Lang v Monasebian
2022 NY Slip Op 33878(U)
November 15, 2022
Supreme Court, New York County
Docket Number: Index No. 805125/2017
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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MARY LANG,

Plaintiff,

- v -

DOUGLAS M. MONASEBIAN, M.D., and PARK AVENUE PLASTIC SURGERY

Defendants.

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INDEX NO. 805125/2017

MOTION DATE 08/10/2022

MOTION SEQ. NO. 004

DECISION + ORDER ON MOTION

The following e-filed documents, listed by NYSCEF document number (Motion 004) 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111

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 practice and lack of informed consent, the defendant Douglas M. Monasebian, M.D., moves pursuant to CPLR 3212 for summary judgment dismissing the complaint insofar as asserted against him. The plaintiff does not oppose the motion. The motion is granted, and the complaint is dismissed insofar as asserted against Monasebian.

The crux of the plaintiff's claim is that Monasebian, a plastic surgeon, improperly performed liposuction, as well as breast augmentation, abdominoplasty, umbilical repair, capsulotomy, and scar revision surgeries, thus causing injuries and damages, including pain, additional scarring, capsular contracture, and the need for additional surgeries. Monasebian denies that he departed from good and accepted practice, that anything he did nor did not do caused or contributed to the plaintiff's injuries, or that he failed fully to inform the plaintiff of the risks and benefits of the various procedures, or acceptable alternatives thereto.

In or about September 2011, the plaintiff delivered her second child. The plaintiff presented to Monasebian on January 3, 2012 for an initial consultation regarding body

contouring, specifically breast augmentation, and repair of an umbilical hernia. At that time, she was 5'4" tall, weighed 174 pounds, and wore a size 14 dress and a size 36B bra. Upon examination, Monasebian noted a reducible diastasis recti, a type of weakening of the abdominal muscles, characterized both by thinning and widening of the linea alba, combined with laxity of the ventral abdominal musculature, as well as a para-umbilical hernia, small breasts with volume loss, and abnormal distribution of fat within the flanks. He discussed performing a full abdominoplasty, with repair of the diastasis recti and hernia, as well as breast augmentation with silicone implants that would increase the plaintiff's bra size to a "C" cup. The plan was for breast augmentation with smooth silicone implants, both submuscular and periareolar, that is, around the areolas of the breasts.

Medical records reflect that Monasebian discussed the risks, complications, and benefits of the procedures with the plaintiff, as well as alternatives thereto. On January 17, 2012, the plaintiff returned to see Monasebian and discussed also undergoing a suction-assisted lipectomy of her outer flanks and thighs. As set forth in the relevant medical records, the plaintiff executed lengthy, detailed informed consent documents, including separate forms for breast augmentation, liposuction, and abdominoplasty. The forms described the relevant risks and possible complications, including specific recognition that capsular contracture, that is, the formation of a capsule of scar tissue around an implant, is a risk of breast augmentation surgery. The consent form explained that the occurrence of this condition is not predictable, that treatment for a capsular contracture may include further surgery and replacement or removal of the implant, and that the condition may recur after surgery. The form further enumerated various other risks, including abnormal scarring, breast firmness, skin contour irregularities, skin wrinkling and rippling, chronic pain, chest wall irregularities, and asymmetry. The additional consent forms for abdominoplasty and liposuction were similarly specific and detailed, with the consent form for abdominoplasty including multiple sections explaining that scarring may require revision.

Monasebian obtained the plaintiff's medical history, conducted a physical examination, and thereafter ordered and obtained a medical clearance from her primary care physician.

On February 1, 2012, the plaintiff signed an additional, single-page consent form permitting Monasebian to perform each procedure, which again explaining the risks and benefits of, and alternatives to, the procedures. On that date, Monasebian performed elective bilateral submuscular breast augmentation surgery upon the plaintiff, with silicone smooth implants, an abdominoplasty with repair of an umbilical hernia and diastasis recti, and liposuction of the plaintiff's flanks and outer thighs. The operative report referred to liposuction of 1,200 cubic centimeters (cc) of tissue extracted from each flank and 550 cc extracted from each lateral thigh. The plaintiff's medical chart included a body diagram that outlined the areas that had been contoured by the liposuction, omitting any depiction that the plaintiff's buttocks were the subject of the liposuction therapy. The plaintiff was discharged to her home later on February 1, 2012, with instructions to return in one week. She thereafter presented to Monasebian for follow-up visits, at which she reported feeling happy with the results. At the first few visits, Monasebian noted the scars were healing well, and that the hernia and diastasis were reduced.

In early to mid-June 2012, the plaintiff complained to Monasebian of left breast swelling and pain, along with abdominal scarring. On examination, the left breast manifested what Monasebian characterized as a "questionable" capsule contracture. He reported that the incisions on both breasts were well-healed and soft, and that the abdominal scar was thick, firm, and erythematous, that is, red in appearance. Monasebian's records reflected that he and the plaintiff discussed continued local care, massage, and compression of the breasts, and a regimen of antibiotics and Motrin for the questionable contracture. He also noted the potential benefits of a capsulotomy or capsulectomy and instructed the plaintiff to return in two to three months to reevaluate. Monasebian's records for June 25, 2012 noted the presence of a continued deformity and pain of the left breast, and that a capsular contracture had developed. He and the plaintiff further discussed the possibility of an open periprosthetic capsulectomy or

capsulotomy, and he explained the risks, complications, benefits, and alternatives. When the plaintiff agreed to either of those two procedures, she signed a consent form authorizing Monasebian to perform one of them. As with the prior consent forms, that form indicated that the plaintiff was apprised of and understood the risks and benefits of, and alternatives to, the proposed procedure.

On July 9, 2012, Monasebian performed an open periprosthetic capsulotomy of the left breast, under general anesthesia, to rectify grade III capsular contracture. According to the operative report, the incision was made through a "well-healed scar" that remained on the left breast from the prior surgery. He reported that he encountered dense encapsulation around the implant, and thereafter removed the encapsulation and placed the implant in an antibiotic solution. Monasebian then utilized cautery and performed the capsulotomy in a linear and radial fashion, releasing the capsule and its adhesions and contractures, until the breast was soft and normal appearing again. Monasebian's chart indicated that the surgery was performed without complication. The plaintiff was discharged to her home later that day and returned to Monasebian's office on July 16, 2012, at which time Monasebian recorded that she was healing well. When the plaintiff returned to see Monasebian on September 20, 2012, she complained of right breast pain and abdominal scarring. On examination, Monasebian noted that the right breast was soft but appeared somewhat asymmetric, with less inferior fullness and more superior fullness. He also noted a "questionable" intracapsular rupture or other abnormality and described the abdominal scar as presenting a slight excess of what are colloquially known as "dog ears," that is, protruding skin or tissues at the extreme ends of a closed incision. Monasebian further noted that the central area of the scar remained thick, with a slight keloid. He and the plaintiff discussed further revision options.

The plaintiff returned to Monasebian's office on October 9, 2012, at which time she reported more deflation and tenderness of the right breast implant. Monasebian concluded that these signs were more consistent with rupture than with other conditions. He also noted that

the plaintiff wanted to replace the left breast implant and increase the size. In his chart, Monasebian memorialized that he planned to replace the implants with others that were 450 cc in volume. The plaintiff again signed a detailed, 9-page pre-printed consent form permitting Monasebian to proceed with breast implant removal. As with the prior form, this form listed numerous risks of implant removal, including, but not limited to, healing issues, abnormal scarring, firmness issues, chronic pain, asymmetry, and unsatisfactory results. On October 19, 2012, the plaintiff returned to Monasebian's office and signed an additional, one-page consent form, allowing him to remove the breast implants, possibly debride the right breast, and replace both breast implants. This form indicated that the plaintiff was apprised of and understood the relevant risks, benefits, and alternatives. Monasebian also documented in a progress note that the plaintiff was aware that the right implant might not be ruptured, that she was apprised of all risks, complications, benefits, and alternatives, and that she agreed to proceed. On that date, Monasebian performed bilateral peripheral capsulotomies, removed both implants, and replaced them. With respect to the plaintiff's right breast, the replacement was undertaken not only because of the suspected rupture of the initial implant, but also to satisfy the plaintiff's desire for larger implants. During the course of the procedure, Monasebian did not identify a rupture, but instead detected in-folding.

The plaintiff returned to Monasebian's office on both October 26, 2012 and November 13, 2012. At both visits, she reported that she was doing well. Monasebian documented that his examination revealed that the plaintiff's breasts were soft and symmetric, and that the incisions were healing well. She next returned on June 18, 2013 and reported right breast pain. She also asserted that her right breast appeared smaller than her left breast. On examination, Monasebian confirmed that her right breast appeared smaller than the left, with a grade III capsular contracture, and formulated a plan involving a likely additional capsulotomy and exploration with possible implant exchange. A July 9, 2013 note indicated that Monasebian and the plaintiff had a telephone discussion of the risks and benefits of, and alternatives to, those

procedures, after which the plaintiff signed a consent form permitting Monasebian to perform a right breast capsulotomy or capsulectomy and a lateral abdominal scar revision.

On July 11, 2013, the plaintiff underwent a right breast capsulotomy and exploration that, according to Monasebian, were performed without complication. She subsequently underwent the abdominal scar revision surgery on July 18, 2013, again without complication.

On October 17, 2013, the plaintiff called Monasebian with complaints of pain in her right breast, in response to which he prescribed ibuprofen and the antibiotic Duricef, and noted that the plaintiff might require yet another capsulotomy or implant exchange, or a capsulectomy, in the future. The plaintiff again called Monasebian on February 28, 2014 and April 10, 2014 to report signs of capsular contracture. In response, Monasebian advised the plaintiff that a capsulotomy might be needed, and prescribed the steroidal anti-inflammatory drug Singulair in order to avoid the need for additional surgery. Upon taking that medication, the plaintiff reported that it did not help, upon which Monasebian advised her that additional surgery would indeed be warranted.

Upon returning to Monasebian's office on November 5, 2014, the plaintiff presented with a grade III capsular contracture of the right breast and hypertrophic abdominal scarring. She signed a seven-page pre-printed consent form for scar revision surgery and a one-page consent form for a capsulotomy or capsulectomy and an abdominal scar revision procedure. On November 17, 2014, the plaintiff underwent a capsulotomy of the right breast and scar revision surgery, reportedly without complication. As of December 17, 2014, the plaintiff reported to Monasebian that her scar looked very good, that her breast was soft, and that she was very happy. The plaintiff made a final visit to Monasebian's office on January 7, 2015, at which time Monasebian conducted an examination, reporting that the plaintiff's right breast was soft and symmetrical with the left, and that the incision was well-healed. He observed an area of firmness radiating out from the nipple-areolar complex of the right breast, consistent with the edge of the cut capsule, as well as "questionable" scar tissue. Monasebian further reported

that the left breast felt similar. The plaintiff was scheduled to undergo ultrasound imaging of both breasts the following week, and was instructed both to call Monasebian with the results and return in four to six weeks if no other concerns arose. The plaintiff, however, did not return to see Monasebian after January 7, 2015.

The plaintiff began treating with plastic surgeon Joseph Mark, M.D., in Michigan, who subsequently performed surgery to remove the breast implants and for scar revision of the right areola. In connection with follow-up visits, he noted that the plaintiff had chronic seroma at the area of the areola scar revision, that is, a chronic accumulation of subcutaneous clear fluid. Dr. Mark further noted that he discussed options with the plaintiff, including removal of the scar tissue. The plaintiff reported that she considered having additional implants placed if she was going to have surgery for the seroma in any event. Dr. Mark advised the plaintiff that she was at increased risk for recurrent capsule contracture.

In her bill of particulars, the plaintiff asserted that Monasebian departed from good and accepted medical practice in failing properly to place her breast implants, placing implants that were of an improper size, performing surgery in the wrong area of her body, and improperly creating the pockets in which the implants were placed. She further alleged that Monasebian improperly screened her, failed to take a proper history and physical examination, and failed to heed her medical condition. The plaintiff also alleged that Monasebian failed properly to diagnose several maladies, and failed properly to prescribe and administer medications. The plaintiff faulted him for failing timely to refer her to other specialists and in causing additional unnecessary corrective surgeries due, among other things, to the asymmetry of her breasts. She also averred that the numerous surgical procedures caused extensive scarring and deformities. The plaintiff ultimately asserted that the negligent performance of each surgery necessitated each subsequent surgery.

In support of his motion, Monasebian submitted the pleadings, bill of particulars, deposition transcripts, and relevant medical records, as well as the expert affirmation of plastic

surgeon Jeffrey Ascherman, M.D. Dr. Ascherman concluded that Monasebian did not depart from good and accepted medical practice in connection with any of the procedures that he performed upon the plaintiff, including the liposuction, abdominoplasty, implants, implant removals, capsulotomies, and scar revisions. Dr. Ascherman noted that all of the surgeries were elective and that none was contraindicated. Upon reviewing all of the written consent forms and the parties' deposition testimony, he also opined that Monasebian obtained the plaintiff's fully informed consent to all of the procedures.

Specifically, Dr. Ascherman asserted that Monasebian employed the proper methodology in performing suction-assisted liposuction of the plaintiff's flanks and outer thigh, that he extracted a reasonable amount of fatty tissue, and that he did not perform liposuction on any other portion of the plaintiff's body, including the buttocks. With respect to the last issue, he noted that, as such, there was no need for Monasebian to obtain the plaintiff's informed consent to perform liposuction in her buttocks region.

With respect to the abdominoplasty procedure, Dr. Ascherman asserted that the incision locations were appropriate and reasonable, that Monasebian made all necessary efforts to minimize scarring, and that the plaintiff's personal dissatisfaction with the location and extent of abdominal scarring did not, by itself, reflect a departure from good and accepted practice. He also asserted that Monasebian properly exercised good medical judgment with respect to the method of closure and suturing. In addition, Dr. Ascherman opined that, inasmuch as the plaintiff presented with a ventral hernia and a weakened abdominal muscle known as diastasis recti, both of which arose from her pregnancy, "it was entirely appropriate for Dr. Monasebian to surgically repair same during the 2/1/12 abdominoplasty procedure at issue. This is because doing so allowed the plaintiff to avoid a separate surgery." Moreover, he concluded that, in light of the absence of any complications during that repair surgery, including the absence of any excess or unanticipated scarring, Monasebian did not depart from good and accepted practice in performing the repair.

In connection with the initial breast augmentation procedure, Dr. Ascherman explained that

> "breast augmentation involves and requires surgical creation pockets, either just deep to the breast tissue or just deep to the pectoralis major chest muscle, and then placing breast implants in the pocket. . . .[T]he type and size of the implant utilized is be based on a combination of patient preference, patient anatomy, and the surgeon's judgment. Also, in general, development of capsular contracture (when the scar tissue, or "capsule," which normally forms around the implant tightens and squeezes the implant), breast pain, scarring, infection, implant leakage or rupture and implant position changes."

He asserted that it was well within accepted standards of practice within the plastic surgery community for Monasebian to have created incisions around the nipple to obtain adequate access and visualization needed for creating a precise implant pocket, and that it was appropriate to create the pocket behind the chest muscle, as that was the prime desired location to allow for implants to be placed in order to achieve the most natural-looking and desired result. Dr. Ascherman further opined that the use of smooth silicone 325 cc implants for the plaintiff's breast augmentation was reasonable and appropriate given her preference and anatomy allowing for that size. Nor, he stated, was there any contraindication to the placement of 325 cc implants or the use of smooth silicone implants, as that size and material presented a much lower risk for capsular contracture than other sizes and materials, and a more natural feel for a patient. Dr. Ascherman also averred that Monasebian's method for closing and suturing the incisions was appropriate, as was the selection of suture material, as it allowed for minimum possible scarring and irritation.

Dr. Ascherman proceeded to explain that capsular contracture is a known and accepted risk of breast augmentation surgery "which can neither be prevented nor anticipated," and that the plaintiff was fully informed of that fact on several occasions. As he stated it, "[w]hile the cause of contractures is unknown, there are a few known risk factors, including bleeding at the time of surgery." Although Dr. Ascherman conceded that the plaintiff evinced no known risk factors, he nonetheless concluded that her development of capsular contracture "was

unpredictable and unpreventable," and certainly not the result of any departures on Monasebian's part.

According to Dr. Ascherman,

> "both . . . capsulotomy and capsulectomy, are within the standard of care for treating capsular contractures. However, the surgical risks of a capsulectomy are greater than for a capsulotomy and include bleeding, decreased sensation, longer healing time, and an increased chance of infection. Additionally, both procedures inherently carry the risk of recurrent capsular contractures even when properly performed."

He concluded that Monasebian timely and appropriately diagnosed the left and right capsular contractures and the recurrent right breast capsular contractures. Further, he asserted that Monasebian's evaluation, assessment, and treatment plan for these contractures, including the administration of antibiotics, a trial of steroids following the recurrence, recommendation of massage and compression, and surgical intervention were all recognized treatments within the standard of care. In addition, Dr. Ascherman averred that Monasebian's determination to perform capsulotomy procedures rather than capsulectomies was a standard and reasonable procedure to treat the plaintiff's capsular contractures due to its lower risk. He also concluded that Monasebian

> "properly performed the capsulotomy procedures as evidenced by the fact that he loosened the scar tissue around the implant each time. In fact, recurrence of capsular contracture is common, accepted, and unpredictable risk of breast augmentation, and usually occurs absent malpractice. In fact, it is known and accepted within the plastic surgery community that the determination as to whether to proceed with capsulectomy or capsulotomy cannot be made until the time of the actual surgery used to address the contracture itself. Here, the fact that the patient's right breast capsular contracture recurred prior to the 11/7/14 surgery was not the result of any action or inaction by Dr. Monasebian."

With respect to Monasebian's surgical technique, Dr. Ascherman explained that

> "the implant replacement surgery was appropriately performed utilizing the proper surgical technique. The standard of care requires that ruptured implants be replaced, and rupture can only be confirmed during surgical intervention as an MRI cannot always distinguish between in-folding and rupture. Thus, it is my opinion within a reasonable degree of medical certainty that, based on suspicion of rupture, it entirely within the standard of care to perform replacement surgery even though it was revealed intraoperatively that the implant had in fact not ruptured. Moreover, bilateral capsulotomies would have been appropriately

> accomplished during this procedure as the capsules needed to be cut to access the original implants and to allow room for the larger implants to be placed."

He further concluded that it was not a departure from the standard of care for Monasebian to replace the 325 cc implants with 450 cc implants, inasmuch as the plaintiff requested larger implants, and there was no contraindication based on her anatomy or otherwise to proceed with the placement of larger implants.

In addressing the July 18, 2013 and November 17, 2014 abdominal scar revision surgeries that Monasebian performed, Dr. Ascherman stated that Monasebian appropriately performed the procedures by utilizing a technique to attempt entry through the already existing prior incisions, thus minimizing further scarring from these procedures. As Dr. Ascherman noted, both the plaintiff's deposition testimony and Monasebian's records reflected the fact that these surgeries were not medically necessary but, rather, performed in accordance with the plaintiff's requests for aesthetic reasons. He thus asserted that the plaintiff's scarring, whether it be a "dog ear" or keloid formation, was not a complication caused by a deviation from the standard of care. "Instead, it was a common variation in healing that leaves certain patients dissatisfied." Dr. Ascherman explained that, like any surgical incision, "scars usually fade but do not disappear completely and the extent of fading is unpredictable and different for every patient. Accordingly, . . . the scarring, a known result of the surgery that patient was advised of and accepted, was not caused by any malpractice by Dr. Monasebian."

Although the return date of Monasebian's motion was adjourned twice on consent of the parties to permit the plaintiff to submit opposition, and one additional time by the court for administrative reasons, the plaintiff did not submit any papers in opposition or response to Monasebian's motion.

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 its burden of affirmatively establishing entitlement to judgment as a matter of law merely by pointing to gaps in the plaintiff's case. It must affirmatively demonstrate the merit of its 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]). Where a physician fails properly to diagnose or improperly diagnoses a patient's condition, thus providing less than optimal treatment or delaying appropriate treatment, thus proximately causing injury, he or she will be deemed to have departed from good and accepted medical practice (*see Zabary v North Shore Hosp. in Plainview*, 190 AD3d 790, 795 [2d Dept 2021]; *see Lewis v Rutkovsky*, 153 AD3d 450, 451 [1st Dept 2017]; *Monzon v Chiaramonte*, 140 AD3d 1126, 1128 [2d Dept 2016] ["(c)ases . . . which allege medical malpractice for failure to diagnose a condition . . . pertain to the level or standard of care expected of a physician in the community"]; *O'Sullivan v Presbyterian Hosp. at Columbia Presbyterian Medical Ctr.*, 217 AD2d 98, 101 [1st Dept 1995]).

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).

"'Expert testimony is necessary to prove a deviation from accepted standards of medical care and to establish proximate cause'" (*McAlwee v Westchester Health Assoc., PLLC*, 163 AD3d 549, 551 [2d Dept 2018], quoting *Burns v Goyal*, 145 AD3d 952, 954 [2d Dept 2016]).

Thus, where a moving defendant in a medical malpractice action makes a prima facie showing that he or she did not depart from good and accepted practice, or that the treatment rendered to the plaintiff did not cause or contribute to the plaintiff's injuries, the plaintiff, to defeat summary judgment, must submit an expert affirmation or affidavit in opposition; a plaintiff's failure to submit such an expert affirmation or affidavit under such circumstances requires the court to award summary judgment to the moving defendant (*see Benedetto v Tannenbaum*, 186 AD3d 1596, 1598 [2d Dept 2020]; *Bethune v Monhian*, 168 AD3d 902, 903 [2d Dept 2019]; *Koster v Davenport*, 142 AD3d 966, 969 [2d Dept 2016]; *Whitnum v Plastic & Reconstructive Surgery, P.C.*, 142 AD3d 495, 497 [2d Dept 2016]; *Roques v Noble*, 73 AD3d at 207; *Bailey v Owens*, 17 AD3d 222, 223 [1st Dept 2005]; *cf. Williams v Sahay*, 12 AD3d 366, 368 [2d Dept 2004] [unsworn affidavit of unnamed expert that was not affirmed under the penalties for perjury is insufficient to raise triable issue of fact as to defendants' alleged malpractice]).

With his expert affirmation, Monasebian established his prima facie entitlement to judgment as a matter of law in connection with the medical malpractice cause of action, as that affirmation addressed all of the plaintiff's contentions, explained in detail that Monasebian did not depart from accepted standards in connection with any of the procedures that he performed or diagnoses that he made, and adequately established that none of the plaintiff's injuries resulted from any wrongful act of Monasebian's. Since the plaintiff did not oppose the motion, she failed to raise a triable issue of fact and, thus, Monasebian must be awarded summary judgment dismissing the medical malpractice 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]; *Balzola v Giese*, 107 AD3d 587, 588 [1st Dept 2013]; *Shkolnik v Hospital for Joint Diseases Orthopaedic Inst.*, 211 AD2d 347, 350 [1st Dept 1995]). For a statutory claim of lack of informed consent to be actionable, a defendant must have engaged in a "non-emergency treatment, procedure or surgery" or "a diagnostic procedure which involved invasion or disruption of the integrity of the body" (Public Health Law § 2805-d[2]).

"'The mere fact that the plaintiff signed a consent form does not establish the defendants' prima facie entitlement to judgment as a matter of law'" (*Huichun Feng v. Accord Physicians*, 194 AD3d 795, 797 [2d Dept 2021], quoting *Schussheim v Barazani*, 136 AD3d 787, 789 [2d Dept 2016]). Nonetheless, a defendant may satisfy his or her burden of demonstrating a prima facie entitlement to judgment as a matter of law in connection with such a cause of action where, as here, a patient signs a detailed consent form, and there is also evidence that the necessity and benefits of the procedure, along with known risks and dangers, were discussed prior to the procedure (*see Bamberg-Taylor v Strauch*, 192 AD3d 401, 401-402 [1st Dept 2021]).

Monasebian established his prima facie entitlement to judgment as a matter of law in connection with the lack of informed consent cause of action. In this regard, he made the necessary showing by submitting the numerous detailed consent forms, relying on his own testimony as to the risks, benefits, and alternatives that he discussed with the plaintiff, and pointing to Dr. Ascherman's expert opinions that these forms and discussions established the qualitative sufficiency of the consents. Since the plaintiff did not oppose the motion, she failed to raise a triable issue of fact with respect to that showing and, hence, Monasebian must be awarded summary judgment dismissing the lack of informed consent cause of action insofar as asserted against him.

The court notes that, by stipulation dated August 7, 2017 and entered August 23, 2017, the plaintiff discontinued the action insofar as asserted against Monasebian's sole co-defendant,

Park Avenue Plastic Surgery. Consequently, upon dismissal of the complaint against Monasebian, the action must be marked as disposed.

In light of the foregoing, it is

ORDERED that the motion is granted, without opposition, the defendant Douglas M. Monasebian, M.D., is awarded summary judgment dismissing the complaint insofar as asserted against him, and the complaint is dismissed insofar as asserted against the defendant Douglas M. Monasebian, M.D.; and it is further,

ORDERED that, on the court's own motion, the action is severed as against the defendant Douglas M. Monasebian, M.D.; and it is further,

ORDERED that the Clerk of the court shall enter judgment dismissing the complaint insofar as asserted against the defendant Douglas M. Monasebian, M.D.

This constitutes the Decision and Order of the court.

11/15/2022
DATE

JOHN J. KELLEY, J.S.C.

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