SUPREME COURT OF THE STATE OF NEW YORK
NEW YORK COUNTY

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

Justice

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CHRISTINE DEPALMA,

Plaintiff,

- v -

EMILY RYAN, D.O., and GOTHAM MEDICAL ASSOCIATES, PLLC,

Defendants.

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INDEX NO. 156117/2019

MOTION DATE 11/16/2022

MOTION SEQ. NO. 002

DECISION + ORDER ON MOTION

The following e-filed documents, listed by NYSCEF document number (Motion 002) 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65

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

I. INTRODUCTION

In this action to recover damages for medical malpractice based on departures from good and accepted osteopathic practice, lack of informed consent, and negligent hiring, the defendants move pursuant to CPLR 3212 for summary judgment dismissing the complaint. The plaintiff opposes the motion. The motion is granted only to the extent that the defendants are awarded summary judgment dismissing the lack of informed consent and negligent hiring causes of action, and the motion is otherwise denied.

II. FACTUAL BACKGROUND

The crux of the plaintiff's claim is that, between December 30, 2016 and March 1, 2017, the defendant internist Emily Ryan, D.O., who was employed by the defendant Gotham Medical Associates, PLLC (Gotham), failed to render proper diagnosis, treatment, care, and medical management in connection with an avascular necrosis injury of the femoral head of the plaintiff's right hip joint that, as a consequence, developed into Grade IV avascular necrosis, requiring multiple surgeries and the installation of a prosthetic hip.

The plaintiff, then 24 years old, saw Ryan at Gotham's offices, or spoke with her on the telephone, on December 30, 2016, January 3, 2017, January 6, 2017, January 17, 2017, January 18, 2017, February 28, 2017, and March 1, 2017. The plaintiff asserted that she had been diagnosed generally with avascular necrosis in August 2015.

At the plaintiff's December 30, 2016 visit with Ryan, she presented with right leg pain, and reported having had a limp for the prior two months, asserting that it became worse after sitting for long periods of time. The plaintiff also reported that she had injured her right foot when she had fallen off a staircase a child, but she denied suffering from any related symptoms since that time. She further reported that, in October 2015, she had suffered from paralysis of both of her legs, for which she was hospitalized and treated for hypokalemia, that is, low levels of potassium in her blood. Although the plaintiff had been instructed to remain in the hospital for further workup during that hospitalization, she apparently signed herself out against medical advice and, after she allegedly increased her dietary potassium intake, her symptoms improved. She did not follow up with any health care provider between October 2015 and December 2016 to monitor or treat that condition. According to Ryan, the plaintiff was not taking any medications as of that first visit.

Ryan performed a physical examination of the plaintiff at that visit, involving a head-to-toe examination that included a neurologic examination. According to Ryan, she examined the plaintiff by pressing on the joint in the leg in order to test her range-of-motion for hip pathology, and administered a Flexion Abduction External Rotation (FABER) test, which involved flexing the leg at the hip, placing the right ankle on the opposite side of the left knee, and pressing on both the pelvis and side joint of the left leg, as well as the knee on the right side. As Ryan remembered it, the plaintiff was limping at the outset of the December 30, 2016 examination, and then walked normally during the examination. Ryan's records indicated that the neurological examination was non-focal and that the plaintiff had normal strength in her lower and upper extremities, as well as with respect to her reflexes.

Ryan's differential diagnosis included an unspecified condition of the proximal right leg and hip, a rheumatological cause, and a metabolic abnormality, the latter due to the plaintiff's initial gait, and Ryan thus wanted to check the plaintiff's electrolytes based on the plaintiff's prior history of low serum potassium. Ryan also considered that the plaintiff might have been suffering from radiculopathy, musculoskeletal issues, degenerative skeletal issues, or some sort of inflammatory condition. On December 30, 2016, blood was drawn from the plaintiff to test her electrolyte levels and thereupon to determine whether her condition was metabolic or rheumatologic. On January 3, 2017, Ryan reported the bloodwork results to the plaintiff, indicating that the plaintiff continued to suffer from mild hypokalemia, with a potassium level of 3.2 millimoles per liter (mmol/L) of blood. Ryan advised the plaintiff that this reading might be the cause of the plaintiff's right lower extremity muscle aches, especially in light of her previous episode of paralysis that had been resolved with increased dietary intake of food containing potassium, specifically, bananas. Ryan also advised the plaintiff that she tested positive for transaminitis, that is, high levels of liver enzymes, a condition that had been diagnosed in 2015. Ryan prescribed potassium chloride supplements, although the plaintiff advised Ryan that she already had increased her intake of dietary forms of potassium, including bananas and avocados. Ryan instructed the plaintiff to return in one week for an assessment of her leg pain and to repeat the test for potassium levels in her blood.

On January 6, 2017, the plaintiff called Ryan with complaints of tipsiness and dizziness occurring over the approximately one hour immediately after she took her first dose of potassium chloride that morning, but she informed Ryan that the symptoms had since resolved. At that time, the plaintiff denied any shortness of breath or other symptoms. Ryan advised the plaintiff that the dizziness may have been a side effect of the potassium chloride, and assured her that it was not an allergic reaction. Ryan instructed the plaintiff to continue taking the medication until she returned to the office the following week, at which time she would again test the plaintiff's blood potassium levels.

The plaintiff next saw Ryan on January 17, 2017, at which time, according to Ryan, the plaintiff reported that her right lower extremity pain had resolved after she took the potassium, and that she did not experience numbness or paresthesias in her foot, but that she nonetheless limped occasionally. Upon her physical examination of the plaintiff, Ryan noted normal strength in the proximal and distal right extremity, measuring 5 on a scale of 5, no palpable pain either near the hip or continuing down distally from the hip, and normal gait. According to Ryan, the neurological examination was non-focal and the lower extremity examination was unremarkable. At this juncture, Ryan's differential diagnosis included musculoskeletal issues, radiculopathy, an inflammatory autoimmune process, or a possible psychological component that Ryan explained may have been due to the plaintiff's contentious roommate situation. Ryan formulated a plan that included a repetition of the blood work to check the plaintiff's blood potassium levels and liver enzyme level. Ryan noted in the plaintiff's chart that she was still awaiting records from the plaintiff's 2015 hospitalization that Ryan had requested the plaintiff to provide.

On January 18, 2017, the plaintiff called Ryan and complained of right lower extremity pain that was resolving with potassium supplementation, although the plaintiff also reported recurrent symptoms on the previous night that worsened in the morning, asserting that it made it difficult for her to get out of bed. According to Ryan, the plaintiff denied having any pain at the time of the phone call. Ryan noted that prior blood work revealed low potassium and chloride levels, but she advised the plaintiff to stop potassium supplementation because the potassium level had "normalized." Ryan reported that she encouraged the plaintiff to stay hydrated, and instructed her to return to the office the next week to re-evaluate the leg pain and discuss the next steps, which might include imaging.

The plaintiff's next visit with Ryan was on February 28, 2017, at which time the plaintiff complained of right thigh pain and decreased strength of the right lower extremity. According to Ryan, however, the plaintiff had recently moved out of her prior living situation and obtained new employment, and allegedly was "getting better." The plaintiff again denied any

paresthesias or numbness of the legs, and further stated that the symptoms were only occurring when she stood up quickly. Ryan's impression at that visit was that the etiology of the plaintiff's right inner thigh pain was unclear. Ryan conducted an examination, documenting normal strength in the proximal and distal right extremity at a level of five out of five, no palpable masses or tenderness, and a negative FABER test. The neurological examination was again non-focal. In her differential diagnosis after this visit, Ryan considered the presence of a rheumatological condition such as an inflammatory process, arthritis, an autoimmune condition, or a possible psychosomatic cause. According to Ryan, there were no positive findings for any particular condition, and the plaintiff was reporting that her symptoms had improved, with occasional recurrence only upon engaging in certain activities. Ryan concluded at that time that imaging was unlikely to provide any additional relevant information, as the plaintiff's symptoms were consistent with a flare up of an autoimmune or a similar process. Ryan again ordered blood work, including liver function test levels to assess the plaintiff's transaminitis.

On March 1, 2017, Ryan spoke with the plaintiff on the phone to report that the results of the most recent blood test were indicative of persistent mild transaminitis. Ryan formulated a hypothesis that the elevation of the liver enzymes, in light of the recurrent right lower extremity pain and weakness, likely were related to muscle breakdown, as opposed to liver pathology. Ryan, however, expressed concern that there might have been a rheumatological cause like polymyositis in connection with the thigh pain and occasional lower extremity weakness, given the persistent transaminitis and of normalized electrolytes. Ryan asserted that she thus referred the plaintiff to a rheumatologist for further evaluation, and instructed her to follow up with a rheumatological appointment. The plaintiff never returned to see Ryan because, according to Ryan, the plaintiff left her job and lost her health insurance.

On September 13, 2017, the plaintiff presented to family medicine practitioner, Michael S. DePaolo, D.O., for a general physical examination. Dr. DePaolo documented that she was

feeling well and had no specific complaints. He further documented an examination without abnormal findings.

On January 15, 2018, the plaintiff presented to internist and family medicine practitioner Levelle Drose Bigatel, M.D., and complained of right hip pain radiating to her thigh, which she reported had started two years previously. The plaintiff reported that she could only cross her legs and rotate her hip internally if she lifted her leg. When the plaintiff first stood up at this examination, she was limping. During the physical examination, the plaintiff was unable to abduct her right hip, and experienced pain upon internal rotation in extension and upon abduction in flexion. Dr. Drose Bigatel noted joint pain in the plaintiff's right hip on movement, along with other specific derangements of the right hip. She thus ordered an x-ray of the plaintiff's right hip and pelvis, which the plaintiff underwent on January 18, 2018 at Main Line Health in Bryn Mawr, Pennsylvania. The radiologist's impression was sclerosis and deformity of the right femoral head that likely constituted sequelae of avascular necrosis. On January 23, 2018, the plaintiff followed up with Dr. Drose Bigatel, who concluded that the plaintiff had sustained no specific major trauma to her hip. Dr. Drose Bigatel diagnosed the plaintiff with avascular necrosis of the right hip, which was the first time that any health-care provider concluded that ongoing avascular necrosis was the cause of the plaintiff's hip pain and leg weakness. Dr. Drose Bigatel referred the plaintiff to an orthopedic surgeon.

On January 24, 2018, the plaintiff presented to Eric Levicoff, M.D., an orthopedic surgeon in Bryn Mawr. Dr. Levicoff reviewed the imaging from the x-ray of the right hip. Dr. Levicoff determined that the images of the right hip x-ray revealed right femoral head osteonecrosis with significant subchondral collapse, concluding that the plaintiff was not a candidate for hip preservation procedures and that her symptoms at that time did not seem to warrant reconstructive surgery. On February 3, 2018, plaintiff underwent a magnetic resonance imaging (MRI) scan of the pelvis, which confirmed the presence of Stage IV avascular necrosis of the right hip. On February 7, 2018, the plaintiff returned to Dr. Levicoff, whose notes reflected

that her symptoms were "fairly mild." The plaintiff reported to Dr. Levicoff that she was unable to go running, but had experienced no pain upon ambulation and recently had no serious physical discomfort while exercising on an elliptical training machine. Dr. Levicoff noted that she was ambulating without an obvious limp. In light of the plaintiff's historic habits of consumption of alcoholic beverages, which included binge drinking while a college student, Dr. Levicoff documented his advice that the plaintiff should continue with only prudent consumption of alcohol, if any, thus corroborating one of Ryan's stated concerns that the plaintiff's alcohol consumption may have been a cause of her avascular necrosis. By 2018, however, the plaintiff had reported that she had been only a social drinker for several years, and that she had ceased any heavy alcohol consumption after she graduated from college.

During May 2018, the plaintiff was in pain and required a cane, but her symptoms resolved to a large extent. On August 1, 2018, she followed up with Dr. Levicoff. She reported that she was doing fairly well. Dr. Levicoff recommended a conservative approach until her symptoms became more frequent, and instructed her to continue with her activities to the extent that she could tolerate them, and to follow up with him at least once per year.

On November 15, 2018, the plaintiff presented to John Dundon, M.D., an orthopedic surgeon in New Jersey, who documented that her hip pain dated back to August 2015, noted that she was walking with a limp, and reported that the plaintiff had evaluated her own pain at a level of six out of ten. On November 29, 2018, Dr. Dundon performed right hip replacement surgery on the plaintiff, without complications. Dr. Dundon documented that a post-operative x-ray confirmed good alignment of the prosthesis.

III. THE PLAINTIFF'S ALLEGATIONS

In her complaint, the plaintiff alleged that, during the time that she was Ryan's patient at Gotham, Ryan failed timely or properly to diagnose avascular necrosis as the cause of the plaintiff's right hip pain and right leg weakness. She further asserted that Ryan failed to render timely or proper nonsurgical medical management. Interventional treatment, vascular treatment,

surgical medical management, or medical care and treatment of an avascular necrosis injury of the femoral head of the right hip joint, such as therapy options for revascularization or avoidance of progression to grade four avascular necrosis. The plaintiff added that Ryan improperly performed physical examinations and evaluations, and failed to recommend conventional methods to treat the avascular necrosis in her hip. In addition, the plaintiff asserted that Ryan failed to undertake a complete and proper differential diagnosis, inasmuch as she improperly attributed the plaintiff's complaints of hip joint pain to psychological causes. Moreover, the plaintiff alleged that Ryan failed to provide her with a timely referral to, or recommendation of, an appropriate medical specialist, orthopedist, or vascular surgeon.

The plaintiff further alleged in her complaint that, as a consequence of the defendants' malpractice, she sustained severe, serious, and permanent injuries, including Grade IV avascular necrosis of the right femoral hip joint, impaction of the femoral head, multiple invasive surgeries and sequelae thereto, the need for installation of a prosthetic hip and sequelae thereto, and the need for future surgeries. She asserted that she suffered from osteopathic deterioration and sequelae thereto and that, as a consequence, she would sustain physical difficulties with pregnancy, childbirth, and motherhood, and that her risk of developing osteoporosis was heightened.

The plaintiff further alleged that Ryan failed to obtain her fully informed consent to any treatment that Ryan rendered to her. In addition, she alleged that Gotham was vicariously liable for Ryan's malpractice, and was negligent in their hiring, training, supervision, and retention of Ryan as an employee.

In her bills of particulars as to both Ryan and Gotham, the plaintiff reiterated the allegations in her complaint as to the alleged departures from good and accepted osteopathic practice that the defendants allegedly committed. She further asserted that the defendants failed to take a proper history or investigate her complaints in light of that history. The plaintiff averred that the defendants were negligent in failing to consider avascular necrosis as a cause

of the ongoing hip pain and leg weakness, failing to recognize the risk of infection, failing to order or administer radiographic imaging of the hip, hip joint, and femoral head, and failing to treat vascular occlusion and impairment of blood vessels such as internal iliac arteries, obturator arteries, retinacular arteries, femoral lateral circumflex arteries, femoral medial circumflex arteries, the subsynovial intracapsular arterial ring, and external iliac arteries. The plaintiff reiterated that the defendants failed to administer appropriate treatment to effectuate the revascularization of the hip joint, failed to take steps to prevent ongoing degenerative necrosis, failed to include bone deformity and other complications in their differential diagnosis, and failed thereupon to treat those conditions.

The plaintiff claimed in her bills of particulars that, as a consequence of these departures from good and accepted practice, she was caused to sustain undiagnosed avascular that progressed to Stage IV, bleeding, blood clots, and numerous sequelae thereof, thus necessitating prosthetic implantation and replacement surgery, with sequelae thereof. She asserted that these injuries caused a substantial decrease in her quality of life, an inability to run or engage in athletics, mental anguish, the inability to have natural spontaneous vaginal birth. In her amended bills of particulars, the plaintiff further asserted that the defendants departed from good and accepted medical practice

> "in failing to appreciate plaintiff's symptoms including right leg pain, limping, weakness, alcohol consumption and/or low potassium; failing to do imaging; failing to perform x ray; failing to perform mri; failing to order imaging when the subsequent doctor did so immediately; in failing to refer to specialists; in failing to appreciate lack of flexibility and inability to move very far; in failing to have avascular necrosis on the differential diagnosis; and in failing to appreciate, diagnose and/or rule out avascular necrosis given pain at the joint, gradual progression of symptoms, feeling unstable on the joint limping when first standing up and limited range of motion."

IV THE SUMMARY JUDGMENT MOTION

In support of their motion, the defendant submitted the pleadings, the plaintiff's bills of particulars, amended bills of particulars, medical and hospital records, transcripts of the parties'

depositions, and the expert affirmations of board-certified internist Brian Feingold, M.D., and board-certified orthopedic surgeon Michael Bronson, M.D.

Dr. Feingold explained that avascular necrosis of the hip, also known as osteonecrosis, is a bone disease arising from a lack of a blood supply to the femoral head of the bone, which he described as the ball at the top of the thigh bone in the hip joint. He asserted that the lack of blood causes bone tissue death and eventually causes the bone to collapse, necessitating a hip replacement. Dr. Feingold stated that avascular necrosis does not arise from an infection and, thus, there was no basis for any claim that the defendants departed from good practice for failing to diagnose an infection. He noted that the risk factors for the development of avascular necrosis included a traumatic injury such as a hip dislocation, excessive alcohol consumption, the administration of corticosteroid medication, and several other medical conditions, including metabolic conditions such as eating disorders.

Dr. Feingold opined the plaintiff did not report any risk factors that would have led Ryan to suspect or diagnose her with avascular necrosis as the cause of her hip pain and leg weakness. As he characterized it, the plaintiff reported a broad range of symptoms to Ryan, including right leg pain, a limp, a hospitalization related to paralysis of both legs, skin lesions, low potassium, and transaminitis, as reflected by elevated liver enzymes, none of which was indicative of right hip pathology. According to Dr. Feingold, however, the plaintiff "was not forthcoming with Dr. Ryan about her troubling history of alcohol abuse, as well as her eating disorder and bulimia, or her history of hip pain going back to August of 2015." As he characterized the plaintiff's deposition testimony, she admitted that she did not inform Ryan of her eating disorder because it was "personal" and that she may have told Ryan that she was a "social drinker." Dr. Feingold compared this testimony with Dr. Drose Bigatel's records, which mentioned episodes of binge drinking in college, and the March 2015 records of orthopedic surgeon Mark L. Kavanagh, M.D., which indicated that, in early 2015, when the plaintiff was 22 years old, the plaintiff's grandmother reported to Dr. Kavanagh that the plaintiff had been

suffering from bulimia and had been drinking heavily for several months prior to Dr. Kavanagh's examination of the plaintiff. Dr. Feingold also noted that, despite repeated requests, the plaintiff never provided Ryan with any records from her prior treatments by other health-care providers.

According to Dr. Feingold, a work-up for avascular necrosis of the hip or a referral to a specialist was not warranted since the plaintiff made only non-specific complaints of hip and leg pain, reported that the pain had improved at certain times throughout the treatment, made other multiple complaints, and did not present with any known risk factors. As he phrased it, at the time of the plaintiff's treatment with Ryan, she was a young and relatively healthy patient who, in light the medical history that she did elect to provide, was not at increased risk for avascular necrosis. Dr. Feingold thus concluded that there no merit to the plaintiff's claims that Ryan departed from good practice by failing to prevent the development or exacerbation of avascular necrosis in the right hip, or failing to diagnose it.

Dr. Feingold proceeded to address Ryan's performance in connection with each of her contacts with the plaintiff.

With respect to the December 30, 2016 office visit, Dr. Feingold opined that Ryan comported with all applicable standards of care by taking a proper history and properly formulating a differential diagnosis. As he characterized it, the plaintiff reported to Ryan that she had been limping for the previous two months and experienced pain in her right leg. Based on Ryan's deposition testimony, in which she detailed how she assessed the plaintiff's range of motion by pressing on her hip and knee, flexing her hip, rotating her ankle, and pressing on her pelvis, Dr. Feingold concluded that Ryan conducted a thorough and focused evaluation. He further noted that Ryan had also requested that the plaintiff provide her with records of prior treatments and hospitalization, but that the plaintiff never did so. In light of the history that the plaintiff did provide to Ryan, Dr. Feingold concluded that Ryan properly ordered laboratory testing "given her broad differential of a condition of the proximal right leg and hip or a rheumatological cause, metabolic abnormality (owing to a prior history of low potassium

reported by the patient), radiculopathy or an inflammatory issue." He opined that, based on the plaintiff's complaints, Ryan's examination, and the medical history available to Ryan, "there was no reason to suspect Avascular Necrosis or include it in the differential."

With respect to the January 3, 2017 and January 6, 2017 telephone calls, Dr. Feingold asserted that the plaintiff did not relate any leg related complaints, that Ryan appropriately prescribed potassium chloride to treat the plaintiff's low potassium levels, and also properly discussed the plaintiff's slightly elevated liver enzymes. As he interpreted the records, Ryan again requested that the plaintiff provide prior medical records. He also concluded that, upon learning on January 6, 2017 that the plaintiff experienced an episode of dizziness, Ryan properly instructed her that the dizziness might have been a side effect of the potassium chloride, but that she should continue taking it until she returned to Ryan's office the following week. Dr. Feingold further opined that the care and treatment that Ryan rendered to the plaintiff at the January 17, 2017 office visit comported with applicable standards of care, as Ryan conducted a thorough and focused evaluation that was unremarkable other than for improving hip and leg conditions. He asserted that, consequently, "there was no indication for Dr. Ryan to suspect an underlying hip pathology--let alone Avascular Nercosis or recommend a further workup via CT, CTA, MRI and x-ray or any other diagnostic or imaging modality." Dr. Feingold also concluded that Ryan appropriately repeated blood work to check potassium and liver enzyme levels. He further asserted that Ryan satisfied the appropriate standards of care during the January 18, 2017 phone call by requesting the plaintiff to return to her office during the next week so that Ryan could evaluate the plaintiff's recurrent leg pain and discuss the next steps that should be taken, including possible imaging.

Dr. Feingold opined that, when the plaintiff finally returned to see Ryan several weeks later, on February 28, 2017, Ryan's care and treatment was in accordance with good and accepted medical practice in all respects. As he explained it, during that visit, the plaintiff complained of pain in the right thigh and prior decreased strength of the right lower extremity,

which nonetheless had improved "since she moved out of her prior living situation and got a new job." Dr. Feingold asserted that, consequently, Ryan reasonably and appropriately felt that the plaintiff's symptoms were consistent with a flare up of an autoimmune or a similar process. He further concluded that Ryan conducted a thorough and focused evaluation on February 28, 2017, and that Ryan's plan to repeat blood work, including a test for liver enzyme levels, was reasonable and appropriate. In addition, Dr. Feingold asserted that Ryan's decision to defer actual treatment until the next day, when laboratory results became available, was a proper exercise of medical judgment.

Dr. Feingold stated that, on March 1, 2017, Ryan appropriately referred the plaintiff to see a rheumatologist for further evaluation of the thigh pain and occasional lower extremity weakness, and to rule in or out polymyositis, but that the plaintiff failed to follow up with such a specialist at that juncture. He rejected the plaintiff's contention that Ryan failed to appreciate her inflexibility, immobility, instability, or limited range of motion, concluding that, during the plaintiff's three in-person visits with Ryan over a two-month period, Ryan's examination of the hip did not reveal such findings. Dr. Feingold further concluded that there was no merit to the plaintiff's contention that Ryan departed from good practice by failing to order imaging because "a subsequent doctor did so immediately," since Dr. DePaolo, the internist whom the plaintiff first saw six months after her last appointment with Ryan, also did not order any imaging.

Dr. Bronson similarly concluded that Ryan did not deviate from the applicable standard of care by failing to detect avascular necrosis or failing to attribute the plaintiff's right hip pain and lower right leg weakness to that condition. In this regard, he opined that, at the time that the plaintiff first presented to Ryan, the plaintiff already suffered from late Stage III or early Stage IV avascular necrosis, and that "[n]othing Dr. Ryan did or did not do caused or resulted in the progression of this patient's Avascular Necrosis resultant in a hip replacement." He reiterated many of the assertions that Dr. Feingold made in his affirmation.

Dr. Bronson also reiterated Dr. Feingold's description and characterization of avascular necrosis, as well as the leading known causes of the condition. As he described it,

> "Avascular Necrosis develops through four stages. Stage I and Stage II are the early stages of the disease without involvement of a large area of the ball of the hip joint. During the early stages of the disease the patient can be asymptomatic. Once the afflicted hip reaches late stages, Stages III and Stages IV and there is an 80-90% ball collapse, hip replacement is the only available treatment. Avascular Necrosis of the hip typically progresses to late stages within 2-3 years."

Mirroring Dr. Feingold's analysis, Dr. Bronson asserted that the plaintiff did not report any risk factors that would have led Ryan to suspect or diagnose her with avascular necrosis. He criticized the plaintiff for failing to be forthcoming with Ryan about her "history of alcoholism, as well as her eating disorder and bulimia, or her history of hip pain going back to August of 2015." He concurred with Dr. Levicoff, one of the plaintiff's later treating physicians, that "the patient's alcohol consumption was one of the causes of her orthopedic issue." Dr. Bronson also faulted the plaintiff for being a noncompliant patient who failed to provide Ryan with relevant prior medical records, waited six weeks to follow up with Ryan despite being asked to return in one week, and declined to follow up with a rheumatologist.

Dr. Bronson concluded that the complaints that the plaintiff did make to Ryan, and the history that she did provide to Ryan, including right leg pain, a limp, a hospitalization related to paralysis of both legs, skin lesions, low potassium, and transaminitis, were not indicative of right hip pathology. He noted that the plaintiff never had any hip trauma, was never on corticosteroid medication, and never advised Ryan of her "troubling history with alcohol abuse and eating disorder." As he phrased it, "[a] non-specific complaint of leg pain that the patient reported improved at certain times throughout the treatment, coupled with her other multiple complaints and in the absence of risk factors, did not warrant a work-up for Avascular Necrosis of the hip or a referral to a specialist for it."

Dr. Bronson expressly concluded that Ryan's treatment was not a cause of the plaintiff's injuries, as she likely already had Stage III or Stage IV avascular necrosis when she first

presented to Ryan, and never reported hip pain to Ryan during any encounter in any event. Dr. Bronson opined that, even had an earlier diagnosis of avascular necrosis been made in late 2016, it would not have altered the plaintiff's outcome. As Dr. Bronson explained,

> "Avascular necrosis typically runs its course eventually resulting in total ball collapse of the femoral bone necessitating a hip replacement. For some hips in early stages of the disease (Stage I and Stage II) revascularization procedures such as core decompression (surgical procedure that involves drilling holes in the bone to release the pressure) can be attempted to try to preserve the native hip ball. Once the hip reaches later stages (Stage III and Stage IV), like it did in Ms. Depalma's case by the time she first saw Dr. Ryan, total hip replacement is the only treatment option."

Thus, Dr. Bronson concluded that it did not matter whether the plaintiff was referred for imaging *prior to* treating with Ryan, during her treatment with Ryan, or shortly after her treatment with Ryan, as she would have had the same outcome under any of these circumstances. Specifically, Dr. Bronson concluded that the only possible course at any point along this timeline was for the plaintiff to get as much use as possible use out of her natural hip while her symptoms remained mild, and to undergo a replacement surgery when the symptoms worsened, which occurred here by late 2018.

Dr. Bronson further asserted that it was irrelevant to the plaintiff's outcome as to how early the hip was replaced, as she would have received "the same amount of cure" regardless of the timing, that is, a cure consisting of the placement of a prosthetic joint. He opined that "[t]here is no downside to non-treatment of Avascular Necrosis once it has advanced to Stage III or Stage IV," but that it actually is "beneficial to prolong the inevitable hip replacement surgery and let the patient use her natural hip until it was no longer an option."

Finally, Dr. Bronson asserted

> "I am also aware that secondary to the hip replacement surgery, plaintiff is claiming various limitations of her physical activities. There is also a puzzling claim that plaintiff is unable to have natural spontaneous vaginal birth. In my opinion, if the hip replacement surgery was properly done, none of the patient's claimed limitations should have occurred. If there was a problem with the hip replacement, the subsequent issues can only be attributable to the physician who performed the hip replacement, not Dr. Ryan who did not participate in that at all. Based on the records, plaintiff had a successful hip replacement without

> any complications. In my opinion, this sort of patient should have made a full recovery without any physical limitations, including running, playing sports, and delivering a baby by vaginal childbirth. Plaintiff's claims otherwise are not substantiated by her medical records."

In opposition to the defendants' motion, the plaintiff relied on the defendants' submissions, and also submitted the expert affidavit of a board-certified internist, the expert affirmation of a board-certified orthopedist, a counter statement of material facts, an attorney's affirmation, and a memorandum of law. The plaintiff argued that there were triable issues of fact both as to Ryan's departure from accepted practice and proximate cause, inasmuch as Ryan and her experts conceded that Ryan knew about the plaintiff's August 2015 diagnosis of a generally occurring avascular necrosis, that the hip necrosis significantly worsened after the plaintiff last treated with Ryan, and that revascularization was still an option in early 2017. She also contended that, contrary to Ryan's contention, she did, in fact, inform Ryan about the current level of her alcohol consumption, which was then less than 10 drinks per week.

The plaintiff's expert internist concluded that Ryan departed from good and accepted practice when she failed to diagnose avascular necrosis as the cause of the plaintiff's ongoing hip pain and leg weakness, particularly because the plaintiff had been generally diagnosed with that condition 18 months earlier, and because, contrary to the defendants' expert's conclusion, the plaintiff was not suffering from late-stage necrosis in late 2016 and early 2017, when she was under Ryan's care. Consequently, the plaintiff's expert internist concluded that the failure to test for and diagnose necrosis as the cause of the symptoms deprived the plaintiff of any opportunity for a cure less invasive than hip replacement.

The internist explained that, at the time that the plaintiff treated with Ryan, the plaintiff was a 24-year-old woman with right-leg pain that caused gait abnormalities, a complaint that the expert described as "very unusual and concerning" for "such a young, otherwise healthy woman." The expert expressly disagreed with Ryan position's that, even where "avascular necrosis is on the differential diagnosis, the standard of care does not require ruling it out." The

internist explicitly opined that, in such a situation, the standard of care does indeed require ruling out the condition, as it is "a severe, debilitating condition that if not timely diagnosed in its early stages can have lifelong implications for the patient." The expert concluded that "the standard of care was to rule it out by imaging, and Dr. Ryan's failure to do so was a deviation in the standard of care that was a substantial contributing factor to Ms. Depalma's severe injuries." The expert internist, citing to Dr. Bronson's affirmation, asserted that

> "[i]t is not disputed that Ms. Depalma had avascular necrosis since August of 2015. Further, it is not disputed that avascular necrosis advances to later stages over two to three years, at which time hip preservation is no longer an option. As such, I disagree with Dr. Brunson [sic] that Ms. Depalma would not have had better treatment options in 2016 or early 2017. Approximately 1.5 years had passed from the time of onset until Dr. Ryan saw the patient, and her diagnosis was made in January 2018. Dr. Brunson [sic] himself indicated that this was the amount of time it would take for avascular necrosis to progress to a late stage when hip preservation was no longer an option. Therefore, according to the timeline set forth by Dr. Brunson [sic], Dr. Ryan's failure to diagnose Ms. Depalma's avascular necrosis was a substantial contributing factor to progression of her condition to endstage, with more debilitating injuries and adverse impacts on lifestyle, as Ms. Depalma testified, and this delay in diagnosis caused loss of her hip, whereas hip preservation surgery would have been a treatment option if her avascular necrosis of the hip been diagnosed at the time when Dr. Ryan saw her in late 2016 and early 2017"

(record citations omitted).

More specifically, the plaintiff's expert internist opined that Ryan failed to perform complete and appropriate physical examinations of the plaintiff at her three in-person visits, that Ryan did not document the leg flexion testing she claimed to have performed, and that "all the other elements of the standard hip examination are also missing from her notes," while the plaintiff did not remember Ryan performing any flexion testing. The internist further concluded that the failure to perform all necessary motion testing of the hip and leg caused or contributed to the failure to recognize "an orthopedic condition that she should have diagnosed with radiographic imaging as avascular necrosis of the femoral head." In this regard, the expert further concluded that the failure immediately to order imaging, in light of the plaintiff's presenting symptoms, constituted a departure from the standard of care that delayed the proper

diagnosis and deprived the plaintiff of an opportunity for treatment that would not have required a hip replacement. In addition, the plaintiff's expert internist opined that Ryan departed from accepted practice in failing to refer the plaintiff to an orthopedist in late 2016 and early 2017, and that this failure contributed to preventing the plaintiff from benefiting from joint preservation procedures. The internist explained that

> "[a]t the office visit on December 30, 2016, Dr. Ryan wrote that the 'etiology [of the patient's pain] is unclear' and she ordered bloodwork to explore rheumatologic and metabolic causes. She noted that she would potentially consider imaging if bloodwork was within normal limits. Dr. Ryan testified . . . that her differential diagnosis was metabolic given that she thought that there was a similar episode about one year prior, 'certainly musculoskeletal issues,' radiculopathy, skeletal issues degenerative or inflammatory. She thought . . . the problem was rheumatologic in nature versus a cancerous lesion and she ordered bloodwork to determine whether the patient had a rheumatologic condition. Here the labs did not provide any etiology as to the cause of Ms. Depalma's pain. The slightly low potassium and slight liver function abnormalities did not explain the gait abnormality or the right leg pain. Indeed, Dr. Ryan testified . . . that metabolic causes were ruled out by the labs. Even with Dr. Ryan's incomplete differential diagnosis, an x-ray of the hip, pelvis and right femur was mandated by the standard of care to rule out musculoskeletal conditions, cancer and rheumatologic causes of pain."

As the internist characterized Ryan testimony, she "admitted" that the plaintiff's symptoms of right-leg pain and limping were both potential manifestations of avascular necrosis of the femoral head.

The plaintiff's expert internist also faulted Ryan for suggesting that the plaintiff's pain may have been psychosomatic, without performing the tests necessary to rule that conclusion in or out. As the expert explained it, "[t]he standard of care therefore mandated an x-ray of the hip, pelvis and femur and/or referring the patient to an orthopedist before ascribing her condition to a psychosomatic syndrome," that timely imaging or an orthopedic referral would have revealed that avascular necrosis was the case of the pain, and that timely diagnosis would have allowed treatment far less invasive than a hip replacement. The expert noted that, at the January 18, 2017 visit, Ryan mused that, inasmuch as the plaintiff's bloodwork was mostly within normal limits, the plaintiff "may need imaging," but that Ryan nonetheless failed seasonably to order an

x-ray despite that consideration. The expert internist opined that Ryan should have taken an x-ray of the lower leg and hip, as that test that would have taken less than one minute to perform. The expert asserted that, at her deposition, Ryan testified that her differential diagnosis included degenerative or inflammatory arthritis, but that avascular necrosis was not on the differential diagnosis due to the lack of history and risk factors. The expert concluded that Ryan's differential diagnosis thus was deficient insofar as the standard of care mandated consideration of avascular necrosis of the femoral head, which would have necessitated further diagnostic testing that would, in turn, have revealed the plaintiff's true condition. The expert made it clear that, with or without Ryan's knowledge of the plaintiff's history of alcohol consumption, the standard of care mandated a radiographic workup of the hip pain and leg weakness.

Finally, the plaintiff's expert internist interpreted the medical records as reflecting that the plaintiff was, contrary to the defendants' contention, a compliant patient, and that the plaintiff did not remember being referred by Ryan to any particular specialist, let alone a specific rheumatologist.

The plaintiff's expert orthopedist reiterated most of the opinions and conclusions articulated by her expert internist. The orthopedist concluded that Ryan deviated from accepted practice by failing to diagnose avascular necrosis as the cause of the plaintiff's hip pain and leg weakness, and that this departure caused a delay in treatments short of hip replacement that would have addressed the condition. In this regard, the orthopedist agreed with the internist that, from December 2016 through February 2017, when the plaintiff treated with Ryan, the plaintiff had only early-stage avascular necrosis. The orthopedist asserted that the symptoms of right-side leg pain and limping that the plaintiff presented were both symptoms that could have been caused by avascular necrosis, and that, given the plaintiff's symptoms, age, and history, the standard of care required the inclusion of avascular necrosis as part of the differential diagnosis and the ordering of imaging, including an x-ray, to evaluate her pelvis and hip. The orthopedist reiterated the internist's conclusion that, had Ryan timely ordered an x-ray, the

plaintiff would have been diagnosed earlier and received treatment before the advancement of symptoms and deterioration had progressed too far, permitting the plaintiff to undergo likely successful treatment before a hip replacement became her only option. The orthopedist also asserted that, although Ryan found low potassium and slight liver function abnormalities, neither of these test results provided any etiology of the plaintiff's symptoms, as they merely ruled out a metabolic cause of the plaintiff's symptoms. Hence, according to the orthopedist, the standard of care required different testing, such as imaging, or referral to an orthopedist.

In reply, the defendants submitted their attorney's affirmation, in which she asserted that the plaintiff's experts did not address the claims to recover for lack of informed consent and negligent hiring and, thus, summary judgment must be awarded to the defendants dismissing those causes of action. Counsel further argued that the plaintiff's expert's submissions were insufficient to rebut the defendants' prima facie showing of entitlement to judgment as a matter of law, reiterating the defendants' arguments that the plaintiff withheld critical information from Ryan, that there were no signs or symptoms that the plaintiff presented to Ryan that justified a diagnosis of avascular necrosis in the hip, and that the plaintiff already was generally in late-stage avascular necrosis in any event, which ultimately would have required a hip replacement regardless of Ryan's examination, diagnosis, and treatment recommendations.

V. SUMMARY JUDGMENT STANDARDS

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]).

A. MEDICAL MALPRACTICE BASED ON DEPARTURE FROM ACCEPTED PRACTICE

"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 a patient's condition, thus providing less than optimal treatment or delaying appropriate treatment, and the insufficiency of or delay in treatment proximately causes 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]; *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). Thus, the affirmation of a plaintiff's expert should not be credited where it completely "is contradicted by the record" (*Mulroe v New York-Presbyt. Hosp*., 203 AD3d 665, 665 [1st Dept 2022]). The term "record," in this context, refers to medical records, charts, test results, and notes, or party admissions by the plaintiff (*see Wong v Goldbaum*, 23 AD3d 277, 280 [1st Dept 2005] [plaintiff's expert's opinion contradicted by defendant's notes and plaintiff's own testimony]).

The defendants established, prima facie, that they did not depart from good and accepted medical practice, as their experts unambiguously concluded that Ryan comported with applicable standards of care in taking a medical history from the plaintiff, assiduously requesting that she provide her with prior medical and hospital records, properly accounting for the plaintiff's age and known risk factors, performing a proper examination, and ordering proper testing. They further established, prima facie, that regardless of whether Ryan properly diagnosed the plaintiff's condition, the plaintiff would have been required to undergo hip replacement surgery within a few years of Ryan's last date of treatment in any event.

In opposition to the defendants' showing, however, the plaintiff, through her own testimony, medical records, and expert affidavit and affirmation, raised a triable issue of fact as to whether Ryan departed from good and accepted practice in failing to conduct a proper examination, failing to take a proper history, failing to consider avascular necrosis as a cause of hip pain and leg weakness in the differential diagnosis, and failing to order x-rays, thus delaying a proper diagnosis and treatment that would not require a hip replacement. The experts' submissions also raised a triable issue of fact as to whether the plaintiff had early-stage avascular necrosis when she first presented to Ryan and, thus, whether a timely diagnosis would have permitted less-intrusive treatments to address the avascular necrosis before the plaintiff's hip had deteriorated to the point where a hip replacement was the only possible course of treatment.

Consequently, that branch of the defendants' motion seeking summary judgment dismissing the medical malpractice cause of action must be denied.

B. LACK OF INFORMED CONSENT

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]).

Nonetheless, "[a] failure to diagnose cannot be the basis of a cause of action for lack of informed consent unless associated with a diagnostic procedure that 'involve[s] invasion or disruption of the integrity of the body'" (*Janeczko v Russell*, 46 AD3d 324, 325 [1st Dept 2007], quoting Public Health Law § 2805-d[2][b]; *see Lewis v Rutkovsky*, 153 AD3d at 456), and that invasion or disruption is claimed to have caused the injury. Moreover, a claim to recover for lack of informed consent cannot be maintained where the alleged injuries resulted either from the failure to undertake a procedure or the postponement of that procedure (*see Akel v Gerardi*, 200 AD3d 445 [lack of informed consent cannot be based on failure to perform procedure or administer drug]; *Ellis v Eng*, 70 AD3d 887, 892 [2d Dept 2010]; *Jaycox v Reid*, 5 AD3d 994, 995 [4th Dept 1994]).

The defendants established, prima facie, that the plaintiff's lack of informed consent claim was based solely on the alleged failure to diagnose avascular necrosis as the cause of her hip pain and leg weakness, thus delaying the opportunity for a cure employing procedures less invasive than a hip replacement. They also established, prima facie, that the consent that they obtained from the plaintiff was qualitatively sufficient. The plaintiff did not address the issue in opposition to those showings and, thus, did not raise a triable issue of fact as to whether any failures in this regard involved some intrusion upon her bodily integrity and, if so,

whether the consent obtained by the defendants was qualitatively insufficient. The defendants are thus entitled to summary judgment dismissing the lack of informed consent cause of action.

C. VICARIOUS LIABILITY

"'In general, under the doctrine of respondeat superior, a hospital may be held vicariously liable for the negligence or malpractice of its employees acting within the scope of employment, but not for negligent treatment provided by an independent physician, as when the physician is retained by the patient himself'" (*Valerio v Liberty Behavioral Mgt. Corp*., 188 AD3d 948, 949 [2d Dept 2020], quoting *Seiden v Sonstein*, 127 AD3d 1158, 1160 [2d Dept 2015]; *see Hill v St. Clare's Hosp*., 67 NY2d 72, 79 [1986]; *Dupree v Westchester County Health Care Corp*., 164 AD3d 1211, 1213 [2d Dept 2018]). This rule applies to private medical practices as well (*see Yaniv v Taub*, 256 AD2d 273, 274 [1st Dept 1998]). Inasmuch as Gotham essentially conceded that Ryan was its employee when she treated and examined the plaintiff, and the court is denying summary judgment in connection with the plaintiff's medical malpractice cause of action against Ryan, the court must also deny summary judgment to Gotham in connection with the summary judgment claim insofar as asserted against it.

D. NEGLIGENT HIRING

Gotham demonstrated that it neither "knew, [n]or should have known," of Ryan's or other employees' "propensity for the sort of conduct which caused the injury" (*Sheila C. v Povich*, 11 AD3d 120, 129-130 [1st Dept 2004]; *see Kuhfeldt v. New York Presbyt./Weill Cornell Med. Ctr*., 205 AD3d 480, 481-482 [1st Dept 2022]). Inasmuch as the plaintiff did not address this issue in her opposition papers, she failed to raise a triable issue of fact in opposition to the defendants' showing in this regard. Hence, that branch of the defendants' motion seeking summary judgment dismissing the negligent hiring and training cause of action must be granted.

VI. CONCLUSION

In light of the foregoing, it is

ORDERED that the defendants' motion is granted only to the extent that they are awarded summary judgment dismissing the lack of informed consent and negligent hiring causes of action, the lack of informed consent and negligent hiring causes of action are dismissed, and the motion is otherwise denied.

This constitutes the Decision and Order of the court.

2/24/2023
DATE

JOHN J. KELLEY, J.S.C.

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