

**Doyle v Mount Sinai Hosp.**

2022 NY Slip Op 31097(U)

April 4, 2022

Supreme Court, New York County

Docket Number: Index No. 162438/2015

Judge: John J. Kelley

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SUPREME COURT OF THE STATE OF NEW YORK
NEW YORK COUNTY

PRESENT: HON. JOHN J. KELLEY PART 56M

Justice

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MARIE DOYLE, as Administrator of the Estate of ROBERT DOYLE, deceased, and MARIE DOYLE, individually,

Plaintiff,

- v -

THE MOUNT SINAI HOSPITAL and SETH BLACKSBURG, M.D.,

Defendants.

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INDEX NO. 162438/2015

MOTION DATE 01/18/2022

MOTION SEQ. NO. 004

DECISION + ORDER ON MOTION

The following e-filed documents, listed by NYSCEF document number (Motion 004) 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 161, 163, 165, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 196, 198, 199

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

In this action to recover damages for medical malpractice, based on alleged departures from good and accepted medical practice and lack of informed consent, and wrongful death, the defendant Seth Blacksburg, M.D., moves pursuant to CPLR 3212 for summary judgment dismissing the complaint insofar as asserted against him. The plaintiff opposes the motion. The motion is granted to the extent that Blacksburg is awarded summary judgment dismissing the wrongful death cause of action and the lack of informed consent claim insofar as asserted against him. The motion is otherwise denied.

In the complaint, the plaintiff alleged that, between August 16, 2012 and February 19, 2014, Blacksburg treated the plaintiff's decedent, Robert Doyle, at the defendant Mount Sinai Hospital (Mt. Sinai). She also alleged that Blacksburg was an employee of Mt. Sinai. The plaintiff asserted that Blacksburg was negligent

"in failing to render proton beam radiation therapy in a safe manner and in conformity with accepted standards and practices; in failing to take the necessary and indicated safety precautions to ensure that proton beam radiation therapy was rendered in a properly directed and properly regulated and safe manner; in failing to properly utilize the necessary and indicated immobilization devices to

ensure that the plaintiff was adequately positioned as to minimize and/or eliminate the risk of injury; in negligently failing to protect the health of the plaintiff's colon, prostate and/or anatomic elements during the administration of radiation; in failing to ensure that all equipment used in rendering proton beam radiation therapy to the plaintiff was properly calibrated in compliance with manufacturer guidelines and/or medical protocols; in improperly rendering proton beam radiation therapy to the plaintiff in excessive and/or contraindicated doses; in administering radiation therapy in an injurious and negligent manner without due regard for the protection of nearby anatomic structures”

The complaint further asserted that Blacksburg negligently ignored and failed effectively to act upon the decedent's symptoms and conditions, failed to refer him for specialized consultations, and failed to schedule and undertake the proper follow-up examinations, appointments, and diagnostic testing. In addition, it asserted that Blacksburg was negligent in ignoring the calibration of the radiation equipment. Moreover, the complaint asserted a cause of action alleging that Blacksburg failed to obtain the decedent's fully informed consent to the radiation treatment and a cause of action to recover for wrongful death.

In her bill of particulars, the plaintiff reiterated the allegations set forth in the complaint, and also asserted that Blacksburg failed to plan for the course of radiation therapy, undertook an inadequate simulation prior to commencing such therapy, failed properly to aim or position the equipment employed in rendering the therapy, and failed to recognize that radiation was adversely affecting the decedent's colon, prostate, and surrounding vascular tissue. The bill of particulars further asserted that Blacksburg failed immediately to respond to the decedent's condition, failed to heed his signs, symptoms, and complaints, and failed properly to advise him as to his condition and the reason for those signs, symptoms, and complaints. With respect to the lack of informed consent cause of action, the bill of particulars asserted that Blacksburg failed to advise the decedent or his family members of the “risks, problems, alternatives, options and benefits of the medical treatment and/or therapies given that a reasonable provider would have provided under the same or similar circumstances, [as] a result of which the plaintiff was deprived of the ability to make an adequate and informed consent.”

The bill of particulars further asserted that, as a consequence of Blacksburg's negligence, the decedent suffered from radiation proctitis, radiation enteritis, tubular adenoma in the rectal area, a large ulceration in the anterior rectal wall, rectal bleeding with large clots, and blood in the stool. The bill of particulars also asserted that the decedent sustained severe left-side hydronephrosis and moderate right-side hydronephrosis as a consequent of Blacksburg's negligence, as well as gallbladder, biliary, and pancreatic ductal distension, marketed, erythematous, and ulcerated polypoid mucosa, scattered rectal telangiectasias (spider veins), multiple polyps in the transverse, descending, and sigmoid colons, and obstructive uropathy requiring multiple surgeries and ureteral stenting.

The decedent was first diagnosed with prostate cancer on October 1, 2012, following a biopsy at Bellevue Hospital. Pathology showed adenocarcinoma of the prostate, with a Gleason Score---which measures the aggressiveness of the cancer---of 9 out of 10, involving 95% of the tissue and perineural invasion, thus suggesting a fairly high chance the cancer had spread outside the prostate. His pre-biopsy prostate-specific antigen (PSA) level was 30 nanograms per milliliter (ng/ml), a very high level. A computed tomography (CT) scan revealed a thickened bladder wall suggestive of a chronic bladder outlet junction, bilateral hydronephrosis, enlarged prostate, and bilateral lung emphysema, although a bone scan was negative for bony involvement.

Bellevue's urology clinic provided the decedent with the option of undergoing either a radical prostatectomy or external beam radiation therapy with prior transurethral resection of the prostate. The decedent elected the latter option, and thus saw radiation oncologist Richard Cohen for a consultation at NYU Langone Hospital on January 21, 2013. In his records, Dr. Cohen documented that the decedent understood that he was in the high-risk category for prostate cancer, and further explained to him that his treatment options included either a radical prostatectomy with pelvic lymph node dissection, or a course of definitive radiation therapy with long-term androgen deprivation therapy (ADT). According to his records, Dr. Cohen discussed

the risks and benefits of, and alternatives to, both radiation and ADT, explaining that radiation proctitis was a known risk of radiation therapy, and that such a condition could lead to ulcers or other changes in the rectal anatomy, such as perforations or fistulas. In addition, he explained that vasculopathy was a known risk factor for radiation proctitis as well, and that persons with vasculopathy who underwent radiation therapy might sustain adverse results. In addition, he informed the decedent that radiation therapy could result in bloody stool, rectal fullness, rectal pain, and bowel movement changes. As reflected in Dr. Cohen's records, that physician answered all of the decedent's questions, and the decedent again consented to proceed with "Filiation therapy" in conjunction with ADT. Dr. Cohen thereafter prescribed the decedent Lupron, a drug that suppresses sex hormones and that can treat advanced prostate cancer.

On April 5, 2013, the decedent transferred his care to Mount Sinai, and presented to Blacksburg for a radiation oncology consultation. According to Blacksburg's records, the decedent's past medical history as of that date was significant for bladder outlet obstruction, with three urinary tract infections in the prior two years. The decedent also had a history of urinary retention, and endorsed continued urinary frequency, urgency, dysuria, nocturia, and straining with urination. Upon a rectal examination, the decedent evinced normal sphincter tone without blood on the examiner's finger. The decedent's prostate was characterized as moderate in size, with induration noted, greater on the right than the left. Blacksburg's assessment was stage IIB adenocarcinoma of the prostate, which he concluded posed a high risk in light of the decedent's Gleason Score of 9 and a pre-treatment PSA level above 20 ng/ml. Given the decedent's extensive history of obstruction and urinary symptoms, Blacksburg recommended external beam radiation instead of a combination of external beam radiation with radioactive seeds.

Blacksburg's records indicated that he documented his discussion with the decedent of the risks and benefits of radiation therapy, including increased urinary irritative symptoms, urinary retention, radiation proctitis, and erectile dysfunction. Blacksburg further told the

decedent that there was a 5% risk of chronic radiation proctitis, which could lead to ulcers, perforations, and fistulas. Blacksbury informed the decedent that treatment options for chronic radiation proctitis included medication, conservative therapies, hyperbaric oxygen treatment, and, in some cases, surgery. The decedent consented to proceed with Blacksbury's recommendation, with a CT simulation to ascertain the optimal positioning during the course of radiation therapy, which was scheduled for the same day as a magnetic resonance imaging (MRI) scan of his pelvis. The plan was for the decedent to receive a dose of 8,100 centigrays (cGy) of radiation to the prostate across 45 fractions, 5,400 cGy across 30 fractions to the seminal vesicles, and 4,500 cGy to the pelvis over 25 fractions, all over a period of nine weeks. The patient appeared for his CT simulation on April 18, 2013, and began receiving treatment on April 29, 2013.

On June 3, 2013, and thus during the course of the radiation therapy, the decedent presented to the Mount Sinai emergency department with right-sided weakness and was ultimately diagnosed with a transient ischemic attack. The plan that was promulgated on that date was to admit him to the neurology department at the hospital for close monitoring, but he left the hospital against medical advice.

The decedent's radiation therapy continued until July 2, 2013. According to medical records, he tolerated the treatment well, and denied that he suffered from hematuria or rectal bleeding, a conclusion that was supported by the decedent's oncologist, Matthew Gaisky, M.D. As of August 6, 2013, the decedent began seeing Blacksbury for weekly examinations, after which Blacksbury reported that, clinically and biochemically, there was no evidence of disease. The decedent again denied the presence of rectal bleeding. After the decedent's four-month follow-up visit on November 5, 2013, Blacksbury again concluded that the decedent had no evidence of disease, and that the decedent denied rectal bleeding, while the most recent PSA levels had been reduced to zero.

On January 2, 2014, five months after the last administration of radiation, the decedent first reported rectal bleeding. He eventually went to the Mount Sinai emergency department on January 31, 2014, where he was diagnosed with radiation proctitis. He was thereafter hospitalized at Mount Sinai Hospital, and underwent multiple biopsies of the anterior wall of his rectum to rule out cancer. Hospital records reflect that no tumors were found, although a February 7, 2014 colonoscopy revealed a circumferential ulcerated friable non-obstructing rectal mass. The pathology was consistent with radiation proctitis. Blacksbury arranged for the decedent to undergo 60 hyperbaric oxygen therapy sessions at New York Presbyterian Hospital (NYPH) to treat radiation proctitis. Blacksbury last saw the decedent on May 23, 2014, at which time, according to Blacksbury's records, there was still no evidence of metastatic disease despite the decedent's complaints of pain and occasional bleeding. The decedent underwent 49 of the planned 60 hyperbaric oxygen treatments.

On December 9, 2014, a digital rectal exam indicated the presence of a fistula on the right side of the decedent's prostate. He nonetheless refused, on both that date and on January 10, 2015, to undergo a diverting colostomy to treat the fistula, despite being advised that a diverting colostomy could relieve his symptoms.

The decedent was admitted to NYPH on August 26, 2016 and remained there through September 8, 2016. An imaging study undertaken at NYPH revealed the existence of a mass on the left posterior of the urinary bladder, extending posterior to the left distal ureter that, according to the decedent's hospital records, demonstrated central necrosis, and was suspicious for neoplasm. There were also indicia of retroperitoneal inguinal and pelvic lymph node adenopathy that were suspicious for metastasis. No biopsy of the suspicious mass was performed. When the decedent returned to the NYPH emergency department on October 2, 2016, the department's attending physician noted possible metastasis and acute kidney injury, but the decedent refused admission for monitoring. He subsequently died on October 21, 2016. There was no autopsy performed.

In his support of his motion, Blacksbury submitted the pleadings, the bills of particulars, transcripts of the parties' deposition testimony, medical records, discovery orders, an attorney's affirmation, and a statement of material facts that are not in dispute, as well as the affirmation of Jed Pollack, M.D., a board-certified radiation oncologist, with experience in both hospital practice and private medical practice, along with professorial responsibilities at Albert Einstein College of Medicine. Dr. Pollack opined that Blacksbury "complied with the standard of care at all times in his care and treatment of this patient" and that nothing that Blacksbury did or failed to do caused or contributed to the decedent's injuries.

As Dr. Pollack explained it, as part of planning for radiation, a patient will typically have an MRI to determine his other anatomy, followed by a CT simulation, which is performed while the body is positioned the same way it will be positioned during radiation to ensure that the radiation will target the appropriate areas and organs. Because the anatomical structures are small and close together, Dr. Pollack noted that it is impossible completely to prevent radiation from having an impact upon adjacent anatomical structures. He further explained that the dosage of radiation is determined, in part, by consulting Radiation Therapy Oncology Group (RTOG) guidelines, and that, although these guidelines are not binding, they are useful in formulating a plan. As Dr. Pollock interpreted them, the guidelines set forth in RTOG-0924, applicable to high-risk prostate cancer patients, recommend 25 treatments at 1.8 Gy in phase one and 19 treatments at 1.8 Gy for phase two (prostate boost), with up to a 5% variation deemed acceptable to treat a particular patient. He opined that, in patients with more aggressive prostate cancer, like the decedent, radiation oncologists typically administer an additional fraction of radiation fully to treat the cancer. Thus, the RTOG-0924 guidelines recommended a radiation dosage between 7,524 cGy and 8,316 cGy to the prostate. As Dr. Pollock explained it, with a 5% variation deemed acceptable, the RTOG-0924 guidelines would allow for a total of between 42 and 46 fractions of treatment. He noted that patients commonly receive treatment five days a week for nine weeks, totaling 45 fractions.

Dr. Pollock further explained that, once the appropriate dose is determined, a dosimetrist will prepare a dose constraint sheet, and a physicist will program the radiation machine (LINAC-linear accelerator), so that the appropriate amount of radiation is delivered. As he described it, the radiation oncologist has no direct involvement with the actual hands-on treatment delivery of the radiation. Rather, a radiation therapist administers the radiation, by lining up the bony or soft tissue anatomy based on the radiation plan. Dr. Pollock asserted that the radiation oncologist does not need to be present when the patient receives radiation and, in fact, is not expected to be present.

Dr. Pollock opined that Blacksbury formulated a proper plan for radiation therapy, including the dosage and the number of administrations. He further asserted that, given the decedent's Gleason score and PSA levels, the administration of 8,100 cGy of radiation to the prostate over 45 fractions was right within the accepted range of 7,524 cGy and 8,316 cGy over 42 to 46 fractions.

Dr. Pollock noted that Blacksbury prepared a dose constraint sheet that contained

“the prescription for radiation and the different doses and volumes that adjacent anatomical structures could receive with radiation. Because the anatomical structures are small and close together, it is unrealistic to completely spare the anatomy and function of adjacent tissues. Thus, radiation injury to normal tissue is a known and accepted risk of external beam radiation. The dose constraint sheet is used to minimize the risk and protect adjacent anatomical structures to the extent possible. The dosimetrist, in this case James Tam, then prepares a dose volume histogram which contains the information from the dose constraint sheet.”

Dr. Pollock concluded that,

“[h]ere, Dr. Blacksbury measured radiation doses to the penile bulb, rectum, femoral heads, bladder, small bowel, and large bowel. These are the adjacent anatomical structures to the prostate, seminal vesicles, and pelvis. Thus, it would have been impractical and likely impossible to spare those structures from receiving radiation. The proper way to minimize the risk is to prepare a dose constraint sheet and histogram, which occurred in this case. Moreover, the histogram contains the volume, minimum dose, maximum dose, mean dose, modal dose, median dose, and standard of deviation of radiation to be received. Radiation to those structures is a known and accepted risk, and Dr. Blacksbury took the appropriate measures to both minimize that risk and protect the

structures. It is thus my opinion, to a reasonable degree of medical certainty, that Dr. Blacksborg appropriately protected nearby anatomical structures.”

Dr. Pollock went on to opine that proper diagnostic and other testing were performed prior to the decedent’s treatment. As he described it,

“Typically, a patient will have an MRI and CT simulation prior to the beginning of treatment. That was done in this case. The radiation oncologist is not present during the MRI or CT simulation. Moreover, the patient was placed in an immobilization device, and there is no indication there was anything improper about either the simulation or the device. Because the anatomical structures receiving radiation, including the prostate, seminal vesicles, and pelvis, are close together, it is impossible to eliminate the risk of adjacent anatomical structures receiving radiation. The allegation that an adjacent structure becomes irradiated does not implicate the simulation, immobilization device, or plan. Instead, the evidence in this case suggests that the patient was sent for the appropriate planning/testing, and the radiation plan properly incorporated those results.”

Dr. Pollock also concluded that, inasmuch as radiation proctitis is a known risk of radiation treatment, and that as many as 8-12% of patients receiving high doses of such treatment are likely to suffer from grade III or IV toxicity radiation proctitis.

Dr. Pollock further opined that the consent obtained from the decedent was completely in conformance with accepted medical standards, and constituted fully informed consent. He also concluded that nothing that Blacksborg did or did not do caused or contributed to any of the decedent’s injuries. With respect to the cause of the decedent’s death, Dr. Pollock asserted that, when the decedent presented to NYPH in October 2016, he refused to undergo a biopsy, but that, nonetheless, “there was likely either a metastasis [of the prostate cancer] or a new cancer at this point. This is a well-known risk for any cancer patient, including one in remission, as this patient was. There is simply no evidence that . . . this patient’s radiation therapy contributed to his demise.”

In opposition to Blacksborg’s motion, the plaintiff relied upon the same pleadings, bills of particulars, deposition transcripts, and medical records as were relied upon by Blacksborg, and also submitted the expert affirmation of Andrew Zablow, M.D., a board-certified radiation oncologist with significant experience in the practice and teaching of radiation oncology.

Although he essentially agreed with Dr. Pollock's recitation of the decedent's medical history, he provided additional details. Dr. Zablow noted that

"Mr. Doyle commenced radiation treatment on April 29, 2013, which continued for 45 sessions, concluding on July 2, 2013. At some point, during his treatment, Mr. Doyle was subjected to radiation from a machine dripping fluid, not functioning as designed. Mr. Doyle testified that while receiving radiation one day, the machine began to drip fluid onto him. He testified that he then informed the technician and Dr. Blacksbury of the malfunction and he was switched to a different machine. Dr. Blacksbury testified that he did not recall this instance. On May 21, 2013, Mr. Doyle presented to the ER at Mt. Sinai following radiation treatment due to an inability to urinate."

He also provided a more detailed description of the several occasions on which the decedent presented to Mount Sinai subsequent to the radiation treatment, complaining of numerous severe symptoms associated with radiation proctitis. Dr. Zablow opined that

"Seth Blacksbury, M.D. and Mt. Sinai Hospital departed from good and accepted standards of radiation oncology in that they negligently administered radiation to Mr. Doyle and in doing so caused him to sustain Grade 4 radiation proctitis/rectal toxicity including a perforation of the rectal wall, rectal bleeding and extreme pain and suffering. Mr. Doyle sustained the most severe and extreme manifestation of radiation proctitis and rectal toxicity as a direct consequence of the radiation treatment he received from Seth Blacksbury, M.D. and the staff at Mt. Sinai Hospital from April 29, 2013, through July 2, 2013. It is further my opinion within a reasonable degree of medical certainty that Mr. Doyle's severe Grade 4 radiation proctitis and rectal toxicity, and specifically the rectal toxicity inclusive of rectal perforation is an injury that does not ordinarily occur in the absence of malpractice, especially where there were no contraindications to the treatment and no pre-existing conditions that increased Mr. Doyle's risk of suffering such an injury. It is further my opinion within a reasonable degree of medical certainty that this injury was caused by the radiation machines maintained and exclusively controlled by Mt. Sinai Hospital and its staff and the usage of same by Dr. Blacksbury, Mr. Tam, Ms. Powers, the radiation therapists and other staff at Mt. Sinai Hospital. It is finally my opinion within a reasonable degree of medical certainty that Mr. Doyle in no way contributed to his own injury of radiation proctitis and Grade 4 rectal toxicity."

Specifically, Dr. Zablow opined that,

"According to applicable guidelines in practice during Mr. Doyle's treatment, the incidence of radiation proctitis or rectal toxicity as it existed in 2013 in terms of grading is as follows: Grade 0 is 59-74%, Grade 1 is 17-37%, Grade 2 is 3-7%, Grade 3 & Grade 4 is 0.7%. It is my opinion within a reasonable degree of medical certainty *that according to prevalent practice that the occurrence of grade 4 complication of necrosis/perforation/fistula is 0%*. The articles quoted by Jed Pollack, M.D. and Joseph Cirrone, M.D. in support of the Defendants' motions quoting a higher incidence of grade 4 injury that includes fistula are of an

antiquated toxicity criteri[on] used between 1987-2005. Incidence of Grade 3 and Grade 4 rectal toxicity diminished to 0% subsequent to the Defendants' quoted studies. A new toxicity grading system was developed in approximately 2009 which is applicable to the care and treatment provided to Mr. Doyle in 2013 in the advent of improved software, EBRT machines and methodology for administering radiation therapy. Accordingly, the Defendant's statistics concerning the incidence of Grade 4 injury [are] inapplicable to Mr. Doyle's care and treatment.

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"While radiation proctitis and rectal toxicity [are] known complication[s] of radiation therapy, not all degrees of it are.

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"Accordingly, it is my opinion within a reasonable degree of medical certainty that the rectal fistula/perforation/Grade 4 rectal toxicity suffered by Mr. Doyle *was an injury that does not occur in the absence of medical malpractice*. In contrast, when radiation is administered correctly, the incidence of Mr. Doyle's severe injury i.e. the rectal fistula/perforation is 0%"

(emphasis added).

Dr. Zablow asserted that a "patient with active prostate cancer can suffer a perforation due to the effect of the cancer itself destroying rectal tissue," but that "[t]he record is clear that Mr. Doyle was cancer-free following his radiation therapy and therefore his rectum was not destroyed by cancerous cells and there were no contraindications to Mr. Doyle's receiving radiation therapy." As he explained it, while proctitis is a known risk, "radiation proctitis causing Grade 4 rectal toxicity is not. Grade 4 rectal toxicity is a degree of radiation proctitis so severe and extreme that it occurs in 0% of cases." He averred that, although the radiation therapy prescription appeared to be appropriate as to total dosage to each of the target anatomical structures, dosage per administration, and number of administrations, "the outcome of the treatment conclusively demonstrates that the designed radiation plan was not properly designed, approved, implemented and/or administered using functional radiation machines." Specifically, he asserted that

"[t]he injury suffered by Mr. Doyle occurred because his rectum was over radiated. The exact mechanism by which the Defendant[s] caused the injury cannot be ascertained as the testimony demonstrates that the printed copies of

treatment after radiation *cannot reveal whether or not a structure has been over-radiated.*"

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"the graph DVH (dose volume histogram) indicates max doses to rectal wall of 8380.3 cGy, SV ECE sb 8757.7 cGy this the seminal vesicles which is in juxtaposition to the rectum. Prostate sb+ECE 8728 cGy again organs in juxtaposition to the rectum. PT 45 refers to the prostate dose 8771.3 cGy which again is juxtaposed to the rectum. These are the maximum doses each structure received. *The latter volume administered to Mr. Doyle is larger than the doses prescribed by Dr. Blacksburg and the dose constraints of Mt. Sinai for Mr. Doyle's particular prostate cancer. The volume of radiation administered to Mr. Doyle deviated from the standard of care in that it was an excessive quantity of radiation of for type and nature of prostate cancer Mr. Doyle suffered.* The failure to administer the physician's prescribed dosage and to exceed the institutional dose constraints was a departure from the standard of care. Rectal toxicity is directly related to the volume of tissue irradiated and the dose given to that tissue"

(emphasis added). In other words, Dr. Zablow concluded that the decedent's injuries were "caused by excessive radiation and/or direct radiation applied to the wrong structures."

Crucially, contrary to Dr. Pollock's opinions, Dr. Zablow concluded that a radiation oncologist such as Blacksburg is indeed ultimately responsible for the actual administration of the radiation itself at the prescribed dosages, as well as for the proper maintenance and operation of all equipment involved in the radiation therapy.

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).

Even where a plaintiff cannot directly establish that a physician's departure from good and accepted practice caused an injury, the theory of *res ipsa loquitur* may be applied to occurrences "[w]here the actual or specific cause of an accident is unknown" (*Kambat v St. Francis Hosp.*, 89 NY2d 489, 494 [1997]). Under such circumstances, "a jury may . . . infer negligence merely from the happening of an event and the defendant's relation to it" (*id.*; *see States v Lourdes Hosp.*, 100 NY2d 208, 211-212 [2003]; Restatement [Second] of Torts § 328D). To establish a *prima facie* case of negligence in support of a *res ipsa loquitur* charge, plaintiff must establish three elements:

"[1.] the event must be of a kind that ordinarily does not occur in the absence of someone's negligence;

"[2.] it must be caused by an agency or instrumentality within the exclusive control of the defendant; and

"[3.] it must not have been due to any voluntary action or contribution on the part of the plaintiff"

(*Kambat v St. Francis Hosp.*, 89 NY2d at 494; *see James v Wormuth*, 21 NY3d 540, 545-546 [2013]; *Ebanks v New York City Tr. Auth.*, 70 NY2d 621, 623 [1987]; Prosser and Keeton, Torts § 39 at 244 [5th ed]). *Res ipsa loquitur*, a doctrine of ancient origin (*see Byrne v Boadle*, 2 H & C 722, 159 Eng Rep 299 [1863]), derives from the understanding that some events ordinarily do not occur in the absence of negligence (*see id.*; *see also Dermatossian v New York City Tr. Auth.*, 67 NY2d 219, 226 [1986]).

Once a plaintiff satisfies the burden of proof with respect to these three elements, the res ipsa loquitur doctrine permits the jury to infer negligence from the mere fact of the occurrence (see *States v Lourdes Hosp.*, 100 NY2d at 211-212; *Kambat v St. Francis Hosp.*, 89 NY2d at 495). Thus, for example, where “a foreign object is left in the body of the patient, or the patient, while anesthetized, experiences an unexplained injury in an area which is remote from the treatment site” (*McCarthy v Northern Westchester Hosp.*, 139 AD3d 825, 827 [2d Dept 2016] [citation omitted]), the invocation of the doctrine of res ipsa loquitur may be warranted (see *id.*; see also *Mattison v OrthopedicsNY, LLP*, 189 AD3d 2025, 2027 [3d Dept 2020]; *Swoboda v Fontanetta*, 131 AD3d 1042, 1045 [2d Dept 2015]; *DiGiacomo v Cabrini Med. Ctr.*, 21 AD3d 1052, 1054 [2d Dept 2005]; *Escobar v Allen*, 5 AD3d 242, 243 [1st Dept 2004]; *Leone v United Health Servs.*, 282 AD2d 860, 860-861 [3d Dept 2001]; *Hill v Highland Hospital*, 142 AD2d 955, 956 [4th Dept 1988]).

Blacksburg established, through Dr. Pollock’s affirmation, that the grade 4 toxicity level of the decedent’s radiation proctitis could have occurred in the absence of negligence. He also established that he prescribed the proper dosage and frequency of radiation treatments, and that the total dosage actually administered was proper and in accordance with his prescription. He conceded, however, that it was not possible fully to shield structures adjacent to the prostate and vesicles from radiation during the course of treatment. The plaintiff raised a triable issue of fact in opposition to Blacksburg’s showing with Dr. Zablow’s affirmation, in which he opined that, although the exact mechanism could not be ascertained with specificity, Blacksburg permitted those adjacent anatomical structures to be over-radiated, that the over-radiation constituted a departure from good and accepted practice, and that the decedent’s radiation proctitis with a grade 4 toxicity could not have occurred in the absence of such a departure. Dr. Zablow also opined, contrary to Dr. Pollock’s suggestion, and essentially conceded that there was no way to measure the exact amount of radiation absorbed by those adjacent anatomical structures. Hence, the court must deny that branch of Blacksburg’s motion seeking summary judgment

dismissing the medical malpractice cause of action to the extent that it was premised on alleged departures from good and accepted practice, and sought to recover for the decedent's conscious pain and suffering.

Blacksburg established, prima facie, that, even if any malpractice on his part caused or contributed to the decedent's radiation proctitis, and the symptoms associated therewith, including rectal fistula, neither radiation proctitis nor those symptoms caused or contributed to the decedent's death (*see Wolfe v Samaritan Hosp.*, 104 AD2d 143, 145 [3d Dept 1984]; *see generally Roques v Noble*, 73 AD3d 204, 206 [1st Dept 2010]). In opposition, the plaintiff's expert did not address Blacksburg's showing in this regard, referring only once in his 20-page affirmation to the cause of the decedent's death, and opining that the decedent suffered from "a severe and fatal complication of rectal fistula." This conclusory opinion is insufficient to raise a triable issue of fact as to whether the decedent's death was actually caused by Blacksburg's malpractice and the injuries sustained by the decedent as a consequence of that malpractice (*see Imperati v Lee*, 132 AD3d 591, 592 [1st Dept 2015]). In any event, the decedent's refusal to undergo treatment to repair or alleviate the symptoms of the rectal fistula on several occasions beginning more than 18 months prior to his death further defeats any claim that the plaintiff might have that Blacksburg's malpractice caused or contributed to the decedent's death. Hence, Blacksburg is entitled to summary judgment dismissing the wrongful death cause of action insofar as asserted against him.

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]). Blacksburg established, with his own testimony, the medical records, and Dr. Pollock’s opinion that he fully informed the decedent and his family of the risks and benefits of radiation therapy, and the alternatives to that therapy. Since Dr. Zablow did not address this issue, the plaintiff failed to raise a triable issue of fact in opposition to this showing, and Blacksburg must be awarded summary judgment dismissing so much of the medical malpractice cause of action as was based upon lack of informed consent.

Accordingly, it is

ORDERED that the motion of the defendant Seth Blacksburg, M.D., is granted to the extent that he is awarded summary judgment dismissing, insofar as asserted against him, the wrongful death cause of action and so much of the medical malpractice cause of action as alleged lack of informed consent, and the motion is otherwise denied.

This constitutes the Decision and Order of the court.

4/4/2022  
DATE



J. MICHAEL KELLEY, J.S.C.

CHECK ONE:	<input type="checkbox"/> CASE DISPOSED	<input checked="" type="checkbox"/> NON-FINAL DISPOSITION
APPLICATION:	<input type="checkbox"/> GRANTED <input type="checkbox"/> DENIED	<input checked="" type="checkbox"/> GRANTED IN PART <input type="checkbox"/> OTHER
CHECK IF APPROPRIATE:	<input type="checkbox"/> SETTLE ORDER	<input type="checkbox"/> SUBMIT ORDER
	<input type="checkbox"/> INCLUDES TRANSFER/REASSIGN	<input type="checkbox"/> FIDUCIARY APPOINTMENT <input type="checkbox"/> REFERENCE