*, 161 AD2d 480, 480 [1st Dept 1990]). Thus, a moving defendant does not meet his or her burden of affirmatively establishing entitlement to judgment as a matter of law merely by pointing to gaps in the plaintiff's case. He or she must affirmatively demonstrate the merit of his or her defense (*see Koulermos v A.O. Smith Water Prods.*, 137 AD3d 575, 576 [1st Dept 2016]; *Katz v United Synagogue of Conservative Judaism*, 135 AD3d 458, 462 [1st Dept 2016]).

"To sustain a cause of action for medical malpractice, a plaintiff must prove two essential elements: (1) a deviation or departure from accepted practice, and (2) evidence that such departure was a proximate cause of plaintiff's injury" (*Frye v Montefiore Med. Ctr.*, 70 AD3d 15, 24 [1st Dept 2009]; *see Roques v Noble*, 73 AD3d 204, 206 [1st Dept 2010]; *Elias v Bash*, 54 AD3d 354, 357 [2d Dept 2008]; *DeFilippo v New York Downtown Hosp.*, 10 AD3d 521, 522 [1st Dept 2004]). A defendant physician moving for summary judgment must make a prima facie showing of entitlement to judgment as a matter of law by establishing the absence of a triable issue of fact as to his or her alleged departure from accepted standards of medical practice (*Alvarez v Prospect Hosp.*, 68 NY2d 320, 324 [1986]; *Frye v Montefiore Med. Ctr.*, 70 AD3d at 24) or by establishing that the plaintiff was not injured by such treatment (*see McGuigan v*

Centereach Mgt. Group, Inc., 94 AD3d 955 [2d Dept 2012]; *Sharp v Weber*, 77 AD3d 812 [2d Dept 2010]; *see generally Stukas v Streiter*, 83 AD3d 18 [2d Dept 2011]).

To satisfy the burden, a defendant must present expert opinion testimony that is supported by the facts in the record, addresses the essential allegations in the complaint or the bill of particulars, and is detailed, specific, and factual in nature (*see Roques v Noble*, 73 AD3d at 206; *Joyner-Pack v. Sykes*, 54 AD3d 727, 729 [2d Dept 2008]; *Koi Hou Chan v Yeung*, 66 AD3d 642 [2d Dept 2009]; *Jones v Ricciardelli*, 40 AD3d 935 [2d Dept 2007]). If the expert's opinion is not based on facts in the record, the facts must be personally known to the expert and, in any event, the opinion of a defendant's expert should specify "in what way" the patient's treatment was proper and "elucidate the standard of care" (*Ocasio-Gary v Lawrence Hospital*, 69 AD3d 403, 404 [1st Dept 2010]). Stated another way, the defendant's expert's opinion must "explain 'what defendant did and why'" (*id.*, quoting *Wasserman v Carella*, 307 AD2d 225, 226, [1st Dept 2003]). Furthermore, to satisfy his or her burden on a motion for summary judgment, a defendant must address and rebut specific allegations of malpractice set forth in the plaintiff's bill of particulars (*see Wall v Flushing Hosp. Med. Ctr.*, 78 AD3d 1043 [2d Dept 2010]; *Grant v Hudson Val. Hosp. Ctr.*, 55 AD3d 874 [2d Dept 2008]; *Terranova v Finklea*, 45 AD3d 572 [2d Dept 2007]).

Once satisfied by the defendant, the burden shifts to the plaintiff to demonstrate the existence of a triable issue of fact by submitting an expert's affidavit or affirmation attesting to a departure from accepted medical practice and opining that the defendant's acts or omissions were a competent producing cause of the plaintiff's injuries (*see Roques v Noble*, 73 AD3d at 207; *Landry v Jakubowitz*, 68 AD3d 728 [2d Dept 2009]; *Luu v Paskowski*, 57 AD3d 856 [2d Dept 2008]). Thus, to defeat a defendant's prima facie showing of entitlement to judgment as a matter of law, a plaintiff must produce expert testimony regarding specific acts of malpractice, and not just testimony that contains "[g]eneral allegations of medical malpractice, merely conclusory and unsupported by competent evidence tending to establish the essential elements

of medical malpractice" (*Alvarez v Prospect Hosp.*, 68 NY2d at 325; *see Frye v Montefiore Med. Ctr.*, 70 AD3d at 24). In most instances, the opinion of a qualified expert that the plaintiff's injuries resulted from a deviation from relevant industry or medical standards is sufficient to preclude an award of summary judgment in a defendant's favor (*see Murphy v Conner*, 84 NY2d 969, 972 [1994]; *Frye v Montefiore Med. Ctr.*, 70 AD3d at 24). Where the expert's "ultimate assertions are speculative or unsupported by any evidentiary foundation, however, the opinion should be given no probative force and is insufficient to withstand summary judgment" (*Diaz v New York Downtown Hosp.*, 99 NY2d 542, 544 [2002]; *see Frye v Montefiore Med. Ctr.*, 70 AD3d at 24).

It is also well settled that a physician may be held liable for malpractice where he or she departs from good and accepted medical care in failing to diagnose a patient's condition, thus providing less than optimal treatment or delaying appropriate treatment that leads to injury, including the need for more drastic treatment that otherwise would or could have been avoided (*see Vanderpool v Adirondack Neurosurgical Specialists, P.C.*, 45 AD3d 1477, 1478 [4th Dept 2007]).

With their expert's affirmation, the movants established their prima facie entitlement to judgment as a matter of law in connection with claims alleging a departure from good and accepted practice. Inasmuch as the plaintiffs' expert did not address the issue of whether the frequency and dosage of the radiation therapy were proper, the plaintiffs failed to raise a triable issue of fact in opposition to the movants' showing in this regard, and any claim based solely on the propriety of the frequency and dosage of radiation must be summarily dismissed.

The plaintiffs' expert does not rebut the movants' showing that the patient had Stage II squamous cell cancer of the larynx when he presented to them in 2015. Hence, this case does not present the standard type of failure-to-diagnose claim, as there appears to be no difference of opinion as to that diagnosis. Rather, the plaintiffs' expert affirmation raised a triable issue of fact as to whether the movants departed from good and accepted practice by failing to consider

whether the patient's bacterial infection was indicative of a Stage II cancer that was more aggressive than would otherwise be expected, by failing to consult with a specialist who was capable of associating the infection with the level of aggressiveness of the patient's cancer, and by consequently failing to perform a partial laryngectomy rather than administering radiation therapy to address the aggressive nature of the cancer, which would have prevented recurrence and obviated the need for a total laryngectomy. Since that is the crux of the plaintiffs' failure-to-diagnose claim, summary judgment must be denied to the movants in connection therewith.

The elements of a cause of action for lack of informed consent are

> "(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"

(*Spano v Bertocci*, 299 AD2d 335, 337-338 [2d Dept 2002]; *see Zapata v Buitriago*, 107 AD3d 977, 979 [2d Dept. 2013]). For a statutory claim of lack of informed consent to be actionable, a defendant must have engaged in a "non-emergency treatment, procedure or surgery" or "a diagnostic procedure which involved invasion or disruption of the integrity of the body" (Public Health Law § 2805-d[2]).

The movants established their prima facie entitlement to judgment as a matter of law dismissing the lack of informed consent cause of action by submitting Dr. Bosworth's affirmation, which referred to the medical records, the signed consent form, and the parties' deposition testimony. Since the plaintiffs' expert did not address that issue in his or her affirmation, the plaintiffs failed to raise a triable issue of fact in opposition, and summary judgment must be awarded to the movants dismissing the lack of informed consent cause of action insofar as asserted against them. In any event, "[a] failure to diagnose cannot be the basis of a cause of action for lack of informed consent unless associated with a diagnostic procedure that 'involve[s] invasion or disruption of the integrity of the body'" (*Janeczko v*

Russell, 46 AD3d 324, 325 [1st Dept 2007], quoting Public Health Law § 2805-d[2][b]; *see Lewis v Rutkovsky*, 153 AD3d 450, 456 [1st Dept 2017]), and that invasion or disruption is claimed to have caused the injury. Moreover, a claim to recover for lack of informed consent cannot be maintained where the alleged injuries resulted either from the failure to undertake a procedure or the postponement of that procedure (*see Ellis v Eng*, 70 AD3d 887, 892 [2d Dept 2010]; *Jaycox v Reid*, 5 AD3d 994, 995 [4th Dept 1994]; *see also Saguid v Kingston Hosp.*, 213 AD2d 770, 772 [3d Dept 1995]; *Karlsons v Guerinot*, 57 AD2d 73, 82 [4th Dept 1977]).

In light of the foregoing, it is

ORDERED that the motion of the defendants Todd Doyle, M.D., and New York Oncology Hematology, P.C., is granted to the extent that they are awarded summary judgment dismissing the lack of informed consent cause of action and so much of the medical malpractice cause of action as alleged a departure from good and accepted practice based upon their alleged failure to provide radiation therapy at a sufficient dosage and frequency, and the motion is otherwise denied.

This constitutes the Decision and Order of the court.

3/7/2022
DATE

JOHN J. KELLEY, J.S.C.

CHECK ONE:		CASE DISPOSED			X	NON-FINAL DISPOSITION	
		GRANTED		DENIED	X	GRANTED IN PART	OTHER
APPLICATION:		SETTLE ORDER				SUBMIT ORDER	
CHECK IF APPROPRIATE:		INCLUDES TRANSFER/REASSIGN				FIDUCIARY APPOINTMENT	REFERENCE