Whitesides v Randolph
2022 NY Slip Op 30841(U)
March 10, 2022
Supreme Court, New York County
Docket Number: Index No. 805062/2020
Judge: John Kelley
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SUPREME COURT OF THE STATE OF NEW YORK
NEW YORK COUNTY

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

Justice

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CAROL WHITESIDES,

Plaintiff,

- v -

PAULA RANDOLPH, M.D., and NEW YORK PHYSICIANS, LLP

Defendants.

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INDEX NO. 805062/2020

MOTION DATE 11/19/2021

MOTION SEQ. NO. 002

DECISION + ORDER ON MOTION

The following e-filed documents, listed by NYSCEF document number (Motion 002) 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 86, 87, 89, 91, 92, 95, 96

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

In this action to recover damages for medical malpractice, based on departures from good and accepted medical practice and failure to obtain fully informed consent, the defendant Paula Randolph, M.D., moves pursuant to CPLR 3212 for summary judgment dismissing the complaint insofar as asserted against her. The plaintiff opposes the motion. The motion is granted to the extent that Randolph is awarded summary judgment dismissing the cause of action alleging lack of informed consent, and the motion is otherwise denied.

The plaintiff alleged in her complaint that Randolph, a physician employed by the defendant New York Physicians, LLP (NYP), failed to diagnose labial melanoma when examining her on January 18, 2017, and that this failure caused the melanoma to develop into a Stage IV cancer with metastasis.

On January 18, 2017, the plaintiff, who was then 52 years old, presented to NYP, where she completed a patient questionnaire, and provided personal information that indicated she was single, had never been pregnant, was no longer menstruating, was not taking birth control, and was not sexually active. Her most recent mammogram and PAP smear, conducted in

2009, were normal. The plaintiff experienced her final menstrual period in 2014, and was menopausal thereafter. According to Randolph's interpretation of the plaintiff's medical records, the plaintiff's reason for the visit was a complaint of mild pain near her right breast that had lasted three days. The plaintiff, however, asserted that she was there for a regular check-up, and her complaints of pain were incidental to the visit. At the time of her visit, the plaintiff had been taking Advil, as needed, that "seem[ed] to help" the right breast pain, along with a combination of Prednisone, Mucinex, and Doxycycline for the treatment of a current sinus infection.

Randolph saw the plaintiff on that day at NYP, and prepared a "Preventive Medicine-GYN" note that referenced much of the information that the plaintiff provided on the questionnaire, and also included Randolph's assessment that the plaintiff was negative for dysmenorrhea, menorrhagia, and vaginal discharge, and that her breasts had "no masses." Randolph also noted that, a few days before December 25, 2016, the plaintiff had suffered from a stomach illness, with vomiting, on a flight to North Carolina. According to NYP's records, the plaintiff reported a lack of appetite, that her stomach nonetheless had settled, and that she thereafter contracted a cold, with headaches. The plaintiff further reported that she had started getting headaches the week before, and went to an urgent care center, which provided her with azithromycin, a steroidal nasal spray, and Mucinex D, but that she was now taking doxycycline that had been prescribed by her primary care physician. Although the plaintiff reported at the examination that she currently had a mild headache, she was otherwise feeling better.

Randolph noted that the plaintiff had a history of right breast cyst removal and biopsy approximately 30 years prior, and history of a stomach ulcer.

As relevant to the instant dispute, during the genitourinary examination, Randolph noted a "slightly red pimple ? Sebaceous cyst left labia majora." Randolph's assessment, as set forth in her notes, read as follows: "Encounter for GYN exam (general) (routine) w/o [without] abn [abnormal] findings," "normal GYN exam" with "? Sebaceous cyst left labia majora." Her plan

was for "F/U [follow up] prn [as needed] or if size changes," "requisition for mammogram with u/s. . .for pelvic u/s"; "mammogram, breast sonogram, colonoscopy"; "follow-up visit 1 Year."

On March 7, 2018, or more than 13 months later, the patient returned to NYP and completed an annual update form, reporting that there had been no change in her health since her prior visit, that her current medications included multi-vitamins, and that she had allergies to adhesives and penicillin. She also reported "a little bleeding and soreness." Randolph saw the plaintiff on that date and prepared a "Preventive Medicine-GYN" note, indicating that the plaintiff appeared for an annual exam and had reported "vaginal irritation." Randolph noted that the plaintiff had not had a mammogram for five years and had a history that was "negative for dysmenorrhea and menorrhagia; negative for breast lumps; pertinent negatives included anxiety, depression, urinary incontinence and vaginal discharge." Randolph's note further stated that the plaintiff had reported that the "small sore on her labia from last year has not gone away," and that she had "a little bit of spotting the past couple days from it." During a genitourinary examination conducted that same day, Randolph noted "1 inch? Sebaceous cyst-organized, hard, and broad-based located at left labia majora with a slight odor." Randolph noted that she had asked the plaintiff about a three-centimeter firbroepithelial polyp observed on the upper left vulva, to which the plaintiff replied that she didn't see it when she wiped, and denied the presence of both abdominal pain the presence of blood in bowel movements. The plaintiff, however reported feeling some skin irritation at the location of the polyp.

In her March 7, 2018 note, under the title "Procedures," Randolph wrote that she first obtained the plaintiff's consent and performed a "complicated or multiple incision and drainage of an abscess." After the incision was performed, there was actually no drainage, but Randolph noted a "1 inch ? sebaceous cyst-organized, hard, and broad based 2cms; [s]harp dissection of base, bleeding *multip sutu*," and "no drainage." After removing the polyp lesion in its entirety,

Randolph instructed the plaintiff to take one tablet of the antibiotic Bactrim every 12 hours, return in one week, and follow up in one year. She then ordered a pathology report. She also sketched a picture of what she observed on the plaintiff's vulva, describing a "fibroepithelial or fibrous lipoma" and depicting a growth on the upper left side of the labia majora. Randolph made the following entry: "Description-did not print: 3cms on 2cms base, flesh colored, no discoloration, no alteration, probable fibroepithelial or fibrous lipoma, palpation-firm, rule out fibroid, lipoma."

On March 9, 2018, the plaintiff returned to NYP for "follow up of *benign* vulvar fibroma ? or ? fibroepithelial polyp" (emphasis added). Although the plaintiff reported increased bleeding, Randolph noted that "hemostasis is good from previous procedure" and reported that a clot was removed and an additional single suture was used to obtain or maintain hemostasis.

On March 16, 2018, the plaintiff returned to NYP for a follow up for "genital lesion and vulvar lesion." Randolph noted, under the heading "History of Present Illness" that she had spoken with a LabCorp pathologist on March 15, 2018 and was advised that preliminary pathology revealed "Melanoma invasive. Pathologist described amelanotic features, needed to send sample out for definitive/final diagnosis." Randolph discussed the results with the plaintiff, and referred her to Dr. Carol Brown, a surgeon and gynecologic oncologist at Memorial Sloan Kettering Cancer Center. Randolph's assessment was that the plaintiff had a malignant neoplasm of the vulva, and her impression was of an asymptomatic patient who presented for annual exam with a preliminary pathology indicating an invasive vulvar melanoma with amelanotic features. The NYP record includes a report from Mihm Cutaneous Pathology Consultative Service reporting a diagnosis of "malignant melanoma, superficial spreading type, lentiginous variant, invasive to at least level IV, and a measured thickness of at least 7mm, present in all margins." The recommendation was for a "reexcision with appropriate negative margins for further evaluation and therapy, and consideration of a sentinel lymph node biopsy."

On June 6, 2018, Dr. Alexander N. Shoushtari, an oncologist at Memorial Hospital for Cancer and Allied Diseases, examined the plaintiff, and noted that a computed tomography (CT) scan, with contrast, of the plaintiff's chest, abdomen, and pelvis, was performed on March 30. 2018, and showed no evidence of metastatic disease. Dr. Shoushtari further noted that the plaintiff had undergone a partial radical vulvectomy with sentinel lymph node biopsy on May 7, 2018, and that the pathology from that procedure revealed "in situ and invasive melanoma with perineural invasion." The pathology report indicated that margins were negative for invasive melanoma, "although the melanoma in situ extended to the margin," while the left inguinal lymph node was negative for melanoma.

In her bill of particulars, the plaintiff alleged that Randolph departed from good and accepted medical practice by unnecessarily delaying the diagnosis of a left vulvar melanoma and failing timely to diagnose and treat the malignancy, resulting in progression to Stage IV, with metastases to soft tissue, lung, and liver. She further asserted that Randolph improperly diagnosed her with a "pimple" or sebaceous cyst when she presented to her for a checkup examination on January 18, 2017, due to the fact that Randolph failed to perform a thorough examination in order to determine the nature of, pathological makeup of, and any abnormalities in the lesion, thus failing to ascertain that the lesion was, in fact, carcinoma. In addition, the plaintiff averred that Randolph's departures included a failure closely to inspect the vulva and perform or recommend performance of a biopsy or colposcopy at the plaintiff's January 18, 2017 visit, or direct the plaintiff to return for a follow-up visit to assess the condition of the lesion prior to March 2018, when the cancer was finally diagnosed. The plaintiff further alleged that Randolph failed to appreciate the significance of her ongoing signs, symptomatology, and medical history, or attach appropriate significance to such signs and complaints in order to make a proper assessment of her total medical condition. Moreover, the plaintiff contended that Randolph failed to refer her for timely and proper consultations, including, but not limited to, an oncology consultation, and failed to conduct CT scans, positron emission tomography (PET)

scans, magnetic resonance imaging (MRI) scans, sonograms, or biopsies, and thus failed properly to interpret tests so that a correct diagnosis could be made and a proper course of treatment provided. Finally, the plaintiff alleged that Randolph failed to inform her of the dangers and risks of any particular treatment, or alternatives thereto, and failed to obtain her informed consent.

In support of her motion, Randolph submitted the pleadings, the bills of particulars, the parties' deposition transcripts, and the relevant medical records. She also submitted the expert affirmation of Jonathan Lanzkowsky, M.D., a physician board-certified in obstetrics and gynecology (OB/GYN), who had completed his residency in operative obstetrics, gynecological laparoscopy, and endoscopic surgery.

Dr. Lanzkowsky opined that Randolph "rendered careful, thorough, and correct treatment" to the plaintiff at all times, performing a thorough and complete physical examination on January 18, 2017, including a genitourinary examination. As he described it,

> "Defendant evaluated the mons pubis and labia, all the while explaining to Plaintiff the specific anatomy that was being inspected so the patient would 'know what [her] anatomy is.' While thoroughly examining the labia majora, Dr. Randolph correctly described the outside folds of tissue as 'larger lips,' and the inside or 'smaller lips' enclosing the genital organs as the labia minora. Dr. Randolph correctly palpated and inspected both sides of the labia majora."

He further asserted that, upon completing a full and appropriate examination of the plaintiff's vulva, Randolph noted the existence of a two-millimeter sebaceous cyst, that she described as a small pimple that was minimally or slightly raised, while also noting that the skin was essentially flat at that spot. As Dr. Lanzkowsky explained, a sebaceous cyst is a small, noncancerous finding, commonly identified during genitourinary examinations that can occur on the vulva, including the labia majora of the vulva, and that such a lesion usually results from a blocked gland in the skin and is one of the most common, benign lesions to be found during genitourinary examinations. He further explained that, similarly, a genitourinary examination will often reveal an inflamed hair follicle, or folliculitis, often appearing as a pimple in and amongst

the pubic hairs. Dr. Lanzkowsky opined that, when diagnosing a sebaceous cyst or folliculitis during a genitourinary examination, it is good practice to inform the patient of the finding, explain what is observed, and describe the finding in a manner that would be best understood by the patient, including informing the patient of the presence of a sebaceous cyst, folliculitis, or pimple. He also suggested that it would be good practice to make efforts to demonstrate the lesion with a mirror, angling it so the patient can see what is being discussed. He stated that

> "[t]he evidence in this case clearly shows that Dr. Randolph correctly examined the patient and explained to her the finding of a 'one, at most, two millimeter sebaceous cyst' or 'pimple' on the 'upper one Third' of Ms. Whitesides left labia majora. It is my opinion . . ., [that] when I encounter a sebaceous cyst/folliculitis/'pimple' during inspection of the vulva, I advise young doctors on appropriate instructions to communicate to a patient. The correct treatment in such circumstances includes not only advising the patient of the finding and attempting to demonstrate the lesion by pointing it out or using a mirror, but also advising the patient if treatment is indicated or informing the patient that the sebaceous cyst/folliculitis/'pimple' will most likely go away on its own. Dr. Randolph's examination and commentary to the patient and efforts to demonstrate the lesion were all entirely consistent with the standard of care."

In Dr. Lanzkowsky's opinion, the performance of a biopsy is not the standard of care where there is a finding of a sebaceous cyst, folliculitis, or pimple in the pubic hair on the vulva or labia majora. Rather, he concluded that Randolph correctly instructed the plaintiff to follow up as needed if the size of the lesion changed, and otherwise return to NYP in one year. Dr. Lanzkowsky opined that Randolph inspected the vulva in a sufficiently close manner, and that Randolph's diagnosis of the nature of the lesion in January 2017 was correct. Specifically, he asserted that there is no evidence or any reasonable medical opinion to support the plaintiff's claim that the growth that Randolph examined in January 2017 developed into the carcinoma that was diagnosed in March 2018. In reaching this conclusion, he relied, in part, on Randolph's deposition testimony, in which she explained that the growth identified in 2017 was in the same general area as the one identified in March 2018, but that she could not determine whether they were in exactly the same location. With respect to Randolph's statement that she could not

determine whether the carcinoma was a "totally different thing that developed," Dr. Lanzkowsky opined that

> "that there is no way anyone can establish that the sebaceous cyst or 'pimple' that was identified by Dr. Randolph on January 18, 2017, evolved into the 'polypoid mass' or 'large appendage hanging off of her upper labia majora' on March 7, 2018. It is a medical fact that a sebaceous cyst or folliculitis cannot change or evolve into melanoma or other cancer. The record shows that the sebaceous cyst was 'on the upper one-third of the left labia majora' on January 18, 2017, and the 'polypoid mass' identified on March 7, 2018 was 'hanging off of her upper labia majora' in the 'general location'/'general area.' Not only can the exact location of the two findings never be known, Plaintiff is unable to establish beyond mere speculation that the 2017 finding evolved into the large, pendulous cancer the patient presented with in 2018."

Dr. Lanzkowsky further concluded that Randolph made a correct and proper diagnosis of a noncancerous sebaceous cyst when she examined the plaintiff on January 18, 2017, explaining that her thorough assessment of the lesion's asymmetry, borders, color, diameter, and evolution led her to the correct diagnosis. Specifically, he noted that Randolph's assessment was that the lesion was symmetrical, with an even border, had the same color as the plaintiff's skin, was small in diameter, and was not evolving or spreading. He asserted that the carcinoma was a "new" mass, as a noncancerous sebaceous cyst cannot morph or evolve into a melanoma or other cancer. He suggested that, in connection with the evolution of the carcinoma, the plaintiff was not diligent or attentive to her own health and medical needs, as she clearly would have noticed the increasing size of any vaginal lesion when she was on the toilet, showering, or changing her underpants during the months leading up to March 2018.

In opposition to the motion, the plaintiff relied upon the same submissions as did Randolph, and also submitted affidavit of Michele Batista, M.D., a physician board certified in obstetrics and gynecology.

Contrary to Dr. Lanzkowsky's opinion, Dr. Batista concluded that the growth that Randolph examined on January 18, 2017 was not a noncancerous sebaceous cyst, but, instead, a malignant melanoma that went undiagnosed for more than 14 months, thus causing it to spread.

Dr. Batista noted that the question marks preceding each record entry of Randolph's tentative 2017 diagnosis established that Randolph did not know with any certainty what she had found and that, without knowing what she was looking at, she could not determine the appropriate treatment and care. She further noted that the plaintiff, at her deposition, asserted that Randolph at one point remarked "you know, I think it's fine, I think it's like fatty tissue." In light of the fact that Randolph was unsure of the nature of the growth, Dr. Batista opined that, at the very least, the standard of care required her to have the plaintiff return on a regular basis for interval monitoring, rather than waiting one year before returning or only to return if the affected area became itchy or irritated. Alternatively, Dr. Batista contended that Randolph should have performed a "punch" or excisional biopsy. In addition, Dr. Batista averred that, in light of the red color of the growth, which was in fact different than the plaintiff's skin color, Randolph should have instructed the plaintiff to take warm baths, apply warm and wet washcloths to the affected area, and apply a topical antibiotic and, if there were no improvement, to return for further evaluation. Moreover, Dr. Batista asserted that, in light of the thickness of the plaintiff's public hair, Randolph should have instructed the plaintiff to trim back or shave the area so that she could self-monitor the condition and appearance of the lesion. She asserted that Randolph's failure to do any of these things was a departure from good and accepted practice.

The plaintiff's expert further pointed out that, in her notes for the January 18, 2017 visit, Randolph failed to document the size of the lesion, and that it was not until her deposition that she revealed the size of the growth in 2017. Dr. Batista opined that the failure to document the size of the lesion contemporaneously with the examination was a departure from good practice, the responsibility for which lies with Randolph, and not the employee transcribing the final note.

In addition, Dr. Batista explained that

> "[t]he plaintiff clearly indicated to defendants that she did not know of the existence of the cyst in January 2017. Dr. Randolph testified that plaintiff had a great deal of pubic hair and that she attempted to show her the area with a mirror. Dr. Randolph assumed but never confirmed that her patient was able to see the lesion while holding this mirror. After seeing the questionable lesion and

> learning that the patient did not know of its existence, and the abundant amount of pubic hair, defendants deviated and departed from accepted medical practice in failing to instruct Ms. Whitesides to trim or shave back the pubic hair so that the patient could see the lesion and continue to monitor it."

She continued that that Randolph deviated from good practice by failing to confirm with the plaintiff that the plaintiff knew the precise area that was to be monitored so that the plaintiff could locate it on her own for self-monitoring.

Dr. Batista asserted that

> "Remarkably, defendants and the expert presume that defendants' diagnosis of a sebaceous cyst was accurate, despite the documented findings and without any concrete medical evidence as no tissue sample was taken. However, given the findings of January 18, 2017 and March 7, 2018, it is my opinion within a reasonable degree of medical certainty that Ms. Whitesides presented with an amelanotic malignant melanoma on January 18, 2017 which defendants failed to properly and timely diagnose. Dr. Randolph testified that while red, the lesion was the color of plaintiff's skin meaning it was lacking pigment which is consistent with an amelanotic melanoma. A physician cannot merely dismiss such a finding as 'nothing to worry about.' Having done so, Dr. Randolph deviated and departed from accepted medical practice and provided the patient with a false confidence. Had she taken a biopsy of the lesion in January 2017, Ms. Whitesides cancer would have been diagnosed and treated in a timely fashion when it was at an early stage."

She further averred that it was conclusory and speculative for Randolph to claim that the two findings, 14 months apart, were not in the exact same location.

Dr. Batista concluded that the plaintiff's disease was confined to the vulva as of January 2017, but the failure to diagnose it at that juncture delayed any possible treatment, and that, by March 2018, the plaintiff had "incurable metastatic disease," characterized as Stage IV cancer. She opined that Randolph's departures from good practice allowed the cancer to remain undiagnosed for 14 months, and that the delay caused the cancer to metastasize to Stage IV.

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 (s*ee 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 (s*ee 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 her expert's affirmation, Randolph established her prima facie entitlement to judgment as a matter of law in connection with claims alleging a departure from good and accepted practice. The plaintiff's expert affirmation, however, raised a triable issue of fact as to whether Randolph departed from good and accepted practice by failing to recognize the nature of the lesion seen on January 18, 2017, and failing undertake the appropriate testing and examination protocol with respect to lesion, thus allowing the lesion to remain improperly diagnosed and the cancer undiagnosed for 14 months. That affirmation also raised a triable issue of fact as to whether the failure to diagnose caused or contributed to the spread of the

cancer and the loss of an opportunity to cure it. Hence, summary judgment must be denied Randolph in connection with that cause of action.

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]).

"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]).

Randolph established her prima facie entitlement to judgment as a matter of law dismissing the lack of informed consent cause of action by establishing that the crux of the plaintiff's claims were premised solely on a failure to diagnose cancer, and that the plaintiff claims no injuries arising from an invasion or disruption of bodily integrity. Since the plaintiff's

expert did not address that issue in her affidavit, the plaintiff failed to raise a triable issue of fact in opposition, and summary judgment must be awarded to Randolph dismissing the lack of informed consent cause of action insofar as asserted against her.

The court notes that, although the plaintiff did not submit a statement of disputed material facts, as required by 22 NYCRR 202.8-g(b), the court would reach the same conclusions even if the facts alleged by Randolph to be undisputed must be deemed admitted (*see* 22 NYCRR 202.8-g[c]). These court rules apply to facts and not opinions and, even if Randolph's explication of the facts are accepted by the court, the conflicting opinions of the experts require the denial of summary judgment in connection with the claim that Randolph departed from good practice.

In light of the foregoing, it is

ORDERED that the motion is granted to the extent that the defendant Paula Randolph, M.D., is awarded summary judgment dismissing the cause of action alleging lack of informed consent, that cause of action is dismissed, and the motion is otherwise denied.

This constitutes the Decision and Order of the court.

3/10/2022
DATE

JOHN KELLEY

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