Padilla v Labow
2022 NY Slip Op 31484(U)
May 4, 2022
Supreme Court, New York County
Docket Number: Index No. 805098/2018
Judge: John J. Kelley

SUPREME COURT OF THE STATE OF NEW YORK
NEW YORK COUNTY

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

Justice

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WILFREDO PADILLA,

Plaintiff,

- v -

DANIEL LABOW, M.D., ARZU BUYUK, M.D., GEORGE LEE, CT, MOUNT SINAI HOSPITAL, MOUNT SINAI WEST, and MOUNT SINAI HEALTH SYSTEM, INC.,

Defendants.

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INDEX NO. 805098/2018

MOTION DATE 02/16/2022

MOTION SEQ. NO. 001

DECISION + ORDER ON MOTION

The following e-filed documents, listed by NYSCEF document number (Motion 001) 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 96, 97, 98, 104, 105, 106, 107, 108, 109, 110, 112, 114, 116, 117

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, the defendants Arzu Buyuk, M.D., George Lee, CT, and Mount Sinai West (collectively the Mount Sinai West defendants) together move pursuant to CPLR 3212 for summary judgment dismissing the compliant insofar as asserted against them. The plaintiff opposes the motion. The motion is granted to the extent that summary judgment is awarded to Buyuk and Lee dismissing the complaint insofar as asserted against them, and to Mount Sinai West dismissing all claims premised on vicarious liability for the negligence of Buyuk and Lee, and the motion is otherwise denied.

In his complaint, the plaintiff made general allegations that the Mount Sinai West defendants departed from good and accepted medical practice. In his bills of particulars, the plaintiff asserted that those defendants failed properly to interpret a cytopathology specimen taken from his pancreas, resulting in unnecessary surgical intervention performed by the defendant Daniel Labow, M.D.

On April 14, 2016, at which time the plaintiff was 51 years old, he presented to Bedford-Stuyvesant Family Health Center in Brooklyn for pancreatic cancer screening. The plaintiff had a family history of pancreatic cancer, as both of his parents had died from that condition. Laboratory testing revealed that the plaintiff had a slightly elevated carbohydrate antigen (CA 19-9), also known as cancer antigen, level in his blood sample, which is a measure of risk for pancreatic cancer. As of that date, his CA 19-9 level was 40.4 units per milliliter (U/ml). The high end of the normal reference range for that antigen is generally accepted as 35-40 U/ml.

On May 23, 2016, Dr. Asha Nayak, an oncologist at The Brooklyn Hospital Center (BHC), met with the plaintiff, who had been referred to her to rule out pancreatic cancer. He thereafter presented to the Division of Hematology and Oncology at BHC on July 15, 2016. The plaintiff reported intentional weight loss over the previous month, and had smoked cigarettes for 10 years, but had quit six months prior to his appointment. He also presented with Type II diabetes, coronary artery disease, and hypertension, and was characterized as obese, weighing 259 pounds. Dr. Nayak noted that the plaintiff had slightly elevated CA 19-9 levels, measured at 41.3 U/ml. He was then sent for an evaluation of those CA 19-9 levels. Dr. Nayak informed the plaintiff that he might have a tumor on his pancreas, but she did not tell him whether it was cancerous or not.

BHC developed a plan to repeat the CA 19-9 test, undertake additional laboratory testing, including a carcinoembryonic antigen (CEA) test, and schedule the patient for a computed tomography (CT) scan, with pancreatic protocol and genetics counseling. The plaintiff underwent an abdominal CT scan on July 15, 2016, and the impression was of a poorly defined soft tissue opacification interposed between the stomach and pancreatic body and tail, and extending around the pancreatic tail to the splenic hilum, left upper perinephric space, and inferior/inferolateral perisplenic region. The splenic vein was only partially visualized as it entered the main portal vein, containing central decreased attenuation suspicious for thrombus. The relevant note indicated that "[o]verall, findings raised concern for infiltrative neoplastic

involvement." Diagnoses included a history of slightly elevated CA 19-9 levels, and a mass of the pancreas, with a working diagnosis characterized as a "concern" for malignancy. Specifically, laboratory testing reported the plaintiff's CA 19-9 levels at 26.3 U/ml on September 7, 2016, a figure within the reference range, with a CEA level of 1.9 U/ml on that date as well. The plaintiff returned on to BHC on September 16, 2016, and was referred to a surgeon

On September 28, 2016, the plaintiff presented to the defendant surgeon, Daniel Labow, M.D., at the defendant Mount Sinai Hospital for further evaluation of the pancreatic mass. According to Labow's notes, the plaintiff denied any symptoms and was eating well with a good appetite. He denied unintentional weight loss or any other symptoms. In addition to the past medical history that he reported to Dr. Nayak, the plaintiff now reported that he had three stents placed in his heart. He also reported prior occasional drug use, including marijuana and crack.

Labow noted that a physical examination of the plaintiff revealed an abdominal or pancreatic mass that was "unlikely" for malignancy. According to Labow, he had a long discussion with the plaintiff about differential diagnosis, risk factors, causes of disease, and the spectrum of different treatments, both surgical and non-surgical, that could address his condition. Labow asserted that he provided the plaintiff with a detailed description of surgical procedures, expected hospital course, the need, if any, for further testing, including bloodwork, radiology, or medical clearance, the need for adjuvant therapy, if indicated, and the plaintiff's long-term prognosis. The plaintiff, however, denied that such a discussion took place, and averred that Labow told him only that he had pancreatic cancer, and never told him that he might have nonmalignant chronic pancreatitis. According to the plaintiff, Labow solely recommended that he undergo surgery to save his life, declining to offer any options other than surgery. The plaintiff also asserted that Labow never discussed how surgery could help diagnose the presence or absence of cancer.

On October 20, 2016, the plaintiff presented to the defendant Mount Sinai West, then known as St. Luke's-Roosevelt Hospital Center, for an endoscopic ultrasound (EUS) and a fine-

needle aspiration (FNA) biopsy, which were performed under the supervision of Dr. Edward Lung, a gastroenterologist. A hypoechoic mass, measuring 40 millimeters by 30 millimeters in maximal cross-sectional diameter, was identified in the plaintiff's pancreatic body, extending to the pancreatic tail, with endosonographic borders that were difficult to define. The endosonographic appearance of parenchyma and the upstream pancreatic duct indicated no ductal or parenchymal calcifications. An FNA biopsy to obtain a specimen for cytological testing was undertaken, and the specimen was provided to Buyuk, a pathologist employed by Mount Sinai West, for a pathology study. A cytologist, identified by Buyuk as the defendant cytotechnologist George Lee, was present, and performed a preliminary cytologic examination.

The post-operative diagnoses that were enumerated included an ill-defined mass identified in the pancreatic body, extending to the pancreatic tail. Dr. Lung recommended that the patient await the final cytology results, return to the gastroenterology department of Mount Sinai West two weeks later, and consider having a magnetic resonance imaging (MRI) scan performed, with gadolinium contrast media, at the next available appointment. Dr. Lung further suggested that the plaintiff follow up with Labow.

Preliminary results of the cytology examination, reported while the final results were pending, were suggestive of a benign lesion. Lee performed the initial pathology evaluation of the specimen, after which he wrote the following note:

> "FNA- PANCREAS
> Satisfactory for evaluation
> High cellularity specimen
> Positive for neoplasm
> Many sheets or clusters of loosely cohesive epithelial cells.
> The tumor cells are generally small and relatively uniform.
> Suspicious for low-grade pancreatic endocrine tumor."

On November 2, 2016, Buyuk finalized and signed the cytopathology report for the procedure. The clinical history that was documented included "pancreatic mass and increase in CA19-9, recent DM, FH and pancreatic CA in both parents." Buyuk never concluded that the plaintiff had pancreatic cancer or acinar cell carcinoma. Rather, in her report, Buyuk wrote as follows:

"FINAL DIAGNOSIS: PANCREAS, MASS: FINE NEEDLE ASPIRATION (INCLUDING THINPREP AND CELL BLOCK)
- ATYPICAL. See comments."

In the comments section of her final report, she noted that the cellular aspirate showed uniform population of round/polygonal cells in sheets and clusters with acinar or "berry"-like cell formations and many single cells. She further wrote that the cells had abundant granular cytoplasm with indistinct cell borders reminiscent of acinar cells and did not display significant atypia or mitotic figures. Buyuk further noted the presence of scattered benign ductal sheets. The morphologic features and immunohistochemical studies supported the conclusion that the cells were of an acinar phenotype. Buyuk commented that "*[i]f there is a distinct mass*, the overall features are suspicious for acinar cell carcinoma. However, *normal acinar tissue can yield numerous glandular/acinar structures mimicking carcinoma*. Clinical and radiologic correlation recommended" (emphasis added). Although she found that "the cells looked very normal," she nonetheless categorized the pancreatic cells as "atypical" because "although the cytologic features were not very impressive, the presentation, the presence of mass and the family history was [sic] worrisome." Buyuk herself performed additional immunohistochemical staining on November 8, 2016, which were negative for CEA(p) and progesterone receptors.

Meanwhile, Labow, upon finding abnormal laboratory values and a pancreatic abnormality, as seen on imaging, referred the patient to NYU Langone Medical Center for an abdominal MRI, which was performed on October 31, 2016. The scan revealed mild increased diffusion signal throughout the pancreas, predominantly in the pancreatic tail. In addition, the scan reflected a T2 hyperintense signal surrounding the pancreas, a line of delayed peripancreatic enhancement, and a small amount of peripancreatic fluid in the left upper quadrant, as well as mild T2 hypodense thickening of the anterior perirenal fascia. The scan further showed a tethering of the pancreas in the gastric fundus/body with wall thickening along the lesser curvature. There was no pancreatic ductal dilatation or soft tissue pancreatic mass. The radiologist's impression ended with "Malignancy is considered unlikely."

Labow next saw the plaintiff on November 2, 2016. According to Labow, at that visit, the plaintiff denied the presence of any symptoms, and claimed to be eating well with good appetite. Labow noted that "EUS and bx were done and showed ? mass - pathology pending." In his assessment and plan, Labow noted abdominal/pancreatic mass, unlikely for malignancy, but nonetheless noted that he "will await path results and likely follow up in 4-6." Labow claims to have reviewed the images and had a long discussion with the plaintiff regarding the symptoms and diagnosis, asserting that these discussions included

> "differential diagnoses, risk factors/causes of disease, spectrum of different treatments (both surgical and nonsurgical), detailed description of surgical procedures, expected hospital course, need (if any) for further testing (including bloodwork, radiology or medical clearance), need for adjuvant therapy (if indicated), and long term prognosis."

The plaintiff, however, claims that this discussion did not occur as Labow described it but, rather, that Labow unambiguously told him that he had pancreatic cancer, and did not suggest that he merely had chronic pancreatitis as opposed to pancreatic cancer. According to the plaintiff, Labow suggested that he have surgery to save his life, and did not offer any options other than surgery. As the plaintiff recalled it, there was no discussion about whether surgery could assist in any final diagnosis.

Both before and after the plaintiff's November 2, 2016 visit with Labow, his case was presented to the Mount Sinai Tumor Board, first on October 4, 2016 and then on November 8, 2016. The parties agree that the Mount Sinai Tumor Board comprises radiologists, pathologists, surgeons, and oncologists who treat gastrointestinal malignancy as part of The Mount Sinai Faculty Practice. On October 4, 2016, the Tumor Board, based on the plaintiff's age and family history, again performed a CA 19-9 blood test, which was initially mildly elevated at 41 U/ml, but had decreased to 26 U/ml. Subsequent CT imaging showed distal peri-pancreas mass. The plan that the Tumor Board formulated on October 4, 2016 was to conduct another EUS scan and an FNA biopsy. After the November 8, 2016 meeting, the Tumor Board added to its note that the EUS again revealed the existence of a mass measuring 40 millimeters by 30 millimeters

in the pancreatic body, extending to the tail. The pathology remained pending, and an MRI was obtained further to characterize the mass, with a plan to review the imaging and discuss a course of treatment and care. According to the Tumor Board's records, the plan of care was to conduct a distal pancreatectomy, that is, surgery to remove all or part of the pancreas. The plaintiff nonetheless contends that there is no evidence as to what records were in fact reviewed by the Tumor Board, and that it remains unclear as to whether the Tumor Board actually reviewed the picture of the MRI scan that it recommended be undertaken.

The plaintiff returned to Dr. Labow's office on November 9, 2016 and presented to Physician's Assistant Samantha Aycart, with reported pathology that was suggestive of "possible" acinar cell carcinoma, notwithstanding the fact that he remained asymptomatic. Pursuant to an assessment and plan, PA Aycart wrote that plaintiff had acinar cell carcinoma of the distal body/tail of the pancreas. There was, however, no evidence of metastatic disease revealed on the abdominal MRI. Labow thus planned to proceed with lap distal pancreatectomy and splenectomy. The plaintiff thus presented to Mount Sinai Hospital for surgery by Labow on December 2, 2016. His working diagnosis was acinar cell pancreatic cancer in the body of the pancreas, as well as chronic pancreatitis. Labow performed a laparoscopic procedure that was converted to an open distal pancreatectomy, a splenectomy with partial gastrectomy, adrenalectomy, and repair of intra-abdominal vessels intraoperatively. Labow described significant adhesive chronic pancreatitis to the transverse mesocolon, as well as to the retroperitoneum, which had resulted from a longstanding pancreatitis. He also noted varices from the occluded splenic vein from the pancreatitis and likely from a possible malignancy.

When the pathology for the December 2, 2016 surgery was completed, however, it did not reveal any malignancy, but only peripancreatic fibrosis and chronic inflammation. Nineteen lymph nodes that were examined were also negative for tumor, while the pancreas, spleen, gastric, and colonic mucosa otherwise were unremarkable. The overall histology and immunophenotypes were nonspecific and favored non-neoplastic change, probably post-

inflammatory. A post-operative reevaluation of the FNA biopsy also revealed no evidence of malignancy.

The plaintiff asserted in his bill of particulars that both Buyuk and Lee negligently interpreted the October 20, 2016 cytopathology specimen from his pancreas and, thus, failed to observe, report on, recognize, and consider the presence of morphologic and immunohistochemical features and findings consistent with a benign pancreatic mass and pancreatitis. He further alleged that Buyuk failed to engage in a differential diagnosis to rule in or rule out pancreatitis or a benign pancreatic mass, on the one hand, or pancreatic cancer, on the other, inasmuch as she failed to perform a tissue biopsy such as a frozen section biopsy or a computed tomography (CT) or magnetic resonance imaging (MRI scan), or refer the plaintiff for such testing.

The plaintiff further averred in his bills of particulars that Buyuk negligently characterized the overall features of the subject pancreatic as being suspicious for acinar cell carcinoma despite the absence of supporting indicia, and consequently failed to recognize the morphology of what turned out to be a benign mass. He alleged that Buyuk thus negligently reported that the cytology specimen was "atypical," while simultaneously noting that there was no "significant atypia," as the specimen did not display significant atypia or mitotic figures. The plaintiff further asserted that Buyuk departed from good and accepted medical care in failing to request from the referring surgeon a more detailed indication for the cytopathology and diagnosis, and in failing to consult with a pathologist and/or cytopathologist more experienced and qualified to diagnose and interpret a cytopathology sample of the pancreas. In addition, the plaintiff claimed that Buyuk should have requested an additional specimen to the extent that the specimen that was actually taken prevented her from obtaining an accurate diagnosis.

In support of their motion, the Mount Sinai defendants submitted the pleadings, the bills of particulars, the relevant medical and hospital records, and copies of the parties' deposition transcripts, along with an expert affirmation of Seena Aisner, M.D., a board-certified anatomical

and clinical pathologist and cytopathologist. She concluded, with a reasonable degree of medical certainty, that none of the Mount Sinai defendants departed from good and accepted practice.

With respect to Lee, Dr. Aisner asserted that the plaintiff made no specific allegations related to his job responsibilities as a cytotechnologist, as Lee did not make the final diagnosis of atypia and did not author the final cytopathology report because those were not his responsibilities. Dr. Aisner explained that Lee's role as a cytotechnologist, as it pertained to functions in the operating room, was to inform the physician performing the procedure whether the specimen he collected was adequate and that, after the specimen was collected, to take the specimen to the cytology lab and prepare slides. Dr. Aisner noted that Lee was present in the operating room during the FNA biopsy performed on October 20, 2016, determined that the sample was adequate, brought the specimen to the cytology department to prepare the slides, prepared the slides, performed a quick, initial quick study, and made preliminary findings. As Dr. Aisner pointed out, the plaintiff makes no claims that the specimen was insufficient or inadequate or that Lee made a final diagnosis. Rather, Lee noted his concerns, and left the final diagnosis to Buyuk, the cytopathologist assigned to the plaintiff's case. Hence, Dr. Aisner concluded that Lee did not depart from good and accepted cytotechnicians' practice, and that, in any event, nothing that he said, did, or failed to do caused or contributed to any unnecessary surgery.

With respect to Buyuk, Dr. Aisner wrote that the "plaintiff's claim that Dr. Buyuk failed to rule out cancer is without merit." She continued that a

> "cytopathologist is not required to categorize a specimen as benign or malignant. This is because it is not always clear whether or not there is malignancy. Furthermore, while cytologic interpretation can involve identifying benign and malignant disorders/tumors, it is not strictly related to the diagnosis of cancer. Cytologic interpretation also involves identifying inflammatory and reparative conditions. And, as it relates to the pancreas more specifically, it is often difficult to detect cancer because inflammation of the pancreas makes the cells look abnormal and often mimics malignancy.

> "As it relates to diagnosing a specimen as malignant or benign, it is sometimes impossible to determine, thus a cytopathologist can categorize a sample as malignant, suspicious for malignancy or neoplasm, atypical, or negative for malignancy/benign. Malignant means there are cancerous cells on the cytologic sample. Suspicious means there is a suspicion for cancer but a definitive diagnosis cannot be made on a particular sample. This may be due to a paucity of cells present or cellular changes due to inflammation or repair. To be clear, *Dr. Buyuk never characterized the sample as malignant or even as suspicio[us] for malignancy*"

(emphasis added). Dr. Aisner explained that "Atypia" means the cells appear atypical, but not necessarily malignant. She averred that other factors, such as inflammation or a reparative process, may cause cells to appear abnormal. In addition, she explained that the phrase "negative for malignancy" means there is no evidence of cancer on a specific cytology sample. Unlike specimens that are characterized as "suspicious," a designation of atypia is not a high indication of malignancy and generally is not indicative of cancer. Dr. Aisner opined that "[a] finding of atypia is closer to benign than it is to malignancy. In fact, a finding of atypia is as close as one can categorize to 'negative for malignancy' without categorizing the sample as negative." She thus concluded that, although Buyuk did not have responsibility for ruling out cancer in the first instance, she never even purported to claim that the plaintiff's samples indicated malignancy.

Dr. Aisner further explained that

> "Dr. Buyuk's report of 'Atypia' was reasonable, appropriate, and comported with the standard of care as the as the sample demonstrated increased cellularity. The aspirated sample is far too cellular and does not represent what is typically seen in pancreatitis. In the acute phase of pancreatitis, fine needle aspiration cytology typically identifies numerous acute and chronic inflammatory cells and necrotic (dead) tissue. When in the later phases of chronic pancreatitis, the cytologic sample usually demonstrates sparse cellularity or acellularity due to the scarring that has occurred in the healing process. Thus, the cytologic findings in Mr. Padilla's fine needle aspiration cytology are not compatible with features of acute or healing pancreatitis. *Dr. Buyuk's cytologic evaluation was detailed and exhaustive as she defined the lineage of the cells present on the smears.*
>
> Though Dr. Buyuk noted a finding of abundant granular cytoplasm with indistinct cell borders reminiscent of acinar cells that do not display significant atypical or miotic features, *the number of cells was increased.* Thus Dr. Buyuk's diagnosis of atypia was reasonable because atypia can be diagnosed based on the appearance of the cells *or the quantity of cells*"

(emphasis added). Dr. Aisner opined that, where there is even the slightest degree of abnormality, including very slight cytological abnormality, architectural abnormality, or deviation from the expected quantity of cells, then the specimen should indeed be categorized as "atypical."

Dr. Aisner further opined that the additional testing undertaken by Buyuk comported with the standard of care, and that no other types of testing by a cytopathologist would have yielded a definitive determination that there were no cancer cells present in the plaintiff's pancreas. Moreover, she asserted that, because a cytology report cannot be both "atypical" and "negative for cancer," it was appropriate for Buyuk to find that the specimen was "atypical." In addition, Dr. Aisner noted that the plaintiff's allegation that Buyuk failed to recommend further CT or MRI scans is belied by the medical records, in which Buyuk clearly recommended radiological correlation. Furthermore, Dr. Aisner concluded that Buyuk's decision not to recommend a full pancreatic biopsy comported with the standard of care, inasmuch as such a biopsy rarely is indicated and rarely performed due to the significant risks involved. Dr. Aisner also asserted that Buyuk did not need to request Labow to provide her with a more detailed indication for the cytopathology and diagnosis, "as she was already in possession of plaintiff's clinical history including a pancreatic mass, increase in CA19-9, recent DM, FH, and pancreatic cancer in both parents."

Dr. Aisner also stated that "the cytopathology diagnosis of atypia . . . caused no injury and was not relevant with regard to plaintiff's diagnosis or treatment because a finding of atypia is neither a diagnosis of malignancy or suspicion for malignancy," and "a surgeon would not rely on this report for the purpose of diagnosing cancer . .. [or] solely for the purpose of making a decision as to whether to operate." Rather, she concluded that a surgeon would reliably act solely on a cytology report that was unambiguously positive for cancer.

In opposition to the motion, the plaintiff relied on the same submissions upon which the Mount Sinai West defendant relied, and also submitted the affirmation of a physician board certified in Cytopathology, Anatomic Pathology, and Clinical Pathology, although he also submitted the affirmation of a surgeon that was composed for the purpose of opposing Labow summary judgment motion.

The plaintiff's expert cytopathologist opined that Buyuk departed from good and accepted practice by misreading and misinterpreting the cytology specimen, and thereafter mischaracterizing it as "atypical." According to the plaintiff's expert, the alleged atypicality found by Buyuk, premised upon Buyuk's conclusion of hypercellularity, or the presence of an overabundance of cells in the specimen, was incorrect. The expert asserted that his or her own review of the slides revealed no hypercellularity and, in fact, no atypicality whatsoever. The expert criticized Buyuk's diagnosis as having improperly been based on the patient's family history and the mere presence of a mass, rather than on a strict inspection of the cellular material presented in the specimen. As the expert explained,

> "[g]ood and accepted cytopathology practice requires interpretation based on what is within the 'collection of cells on a slide,' not based on extraneous, clinical factors. Dr. Buyuk departed from good and accepted cytopathology practice by allowing extraneous clinical data to shape and formulate her review of the FNA."

The expert further noted that Buyuk did not have access to the plaintiff's medical records from 2007, which did show a prior case of pancreatitis, or his October 2016, which the expert claims did not reflect the presence of a mass, but revealed structural changes that were likely postinflammatory or secondary to pancreatitis. This latter statement, however, appears to be contradicted by the medical records and scans, which appear to reflect the existence of a 40 mm x 30 mm pancreatic mass as of October 2016. In any event, the plaintiff's expert further criticized Buyuk's report as a departure from good practice because, despite a final diagnosis that the specimen was "atypical," Buyuk also wrote in her comments that the "overall features" of the FNA biopsy specimen were "suspicious for acinar cell carcinoma." The expert opined that

the qualifying language used by Buyuk, to the effect that even normal acinar tissue can generate structures that mimic carcinoma cells, was insufficient to negate this finding.

The plaintiff's expert thus concluded that

> "there were no abnormal features of Mr. Padilla's pancreatic FNA that could have reasonably been interpreted to be mimicking carcinoma, or suspicious for acinar cell carcinoma, even in the presence of a mass. Thus, it is my opinion that Dr. Buyuk departed from good and accepted cytopathology practice when she categorized Mr. Padilla's October 20, 2016 FNA as 'atypical,' and that in the presence of a mass, the 'overall features' of the FNA are 'suspicious for acinar cell carcinoma,' when the FNA in fact did not have any features that were atypical, abnormal, or malignant."

The plaintiff's expert further asserted that

> "Dr. Buyuk lead [sic] Mr. Padilla's clinical team to believe that the FNA revealed an atypia or abnormality rising to the level of potential acinar cell carcinoma in the face of a mass, when in reality, by Dr. Buyuk's own admission, there was no such abnormality. The misleading nature of Dr. Buyuk's report is apparent based on Dr. Labow's testimony and the change in his course of action. Dr. Labow testified that based on the report, he believed that the cytopathologist was concerned about potential cancer, and pancreatic cancer became his leading diagnosis. Prior to Dr. Buyuk's report being issued, on November 2, 2016, Dr. Labow's assessment of Mr. Padilla's clinical scenario was that, while pathology results were still pending, malignancy seemed unlikely, and the course of action would likely be to follow up in 4-6 months. That same day, Dr. Buyuk's report was issued. As of November 9, 2016, Dr. Labow's office's assessment of Mr. Padilla was that pathology was suspicious for acinar cell carcinoma, and that they would proceed with laparoscopic distal pancreatectomy and splenectomy."

In reply, the Mount Sinai defendants quoted from Labow's deposition testimony, in which he asserted that

> "[i]n this case, actually surgery was the only way, because there was no other data that was clearly definitive. There was plenty of data that was suggestive. As I mentioned before, to leave in a pancreas cancer, hoping that it isn't, can be deadly. So I don't have the luxury of being able to look six months or a year in the future and to have it turn out to be chronic pancreatitis if it has already metastasized and the patient dies."

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).

The Mount Sinai West defendants established their prima facie entitlement to judgment as a matter of law. Specifically, they established that neither Lee nor Buyuk departed from good and accepted practice, and that Buyuk properly and accurately assessed, interpreted, and reported the relevant cytopathological findings. They also demonstrated that Buyuk's diagnosis of atypicality did not cause or contribute to unnecessary surgery.

In opposition, the plaintiff's expert did not address the claims asserted against Lee. Hence, the plaintiff failed to raise a triable issue of fact, and summary judgment must be awarded to Lee dismissing the complaint insofar as asserted against him.

As to the claims asserted against Buyuk, the plaintiff's expert raised a triable issue of fact as to whether she departed from good and accepted practice by incorrectly noting the presence of hypercellularity in the specimen, which the expert opined was absent, and incorrectly diagnosing the specimen as atypical, which the expert opined was an incorrect

diagnosis in light of appearance of the cells on the slide and Buyuk's own statement that the cells themselves did not appear atypical.

The plaintiff, however, failed to raise a triable issue of fact as to whether an incorrect diagnosis of atypicality, or any other statement in Buyuk's report, proximately caused Labow to perform unnecessary surgery, as his expert's opinion "that the correct diagnosis would have led to an appropriate follow-up plan is conclusory and speculative" (*Rivers v Birnbaum*, 102 AD3d 26, 44 [2d Dept 2012]; *see Sukhraj v New York City Health & Hosps. Corp.*, 106 AD3d 809, 810 [2d Dept 2013]), and thus cannot reasonably be stated with the required degree of medical certainty (*see Callistro v Bebbington*, 94 AD3d 408, 410-411 [1st Dept 2012], *affd* 20 NY3d 945 [2012]; *see also Attia v Klebanov*, 192 AD3d 650, 652 [2d Dept 2021; *Burgos v Rateb*, 64 AD3d 530, 530 [1st Dept 2009]; *Roca v Perel*, 51 AD3d 757 [2d Dept 2008]). Specifically, the plaintiff failed to raise a triable issue of fact as to whether Buyuk's diagnosis of atypicality, or even her expression of a concern for the presence of acinar carcinoma in light of the presence of a mass, caused Labow to recommend or perform surgery. Labow himself read the contents of Buyuk's report, and thus knew that she had reported that the individual cells themselves were not atypical and did not show mitotic activity, which might be indicative of uncontrolled cell growth characteristic of cancer. He also read the qualifying language that Buyuk included in the report, and recognized the fact that she did not definitively report the presence of cancer cells, as well as the fact that she recommended other testing to correlate her findings. In other words, the plaintiff cannot show that any allegedly incorrect diagnoses or findings in Buyuk's report caused or contributed to Labow's decision to recommend and perform surgery; rather, it was his own determination that only surgery definitively could resolve the issue of whether the plaintiff's pancreatic mass was or was not cancerous. Hence, summary judgment must be awarded to Buyuk dismissing the complaint insofar as asserted against her.

Inasmuch as the defendant Mount Sinai West employed Labow as well as Buyuk and Lee, the court declines to dismiss the entire complaint insofar as asserted against it, but only

awards it summary judgment dismissing the claims against it that were premised upon the alleged negligence of Lee and Buyuk.

In light of the foregoing, it is

ORDERED that the motion of the defendants Arzu Buyuk, M.D., George Lee, CT, and Mount Sinai West is granted to the extent that the defendants Arzu Buyuk, M.D., and George Lee, CT, are awarded summary judgment dismissing the complaint insofar as asserted against them, and the defendant Mount Sinai West is awarded summary judgment dismissing the claims asserted against it that are premised upon the alleged negligence of Arzu Buyuk, M.D., and George Lee, CT, and the motion is otherwise denied; and it is further,

ORDERED that the complaint is dismissed insofar as asserted against the defendants Arzu Buyuk, M.D., and George Lee, CT; and it is further,

ORDERED that the claims asserted against the defendant Mount Sinai West that are premised upon the alleged negligence of Arzu Buyuk, M.D., and George Lee, CT, are dismissed; and it is further,

ORDERED that the action is severed as against the defendants Arzu Buyuk, M.D., and George Lee, CT; and it is further,

ORDERED that the Clerk of the court shall enter judgment dismissing the complaint insofar as asserted against the defendants Arzu Buyuk, M.D., and George Lee, CT.

This constitutes the Decision and Order of the court.

5/4/2022
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