Padilla v Labow
2022 NY Slip Op 31617(U)
May 13, 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 J. 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. 002

DECISION + ORDER ON MOTION

The following e-filed documents, listed by NYSCEF document number (Motion 002) 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 99, 100, 101, 102, 103, 111, 113, 115, 118, 119, 120, 121

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 Daniel Labow, M.D., and Mount Sinai Hospital (together the Mount Sinai defendants) together move pursuant to CPLR 3212 for summary judgment dismissing the compliant insofar as asserted against each of them. The plaintiff opposes the motion. The motion is denied.

The facts of this dispute are set forth in detail in this court's May 4, 2022 order disposing of Motion Sequence 001. In short, the plaintiff had a family history of pancreatic cancer, was screened for the disease, and underwent numerous diagnostic tests in connection therewith, including imaging scans, blood work, and a fine needle aspiration (FNA) biopsy. Testing revealed the presence of a 40-millimeter by 30-millimeter mass in the plaintiff's pancreas. None of the tests was positive for pancreatic cancer. The pathologist who reviewed the cytopathology in connection with the FNA biopsy characterized the specimen as "atypical," not because the structure of the cells in the sample were themselves atypical or were suggestive of malignancy, but because she concluded that there were a larger number of cells in the sample than might

otherwise have been expected in a patient who had pancreatitis. She did, however, express some concern that cancer might be present by virtue of the existence of the mass and the plaintiff's family history, and recommended additional testing. Several days after he received that report, Labow determined to remove the pancreas and spleen surgically, and thereafter performed that procedure, which revealed that the plaintiff did not, in fact, have cancer, but only non-malignant pancreatitis. Follow-up surgery was conducted five days later to repair gastric leakage and colonic ischemia. Moreover, subsequent medical records reflected that, only a few days after that, the plaintiff underwent an esophagogastroduodenoscopy (EGD) scan that revealed a remaining seven-millimeter defect near the gastric staple line, with purulent emanations, after which a covered stent was placed over the defect. The plaintiff nonetheless remained febrile. Three weeks thereafter, a CT scan revealed a leak at the proximal end of the gastric stent, after which a gastroenterologist placed a new stent over the defect, as the initial stent and the defect had deteriorated over time. Slightly more than two months later, the plaintiff underwent another EGD that revealed a persistent anastomic leak, with the Jackson-Platt drain that had been installed breaching the fistula and protruding into the stomach. The drain was removed by a surgical oncology team, as the initial stent was noted to have migrated, and was removed, while a new stent was unable to be placed. Four months subsequent to that scan, Labow performed a procedure to reverse the ileostomy.

The plaintiff commenced this action against the Mount Sinai defendants, among others, asserting that Labow departed from good and accepted medical practice by performing unnecessary surgery. In his bills of particulars as to the Mount Sinai defendants, the plaintiff asserted that Labow departed from good and accepted medical practice by failing to undertake a differential diagnosis, "including the very likely probability of pancreatitis [or a] benign pancreatic mass," and that he should have ordered and relied upon a tissue biopsy, a frozen section biopsy, and CT or MRI imaging studies. He asserted that proper reliance on such studies would have ruled out pancreatic cancer. The plaintiff further contended that Labow

negligently failed properly or appropriately to treat his true condition precisely because Labow did not undertake or rely upon the necessary and appropriate tests and procedures, and thus negligently diagnosed the plaintiff with pancreatic tail acinar carcinoma when, in fact, the plaintiff only suffered from pancreatitis. He also asserted that Labow negligently performed the surgery itself, and negligently provided insufficient or improper post-operative care.

The plaintiff alleged in his bill of particulars that, despite no presence of indicia of malignancy, Labow misdiagnosed the presence of pancreatic tail acinar carcinoma, based on his negligent misinterpretation of a November 2, 2016 cytopathology report written by his codefendant Arzu Buyuk, M.D., which stated that

> "[t]he morphologic features and immunohistochemical studies support acinar phenotype. If 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."

The plaintiff alleged that, notwithstanding the recommendation of clinical and radiologic correlation, Labow departed from good and accepted practice by failing to take any steps whatsoever to undertake such a correlation, refer the plaintiff for additional testing, or diagnose the plaintiff's true condition. He asserted that Labow thereupon performed contraindicated surgery, removing his pancreas and spleen based solely on his own misinterpretation of the November 2, 2016 cytopathology report, which did not definitively report the presence of cancer cells, but described the specimen of pancreatic tissue only as "atypical," and reported only a suspicion of acinar cell carcinoma. The plaintiff claimed that Labow failed to take into account that he was asymptomatic despite the presence of a pancreatic mass, failed to account for the plaintiff's history of pancreatitis, failed to appreciate the findings of the plaintiff's prior CT imaging studies, ignored his own conclusion that the mass was "unlikely" for malignancy, and nonetheless proceeded with contraindicated surgery.

In addition, the plaintiff claimed that Labow departed from good and accepted practice in failing to order necessary CT and MRI scans prior to performing surgery, in failing to order other

appropriate and necessary diagnostic testing, and in failing to make appropriate and necessary referrals.

The plaintiff averred that Labow negligently performed a laparoscopic procedure that was converted to an open distal pancreatectomy, splenectomy, partial gastrectomy, subtotal colectomy, and partial adrenalectomy, necessitating the repair of intra-abdominal vessels, and requiring a reopened laparotomy and washout procedure on the next day. He further asserted that Labow was negligent because he was not aware, and did not take heed, of the fact that his pancreatic mass constituted an adhesion to several surrounding structures and organs and, thus, that Labow caused injury to several surrounding structures and organs in the course of the surgical procedure. Specifically, the plaintiff asserted that Labow negligently caused ischemia (lack of blood supply) of the plaintiff's colon and perforated the stomach and colon during surgery, while failing to realize that he had done so because, among other things, Labow failed to be aware of the surgical field and anatomy, failed to visualize the plaintiff's abdomen, failed to perform an inspection of the surrounding structures and organs, and failed to achieve, maintain, and preserve an appropriate and adequate operative field. In addition, the bill of particulars alleged that Labow committed malpractice in closing the plaintiff and concluding surgery despite the presence of an injury to the stomach and bowel, thus preventing a timely repair, causing the plaintiff to suffer a post-operative leak from the site of the gastric perforation, and leaving the plaintiff in critical condition and at an increased risk for infection, peritonitis, and sepsis.

In support of their motion, the Mount Sinai defendants submitted the pleadings, the plaintiffs bills of particulars and supplemental bilsl of particulars, the transcripts of the parties' depositions, relevant medical and hospital records, and the affirmation of Randall S. Zuckerman, M.D., a board-certified surgeon who had served as Medical Director at the Lebo-DeSantie Center for Liver and Pancreas Disease at St. Vincent's Medical Center in Bridgeport, Connecticut. He opined that the Mount Sinai defendants adhered to accepted standards of medical practice while rendering care to the plaintiff.

Dr. Zuckerman asserted that Labow undertook an appropriate differential diagnosis, as he considered both the possibility that the pancreatic mass was either benign or malignant, and took all necessary steps to comply with the standard of care in evaluating the plaintiff's condition, including obtaining and reviewing the results of appropriate radiographic, endoscopic, pathologic, and blood studies. According to Dr. Zuckerman, Labow also properly obtained the plaintiff's medical history and family history, the latter of which was relevant because both of his parents had died from pancreatic cancer. He also opined that Labow employed good medical judgment in recommending and performing surgery to remove the pancreatic tumor, as cancer could not be ruled out preoperatively, and there were grave risks in permitting a potentially cancerous mass to remain in the pancreas. Dr. Zuckerman concluded that Labow performed the December 2, 2016 surgery appropriately and within the standard of care, that the plaintiff experienced well-known risks of pancreatic surgery, and that the gastric leak and ischemia occurred absent any negligence by Labow. He further averred that the Mount Sinai defendants timely diagnosed and appropriately treated the gastric leak and ischemia

With respect to the issue of whether a proper differential diagnosis was undertaken, Dr. Zuckerman asserted that Labow did not diagnose the plaintiff with pancreatic cancer preoperatively, but appropriately referred him for additional studies to evaluate his condition, and eventually recommended surgery, as cancer could not be ruled out and the risks of leaving the mass in place were great. Dr. Zuckerman opined that it was not until after the December 2, 2016 surgery that a final diagnosis could be made.

Dr. Zuckerman averred that Labow conducted a proper work-up to evaluate the plaintiff's condition, and complied with the standard of care in that regard, as the standard required a pancreatic protocol CT Scan or an MRI, an endoscopic ultrasound (EUS) scan, and a test for the presence of tumor markers to be obtained, all of which were done. According to Dr. Zuckerman, the plaintiff's levels of the tumor marker known as carbohydrate or cancer antigen

(CA 19-9) were elevated on two occasions and normal on one occasion, a CT scan with pancreatic protocol identified a mass, and both of the plaintiff's parents died from pancreatic cancer, while the plaintiff himself was concerned that he might have cancer. As Dr. Zuckerman explained it, Labow appropriately sent the plaintiff for an EUS with biopsy and an MRI for further evaluation. He averred that, once all of these studies were completed, the information in Labow's possession included a CT scan and EUS that identified a mass, an MRI that did not identify a mass, and an FNA biopsy characterizing the results as "atypical" that did not conclusively rule out malignancy but suggested that, since a mass was present, the specimen was suspicious for acinar cell carcinoma. He further explained that, while the MRI did not identify a mass, the EUS, which was positive for the presence of a mass, is the most accurate study to identify the existence of a mass. Dr. Zuckerman noted that, as part of his work-up Labow memorialized that the plaintiff had many of the risks for developing pancreatic cancer, including family history, a history of diabetes, smoking, and drug use, and a personal history of pancreatitis. He further noted that Labow submitted the case to the Mount Sinai Hospital tumor board, which recommended surgery.

Dr. Zuckerman further opined that no further referrals were indicated, and that additional studies were not indicated, since an EUS with FNA biopsy, CT scan, and MRI. as well as blood tests, had all recently been performed, while repeat biopsies were unnecessary and would only have served to delay surgery.

The Mount Sinai defendants' expert concluded that Labow's surgical technique complied with the standard of care. He further stated that that the gastric leak and ischemia that the plaintiff sustained following pancreatic surgery are known and accepted asks of surgery, and that those conditions occurred in the absence of any negligence. As Dr. Zuckerman described it, Labow began the surgery laparoscopically, but once the abdomen was explored and dissection began, he appropriately converted the surgery to a hand port and then an open procedure. He stated that a certain level of scarring and adherence is expected when a patient

has chronic pancreatitis, but that the extent cannot be known until a surgeon visualizes the abdomen intraoperatively. Dr. Zuckerman asserted that it was not until the abdomen could be fully visualized that it became clear that the surgery could not be completed laparoscopically. He opined that it was appropriate not to "abandon" the surgery following all of the mobilization that took place, including when the plaintiff began to bleed and experienced a temporary cardiac arrest, as the only reason to abandon surgery at that point would have been if the plaintiff had not been stable enough to continue, which was not the case here. Dr. Zuckerman further averred that it would not have been in the plaintiffs' best interest for Labow to have abandoned the surgery before removing the entire rnass, as a second surgery would have been required to remove the mass in any event, thus increasing the risks attendant to additional surgery.

Dr. Zuckerman concluded that, without the removal of the entire mass, a physician could not rule out cancer due to the fact that any biopsy specimen could present a false negative. He also opined that Labow exercised good medical judgment in declining to perform a frozen section biopsy, as it would not be reliable and, in fact, was less accurate than the EUS and FNA biopsy that had been performed preoperatively, particularly in the context of a patient, such as the plaintiff, with chronic pancreatitis. Dr. Zuckerman asserted that an intraoperative frozen section biopsy would have permitted only a quick look at the resultant specimen, and would not have provided any additional information to Labow as to whether to continue with the surgery, as the pathology of a frozen section sample could not rule out cancer.

Dr. Zuckerman articulated his opinion that the gastric leak that the plaintiff experienced was caused by a failure of the staple line, which can and did occur here absent any surgical error. As he explained it, these types of staple lines can fail because of ischemia, which takes time to develop, or can just fail with no known reason. He concluded that the standard of care does not require any intraoperative testing to look for a leak where, as here, there was no suspicion that a leak had occurred. According to Dr. Zuckerman, "[t]his was clearly a delayed

leak that was not present at the time of the surgery and a CT scan was ordered at an appropriate juncture."

In addition, Dr. Zuckerman asserted that the plaintiff's colonic ischemia that had been identified during the December 7, 2016 follow-up surgery, and resulted in the need for a colectomy and ileostomy, were completely unrelated to Labow's surgical technique or any surgical error, but was solely the result of the compromise of the plaintiff's blood supply due to the necessary dissection of tissue that already had been damaged by the chronic disease process. He opined that the ischemia was not identifiable during the initial December 2, 2016 surgery, as it took several days to develop. Dr. Zuckerman further concluded that the postoperative care provided by the Mount Sinai defendants was appropriate and complied with the standard of care, as the complications arising from poor healing were timely diagnosed and appropriately treated, with continuous monitoring between December 2, 2016 and December 7, 2016. As Dr. Zuckerman described it, this monitoring permitted the Mount Sinai defendants to diagnose an infected hematoma, which was appropriately managed in a conservative manner, as well as to note and treat a fever and significant drainage five days after the initial surgery.

As Dr. Zuckerman further explained, after a CT scan was taken, the plaintiff underwent surgery with diversion that was necessary to help promote healing. Dr. Zuckerman opined that, prior to December 7, 2016, "none of Mr. Padilla's postoperative complaints, vitals and/or blood work, taken separately or together, signified that Mr. Padilla had a problem that required surgical intervention, including a gastric leak or bowel ischemia." He also concluded that the repair surgery performed on December 7, 2016 was performed appropriately, that the leak and ischemia were properly identified and treated, and that any difficulties that the plaintiff experienced in delayed healing and a sustaining a persistent leakage were not due to any surgical errors by Labow. Moreover, Dr. Zuckerman asserted that the care provided by the Mount Sinai defendants to treat the persistent gastric leak was appropriate and within the standard of care, as the leak eventually healed.

In opposition to the Mount Sinai defendants' motion, the plaintiff relied upon the same documentation, and also submitted the affirmation of a board-certified surgeon who had undergone specialized surgical oncology training, had been in the active practice of surgical oncology for more than 40 years, and had treated numerous patients with pancreatitis and pancreatic cancer. The expert opined that Labow departed from good and accepted practice by performing the surgery itself, which he characterized as unnecessary, as well as in the manner that the surgery was performed, concluding that it resulted in a gastric leak, a subtotal colectomy, the placement of an ostomy bag, sepsis, the necessity of stent placement, the resultant stent migration, and multiple permanent gastric surgical staples, along with persistent and ongoing gastric hemorrhage and leakage. The expert also opined that the Mount Sinai defendants departed from good and accepted practice in the provision of post-operative care.

The plaintiff's expert asserted that, by the time that the plaintiff came under Labow's care, his slightly elevated CA 19-9 levels did not raise a concern that he had cancer, as CA 19-9 levels might be elevated for numerous reasons not involving cancer, including inflammation from pancreatitis. As the expert noted, in April 2016, the plaintiff's CA 19-9 level was 40.4 units per milliliter (U/ml), which was only slightly elevated, in May 2016, it was 41.3 U/ml, which again was only slightly elevated, and by September 2016, the CA 19-9 levels had dropped to 26.3 U/ml, which was well within normal range. As such, the expert concluded that the CA 19-9 levels were never indicators of any abnormality or malignancy. The plaintiff's expert further opined that a July 15, 2016 CT scan was also not concerning for cancer, as it only showed calcifications in the pancreas and lines around the pancreas, findings that are "classically associated" with chronic pancreatitis. As the expert explained it, the mass-like finding described in the CT report is a finding that often occurs in the face of fibrotic, calcified fat that develops after pancreatitis, and he or she noted that Labow himself testified that the imaging implied chronic pancreatitis.

The expert asserted that, in addition, the endoscopy report for an October 20, 2016 EUS scan was not concerning for cancer, as it explicitly stated that the preliminary cytologic review was suggestive of a benign lesion. The expert continued that this EUS was performed three months after the July 15, 2016 CT of the plaintiff's abdomen and that the findings in the later EUS endoscopy report, when compared to the report of the prior CT scan, reflected stability in the size and location of the mass. The plaintiff's expert, relying on Dr. Zuckerman's statement that pancreatic cancer is "an aggressive cancer that can spread quickly," noted that, if the plaintiff's lesion were cancerous, it likely would have advanced in size and spread in location over the course of those three months. The plaintiff's expert also opined that an October 31, 2016 MRI was not concerning for cancer as well, as the MRI revealed findings that were categorized as "postinflammatory/secondary to pancreatitis," and for which malignancy was considered "unlikely." The plaintiff's expert stated that the description of the findings on this MRI parallels the description of the findings on the prior CT scan, reflecting the stability of the mass. The expert further described Labow's November 9, 2016 note, which indicated that Labow reviewed the abdominal MRI, and found no evidence of metastatic disease, while the expert pointed out that there was no evidence of any cancer whatsoever on that MRI, let alone metastasis.

The plaintiff's expert disagreed with Dr. Zuckerman's contention that the EUS was more reliable at helping to determine the presence of a mass than the MRI, noting that, while the EUS identified a mass, the EUS report specifically recommended a follow-up MRI further to evaluate the mass. The expert noted that the recommended MRI revealed that the mass was not malignant, but rather, evidence of sequalae of a postinflammatory process.

In addition, the plaintiff's expert opined that, despite the fact that the plaintiff's family history of pancreatic cancer was of general concern, his clinical picture at the time he came under Labow's care was not concerning for cancer, as the plaintiff had both diabetes and chronic pancreatitis as early as in 2007. The expert explained that, while pancreatic cancer can

cause diabetes, the plaintiff's diabetes long antedated his pancreatic cancer work-up, and that the plaintiff's positive history of substance abuse likely further contributed to pancreatitis. As the expert put it, the plaintiff's "long-standing history with pancreatitis . . . should have caused chronic pancreatitis to be very high on Dr. Labow's differential diagnosis list."

According to the plaintiff's expert, the only piece of information that raised any level of concern for pancreatic cancer was Buyuk's November 2, 2016 cytopathology report of an FNA specimen taken from the plaintiff's pancreas. The expert opined, however, that the report did not definitively categorize the findings as malignant but, rather, categorized them as "atypical." The expert noted that the report stated that, if a distinct mass was present, as there was here, the "overall features are suspicious for acinar cell carcinoma," but that "normal acinar tissue can yield numerous glandular/acinar structures mimicking carcinoma." The expert thus concluded that Labow departed from good and accepted medical practice in failing to consider that report in context with the remainder of the information and clinical data that he had obtained about the plaintiff, including stable images of the mass generated by three different methods, the first of which was taken at least three months prior to Labow's determination to perform surgery, as well as stabilized and normalized CA 19-9 levels. The expert concluded that Labow's improper mischaracterization of the November 2, 2016 cytopathology report is evidenced by his change in the plan of care upon his receipt of the report, from accurately noting that malignancy was unlikely, and planning a follow-up visit in four to six months, to improperly concluding that malignancy was either a certainty, as set forth in his November 9, 2016 note, or at least a significant enough concern to proceed with surgery.

With respect to the Mount Sinai Tumor Board's recommendations to proceed with surgery, the plaintiff's expert opined that they were based on incomplete information, as the cytopathology report remained pending when they were made, while at the second Tumor board meeting, the results of the October 31, 2016 MRI---that the mass was unlikely to be malignant---apparently were not considered. Inasmuch as the expert stated that such recommendations are

not binding on a surgeon in any event, the performance of a distal pancreatectomy nonetheless constituted a departure from good and accepted medical practice.

The plaintiff's expert rejected Dr. Zuckerman's opinions that surgery was warranted because Labow did not diagnose the plaintiff with pancreatic cancer preoperatively, and because the only way definitively to rule out pancreatic cancer was to remove the entire tumor and perform pathology. As the expert noted, Labow himself testified that the reason for the surgery was because he felt that the plaintiff had pancreatic cancer, and that his November 9, 2016 note also reflected a preoperative presumptive diagnosis of acinar cell carcinoma. As the plaintiff's expert phrased it, "given all the information Dr. Labow had, pancreatic cancer should have been ruled out within a reasonable degree of medical certainty, well before he considered performing the distal pancreatectomy," as a distal pancreatectomy should only be performed in patients whom a surgeon believes within a reasonable degree of medical certainty are both suffering from pancreatic cancer and have a reasonable chance of cure as a result of the surgery. Conversely, the expert opined that chronic pancreatitis, especially in asymptomatic patients such as the plaintiff, should be treated conservatively, and not with a distal pancreatectomy as an initial treatment. The expert thus concluded that, given all the information that suggested otherwise, it was a departure from good and accepted medical practice for Labow to identify pancreatic cancer as his leading diagnosis as of December 2, 2016, and to perform the surgery.

In the opinion of the plaintiff's expert, Labow should have abandoned the surgery after he commenced it, and hence long before the plaintiff began suffering from complications. As the expert described it, when Labow entered the surgical site laparoscopically, it was apparent that the pancreatic tissue was adherent to the adjacent organs, evincing a clear inflammatory process, and that, in light of the fact that pancreatic cancer was Labow's presumptive diagnosis, Labow, upon visualizing the extent of the inflammation, should have recognized that pancreatic cancer that had spread to such an extent would not be curable with surgical resection. The

plaintiff's expert thus opined that Labow departed from good and accepted medical practice in continuing with the surgery. According to the plaintiff's expert, in the face of this extensive inflammatory process, Labow also should have obtained additional tissue prior to continuing with the surgery so that he would be assured that the mass was not malignant. In this regard, the plaintiff's expert disagreed with Dr. Zuckerman's contention that a frozen section could not or should not have been obtained. As he described, in a patient such as the plaintiff, for whom the greater part of the clinical evidence suggested a benign mass, and who had a clearly extensive inflammatory process that would be incurable if it were cancerous, a frozen section could have been obtained. He averred that, although frozen sections must be interpreted quickly, they are interpreted using actual pathological tissue, rather than cellular aspirate, which produces an equally, if not more, accurate interpretation with respect to benignity or malignancy than other cellular specimens. The expert thus opined that a frozen section biopsy performed early in the operation would have revealed a benign entity, at which time the surgery could and should have been aborted prior to the development of surgical complications that the plaintiff ultimately sustained, including a hemorrhage, cardiac arrest, and subsequent staple-line failure and colon ischemia.

The plaintiff's expert further opined that the postoperative monitoring of the plaintiff was below good and accepted standards of medical practice, and resulted in a failure timely to diagnose and treat gastric perforation. According to the expert, the Mount Sinai defendants' records reflected that the plaintiff had abdominal distension, serosanguinous drainage, tachycardia, and fever as high as 102° F. as early as December 3, 2016, and that he continued to experience these symptoms on the next day, on which his drainage turned bloody. In light of the persistence of these symptoms and the complications of the recent surgery, the expert opined that the plaintiff should have been evaluated for a gastric perforation as early as December 4, 2016. The expert further noted that, on December 5, 2016, the Mount Sinai defendants had still not considered or ruled out the existence of gastric perforation, despite the

fact that the plaintiff continued to exhibit unexplained fevers up to 101.8° F., while blood cultures revealed the presence of e. coli bacteria, at which point the Mount Sinai defendants characterized the plaintiff as septic. As the expert described it, on December 6, 2016, in addition to the persistence of the plaintiff's symptoms, the Jackson-Platt drains continued to emit purulent dark bloody drainage material and that, without any imaging studies, the infectious disease team presumed that the plaintiff was suffering from an infected intra-abdominal hematoma, noting that a CT scan with oral/IV contrast should be considered.

As the expert continued, on December 7, 2016—fully five days after the operation---the Mount Sinai defendants performed a CT scan that identified a gastric leak. When Labow performed a follow-up surgery that day to correct the leakage, Labow noted evidence of a peritoneal abscess and colonic ischemia. The expert opined these latter two issues arose because of technical issues during the unnecessary surgical resection of the pancreas. The expert further stated that a large opening was found in the staple line of the posterior/superior stomach. The expert opined that the size of the gastric perforation and the extent of colonic ischemia that were identified on surgical pathology studies indicated that the gastric leak and the colonic ischemia were directly related to the complications encountered during the initial December 2, 2016 operative procedure. The expert further opined that, given the plaintiff's intraoperative complications and the extent of his surgery, the Mount Sinai defendants, upon their initial findings of fever, distension, and tachycardia, immediately were required a take a CT scan to ensure there was no intra-abdominal breakdown or leakage. As the expert explained it, had the plaintiff's gastric leak been identified as of December 4, 2016, and not three days later, the gastric perforation would have been smaller and easier to repair but, instead, his gastric perforation at the time of diagnosis was large, difficult to repair, and ultimately resulted in persistent gastric leakage. The expert concluded that, had there been a timely diagnosis of the gastric perforation and colonic ischemia, which the expert asserted had developed due to the unnecessary surgical resection of the plaintiff's pancreas in the first intance, he would have

been diagnosed sooner when there was more viable colonic tissue that could have been spared from resection.

The standards for determining a summary judgment motion in a medical malpractice action premised upon departures from good and accepted medical practice were analyzed in detail in this court's May 4, 2022 order disposing of Motion Sequence 001. Although the Mount Sinai defendants established their prima facie entitlement to judgment as a matter of law with their submissions, including Dr. Zuckerman's affirmation, the plaintiff raised a triable issue of fact with his expert's affirmation, in which the qualified expert explicitly identified departures from good and accepted standards of care in determining to perform the surgery, in the manner in which the surgery was performed, and in the provision of postoperative care (*see Kuhfeldt v New York Presbyterian Hosp./Weill Cornell Med. Ctr.*, _____AD3d_____, 2022 NY Slip Op 03076, *1 [1st Dept, May 10, 2022]). The plaintiff's expert further raised a triable issue of fact as to whether those departures proximately caused the plaintiff's injuries (*see Polanco v Reed,* 105 AD3d 438, 441-442 [1st Dept 2013]; *Garrett v University Assoc. in Obstetrics & Gynecology, P.C.,* 95 AD3d 823, 825 [2d Dept 2012]). Hence, the Mount Sinai defendants' motion for summary judgment must be denied.

The court notes that, in the plaintiff's supplement bills of particulars that were responsive to the Mount Sinai defendants' demands, he expressly asserted that he "does not have any claims regarding lack of informed consent."

The court further notes that, in his complaint, the plaintiff alleged that "Defendant, LABOW was an agent, servant, and/or employee of [MOUNT SINAI] WEST." In its May 4, 2022 order disposing of Motion Sequence 001, the court declined to award summary judgment to the Mount Sinai defendants' codefendant, Mount Sinai West (MSW) to the extent that it declined to dismiss any claims that MSW might be held vicariously liable for Labow's malpractice. MSW submitted evidence on that motion reflecting the existence of a triable issue of fact as to whether it employed Labow in November and December 2016, when he consulted with and

operated on the plaintiff. Specifically, MSW submitted Labow's deposition transcript, in which Labow stated that he worked

> "predominantly on the west side at Mount Sinai -- now, at Mount Sinai West and Mount Sinai St. Luke's, although I work at all three of the Manhattan hospitals which includes Mount Sinai Hospital, Mount Sinai West, and Mount Sinai St. Luke's."

In connection with the instant motion, neither the Mount Sinai defendants nor MSW submitted evidence concerning Labow's relationship with MSW. As such, nothing submitted in connection with this motion would entitle MSW to summary judgment dismissing claims asserted against it that are premised upon its employment of Labow.

In light of the foregoing, it is

ORDERED that the motion of the defendants Daniel Labow, M.D., and Mount Sinai Hospital for summary judgment dismissing the complaint insofar as asserted against each of them is denied.

This constitutes the Decision and Order of the court.

5/13/2022
DATE

...N J. K...LLEY, J.S.C.

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