SUPREME COURT OF THE STATE OF NEW YORK
NEW YORK COUNTY

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

Justice

----------X

MARY T. JONES,

Plaintiff,

- v -

NORMAN ROWE, M.D., ROWE PLASTIC SURGERY, DANIEL ROSEN, M.D., JENNIFER CAPLA, M.D., and CENTER FOR SPECIALTY CARE,

Defendants.

----------X

INDEX NO. 805006/2017

MOTION DATE 11/16/2022

MOTION SEQ. NO. 001

DECISION + ORDER ON MOTION

The following e-filed documents, listed by NYSCEF document number (Motion 001) 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 62, 63, 67, 68, 69, 70, 71, 72, 73, 74, 75

were read on this motion to/for SUMMARY JUDGMENT.

I. INTRODUCTION

In this action to recover damages for medical malpractice based on alleged departures from good and accepted practice and lack of informed consent, the defendants Norman Rowe, M.D., and Rowe Plastic Surgery (together the Rowe defendants) move pursuant to CPLR 3212 for summary judgment dismissing the complaint insofar as asserted against them. The plaintiff opposes the motion. The motion is granted, and complaint is dismissed insofar as asserted against the Rowe defendants.

II. FACTUAL BACKGROUND

The crux of the plaintiff's claim is that, although she did not believe that she needed a breast lift procedure, Rowe insisted that she did, and improperly performed a bilateral breast lift, abdominoplasty, and umbilical and epigastric hernia repairs. Specifically, the plaintiff alleged that Rowe failed effectively to drain fluid from her abdomen, creating numerous scars on her abdomen and left and right flanks, and that Rowe caused an unnecessary scarring in her upper abdomen by improperly pulling surgical tape from her abdomen, thereupon generating a wound.

At least since 2006, the plaintiff had a history of skin itchiness, dermatitis, and neurodermatitis, characterized by scattered nodules. Between 2006 and 2014, she also had a history of gastroesophageal reflux disease and varicose veins, and had given birth twice via spontaneous vaginal delivery, but had no history of prior surgeries. She first presented to Rowe on May 27, 2014 for a consultation, complaining of abdominal skin laxity. On examination, Rowe concluded that the plaintiff's breasts were asymmetrical, with the distance from the manubrium to the nipple being 28.5 cm on the left and 29.5 cm on the right. He thus discussed the option of an abdominoplasty with the plaintiff, and claims to have discussed the risks and benefits of, and alternatives to, that procedure. The plan that he formulated was to have the plaintiff follow up in one week after obtaining pre-operative clearance. On June 2, 2014, internist and family medicine practitioner John Abroon, M.D., wrote to Rowe, informing the latter that he had recently diagnosed the plaintiff with recurrent lower abdominal excess adipose tissue fold rash, which had caused frequent discomfort and pruritus. Dr. Abroon had prescribed various over-the-counter antibiotic and antifungal creams to the plaintiff, albeit with little relief, and thus recommended surgery to alleviate her complaints.

The plaintiff returned to Rowe on June 12, 2014, complaining of abdominal panniculitis and intertrigo, neck and back pain, bilateral macromastia, and bilateral inframammary intertrigo. Rowe reiterated the option of an abdominoplasty, and also broached the option of a bilateral breast reduction and umbilical hernia repair. He claims to have discussed the risks and benefits of, and alternatives to, these procedures, and asserted that the plaintiff advised him that she understood and agreed to proceed. Specifically, Rowe asserted that, with respect to the abdominoplasty, he advised the plaintiff of the risks of fluid collection, infection, scarring, asymmetry, the need for further surgery, and residual feelings of "fullness." He also claims to have advised the plaintiff that the risks of a breast reduction procedure included the loss of nipple sensitivity, the need for further surgery, asymmetry, scarring, fluid collection, loss of feeling, and loss of ability to breastfeed. As Rowe recounted it, the plaintiff herself recalled that

Rowe had explained that he would use a technique that would result in a lollipop-shaped scar, reflecting an incision around her areola and one leading straight down below it. Rowe averred that he advised the plaintiff that the risks of a hernia repair included scarring, recurrence, pain, fluid collection, asymmetry, the need for further surgery, and loss of umbilical viability.

On June 12, 2014, the plaintiff executed four informed consent forms, one each for an abdominoplasty, bilateral breast reduction, bilateral mastopexy (breast lift), and umbilical hernia repair. The forms documented specific risks of each surgery, as well as the issues that might arise during the healing process. That same day, Rowe gave the plaintiff prescriptions for the prophylactic antibiotic Augmentin, the pain medication Vicodin, and the anti-nausea medication Zofran, and instructed her to obtain pre-operative laboratory testing.

On July 9, 2014, plaintiff presented to the defendant Center for Specialty Care (CSC), during which Rowe claims that he again discussed the planned procedures, as well as the respective risks, benefits and alternatives, and that the plaintiff again stated that she understood and agreed to the procedures. Rowe documented that the plaintiff was a 48- year-old female, with complaints of bilateral neck and back pain, inframammary intertrigo, and bilateral macromastia that were resistant to non-surgical therapy. According to the operative report, the plaintiff was brought to the operating room and was marked for a medial pedicle vertical type incision, as well as for a standard abdominoplasty incision. The medial pedicles of the left and right breasts were de-epithelialized, and breast tissue was then removed from each breast. After the incision had been tailor-tacked together, Rowe determined that the breast symmetry was good, and then placed the plaintiff in the sitting position Rowe then sutured the incisions closed. Rowe next made a traditional abdominoplasty incision to the anterior rectus sheath, after which dissection was carried superiorly to the level of the umbilicus, where the umbilicus was freed from the abdominal flap and the dissection was carried superiorly. Rowe placed the plaintiff in a beach chair position and excised excess skin. Rowe then identified and repaired an epigastric hernia and an umbilical hernia. Bulb-shaped Jackson-Pratt suction drains were

placed near the incision, and sutures were used to close it. Rowe applied sterile dressings, and transferred the plaintiff to the recovery room in stable condition. Upon discharge, Rowe provided the plaintiff with a topical cream and directed her to apply it two to three times daily to minimize scarring.

On July 10, 2014, the plaintiff returned to Rowe's office for a postoperative visit. Rowe assessed her as doing well and formulated a treatment plan, pursuant to which she was to follow up in one week. The plaintiff next saw Rowe at his office on July 15, 2014. According to Rowe, the two drains were functioning well, with decreasing drainage output according to a drainage output sheet completed by plaintiff herself. On July 15, 2014, the plaintiff documented a flow of 20 milliliters (ml) of fluid per day from the left drain and 40 ml per day from the right drain, and later testified at her deposition that the fluid that had been draining was becoming clearer and less pink-tinged each day during the first week following the surgery. Rowe reported that the plaintiff's umbilicus was clean and dry, and he applied a Telfa dressing with the topical antibiotic bacitracin. Rowe also prescribed the topical cream collagenase to the plaintiff and directed her to apply it to her scars two times per day.

On July 21, 2014, the plaintiff returned to Rowe's office, at which time he removed her left drain. Rowe noted in his chart that the plaintiff's abdomen was soft, and that her breasts were soft with normal nipple sensation. Between July 21, 2014 and July 28, 2014, the plaintiff's right drain averaged 15 ml per day in output. She again returned to Rowe's office on July 28, 2014, at which time her right drain was removed. On examination, Rowe recorded that the plaintiff's abdomen and breasts were soft, and that she had positive nipple sensation bilaterally. The plan that he formulated was for the plaintiff to follow up with him in three weeks. The plaintiff next returned to Rowe's on August 14, 2014 and the again on September 16, 2014, as she had been instructed. Rowe contended that, at each of these appointments, he explained the treatment plan to the plaintiff, which he testified invariably included discussing post-operative care, scar therapy, breast-scar massage to minimize scarring, wearing compression

garments, and limiting the plaintiff's activity, such as strenuous activity and heavy lifting, to minimize seroma formation. Rowe asserted that he also recommended to the plaintiff that she refrain from activities that could cause shearing of the abdominal wall so as to minimize the potential for serous fluid collection and seroma formation. At the September 18, 2014 appointment, the plaintiff complained to Rowe of left upper quadrant fullness. Rowe thereafter aspirate serous fluid from the plaintiff, beginning on September 18, 2014, and continuing on September 22, 2014, October 6, 2014, October 9, 2014, and October 13, 2014.

The plaintiff returned for Rowe's office for evaluation on both October 16, 2014 and October 23, 2014. At each of these appointments, Rowe noted that plaintiff had no remaining fluid collections and, hence, no aspiration was performed. Approximately two months later, on December 15, 2014, the plaintiff again returned to see Rowe, who noted that she was "doing well," and directed her to follow up in three months, or as needed.

The plaintiff next saw Rowe on April 30, 2015, at which time he noted a hypertrophic scar at the left breast incision, as well as a small scar in the area of the left abdominal incision. The plaintiff reported using a silicone patch occasionally on her abdomen to minimize scarring, but asserted that she did not use the patches on her breasts. After the plaintiff reported fullness of her left abdomen, Rowe ordered an abdominal computed tomography (CT) scan. Inasmuch as the plaintiff also reported left breast pain, Rowe provided the plaintiff with a referral to breast surgeon Alyssa Gillego, M.D., and gave her a copy of her most recent mammogram. After Rowe purportedly discussed the risks, benefits and alternatives with respect to the injection of the steroid Kenalog, which is employed to diminish thickened scars, the plaintiff agreed to Kenalog injections into her right periumbilical scar. Rowe's plan at that juncture was to have the plaintiff follow up with him after obtaining the CT scan and consulting with Dr. Gillego.

On May 12, 2015, the plaintiff underwent a CT scan of the abdomen, which revealed a subcutaneous seroma in the left abdomen. On June 10, 2015, the plaintiff presented to East Orange General Hospital in New Jersey with scratches and bruises over her face and body,

after apparently engaging in a fight. On examination, hospital personnel noted that the plaintiff's abdomen was soft, non-tender, and non-distended, with no rebound or guarding.

The plaintiff next presented to Rowe on July 18, 2015, and discussed the CT scan results. Upon the plaintiff's consent, Rowe aspirated the seroma, yielding 10 ml of clear fluid, and thereafter injected Kenalog into the plaintiff's left breast, as well as into her periumbilical and left lower abdominal scars. At that juncture, the plaintiff had yet to consult with the breast surgeon. According to Rowe, when he learned of this, he discussed with the plaintiff the risks of not consulting with a breast surgeon.

On August 3, 2015, the plaintiff again returned to see Rowe, who did not notice any fluid in the left abdomen. He injected Kenalog into the plaintiff's left breast, right periumbilical scar, and left abdominal scar, and directed the plaintiff to follow up with him in three to four weeks' time. The plaintiff last presented to Rowe on September 11, 2015, complaining of fluid in her left abdomen, along with supraumbilical hardness. Notwithstanding her complaints, Rowe observed that her abdomen was soft and without distention, inasmuch as he palpated her abdominal area and did not observe any hardness in the supraumbilical area. Rowe recommended that the plaintiff follow up with Lenox Hill Radiology for a possible catheter placement and general surgery for supraumbilical hardness, and to return to see him after these consults. According to Rowe, he explained to the plaintiff that, if there were any fluid extant, but that he could not observe it, a radiologist would be able to see it on sonogram. After September 11, 2015, the plaintiff had no further communication with Rowe.

On January 8, 2016, the plaintiff presented to family medicine practitioner Uzma A. Chatha, M.D. Dr. Chata noted that the plaintiff was being treated by a gastroenterologist for gastroesophageal reflux disease. On examination, Dr. Chata concluded that the plaintiff's abdomen was soft, non-tender, and non-distended, and noted the surgical scar on the plaintiff's lower abdomen. On August 23, 2015, the plaintiff presented to dermatologist Marc Glashofer, M.D., reporting she had "skin problems" and was breaking out on her arms and legs. On

examination, Dr. Glashofer noted abdominal lichen simplex chronicus (LSC), a localized, well-circumscribed area of thickened skin resulting from repeated rubbing, itching, and scratching of the skin, which appeared to him as a black patch. He also noted dyschromia, a change in the color of the skin, on the plaintiff's abdomen and face, which appeared to him as hyperpigmented patches. Dr. Glashofer additionally reported the presence of a dermatofibroma, or a cutaneous nodule, on the plaintiff's right knee. Dr. Glashofer injected Kenalog into the LSC sites on the plaintiff's abdomen and face.

On December 30, 2016, the plaintiff presented to internist Pranay Bhatt, M.D., who noted that she reported no abdominal pain and did not have any tenderness on palpation. The plaintiff returned to Dr. Bhatt's office on March 16, 2017, reporting dysphagia and heartburn, but denied abdominal pain and, according to Dr. Bhatt, had no abdominal tenderness on palpation. The plaintiff thereafter had follow-up visits with Dr. Bhatt on April 21, 2017, August 14, 2017, November 6, 2017, and December 5, 2017, each time denying the presence of abdominal pain. Dr. Bhatt noted, after each examination, that the plaintiff's abdomen was soft, non-tender, and without rebound or guarding.

The plaintiff thereafter presented to dermatologist Jeanine Downey, M.D., at Image Dermatology, P.C., on December 13, 2017, January 3, 2018, February 14, 2018, April 4, 2018, and May 23, 2018. After each visit, Dr. Downey noted that the plaintiff had hypertrophic papules and plaques on her abdomen, dorsal forearm, right lower extremity, left hairline, and posterior upper thighs/hips. The dermatologist assessed these conditions as lichen planus, a chronic inflammatory and immune-mediated disease that affects the skin, as opposed to prurigo nodularis, a chronic inflammatory skin disease characterized by an extremely itchy rash that appears most commonly on the arms, legs, the upper back, and/or the abdomen. The dermatology charts noted that the plaintiff evinced hyperpigmented papules and plaques, as well as keloids. On April 11, 2018, the plaintiff was examined by gastroenterologist Warren Finkelstein, M.D., whose assessment was that the examination was unremarkable, except for

the scar on the lower abdomen. The plaintiff thereafter saw Dr. Bhatt on June 25, 2018, August 6, 2018, September 20, 2018, and denied complaints of abdominal pain at each of those examinations, which, according to Dr. Bhatt, revealed that the plaintiff's abdomen was soft, non-tender, and without rebound or guarding. On November 21, 2018, the plaintiff presented to the office of internist Richard C. Bezozo, M.D. She denied abdominal pain and, on examination, her abdomen was noted to be soft, and without tenderness or guarding. Dr. Bhatt saw plaintiff again on February 1, 2019 and February 15, 2019. On both of those occasions, she denied complaints of abdominal pain and, on examination, her abdomen was soft, non-tender, and without rebound or guarding. The plaintiff returned to Dr. Finkelstein on May 8, 2019, at which time he noted that her abdomen was soft and non-tender. A May 9, 2019 CT scan of the plaintiff's abdomen and pelvis demonstrated "interval resolution of the previously seen seroma in the left upper ventral abdominal wall, with a small area of residual scarring, [and an] otherwise unremarkable CT of the abdomen."

III. THE PLAINTIFF'S ALLEGATIONS

In her complaint, the plaintiff alleged that, between May 27, 2014 and September 11, 2015, she was a patient of the Rowe defendants. She asserted that they committed medical malpractice by improperly performing a bilateral breast reduction procedure, abdominoplasty, and umbilical, epigastric, and ventral hernia repair procedures. The plaintiff averred that the improper performance of these procedures caused the development of a large fluid collection in her mid and lower abdominal regions, as well as a deformity of her abdomen. In addition, the plaintiff asserted that the Rowe defendants failed to obtain her fully informed consent to the procedures by failing to disclose all of the risks and hazards of the procedures, as well as the alternatives thereto.

In her bills of particulars as to the Rowe defendants, the plaintiff, adverting specifically to her July 9, 2014 surgery, asserted that those defendants committed malpractice in

> "improperly performing bilateral breast reduction; in causing excessive scarring around the left areola; in choosing an improper and inappropriate surgical technique for plaintiff's breast size and shape; in causing a noticeable difference in size and position of plaintiff's breasts bilaterally; in failing to correct scarring of left areola intra operatively; in causing excessive tension on suture lines; in utilizing the wrong surgical approach; in improperly performing abdominoplasty; in improperly performing umbilical and ventral hernia repair; in causing and allowing an inordinate period of severe abdominal swelling with unabating fluid discharge; in causing a fluid collection on the abdominal area and in failing to effectively drain same; in causing and creating numerous scars on plaintiff's abdomen and left and right flanks; in abandoning plaintiff."

The plaintiff claimed that, as a consequence of those departures from good and accepted practice, she was caused to sustain severe hypertrophic scar formation around her left areola, bilateral breast asymmetry, severe hypertrophic scars on her abdomen and flanks bilaterally, fluid collection with prominent bulge in her abdomen, tissue ischemia in her breasts bilaterally, as well as in her abdomen and flanks, cosmetic deformity, shame, humiliation, and embarrassment, and loss of enjoyment of life. In other submissions to the court, the plaintiff alleged that the Rowe defendants also improperly and prematurely removed drainage tubes postoperatively, and failed to prescribe antibiotics prophylactically, particularly where signs of infection, including pain and swelling, were present.

III. THE SUMMARY JUDGMENT MOTION

In support of their summary judgment motion, the Rowe defendants submitted the pleadings, the plaintiff's bills of particulars, the transcripts of the parties' depositions, relevant medical records, an attorney's affirmation, and the expert affirmation of Alan M. Engler, M.D., a physician with experience in both general and plastic and reconstructive surgery. He opined that the Rowe defendants did not depart from good and accepted practice, that the July 9, 2014 surgery was completed without complications, and that, although the plaintiff thereafter developed scarring and seroma formation, those conditions were known complications of the procedure that could not have been avoided in this case. Dr. Engler further concluded that the Rowe defendants' conduct did not cause or contribute to the plaintiff's claimed injuries. In addition, Dr. Engler averred that Rowe appropriately and fully advised the plaintiff of the risks

and benefits of, and alternatives to, a breast lift/reduction procedure, abdominoplasty, and hernia repair, including potential scarring, breast asymmetry, fluid retention, the feeling of "fullness," skin discoloration, delayed healing, infection, the loss of the umbilicus, and the potential need for further surgery. He noted that the informed consent forms signed and initialed by the plaintiff provided detailed descriptions of these potential risks.

Dr. Engler asserted that all breast reduction procedures leave scars in one or more areas of the breast, and that scarring is almost always present around the areola. As he explained it, in many cases, there is also a vertical scar that extends down the face of the breast from the lowest point of the areola, as well as a horizontal scar underneath the breast in the inframammary crease. Dr. Engler opined that any scarring, including hypertrophic and keloid scarring, were known and accepted risks of both the breast-reduction and abdominoplasty procedures, and scarring is more common in patients with darker skin, such as the plaintiff.

Dr. Engler opined that Rowe utilized a proper surgical technique for the plaintiff's bilateral breast reduction procedure, specifically asserting that a medial pedicle vertical type incision reduction was an appropriate surgical technique and was consistent with the standard of care. He further opined that Rowe properly performed the bilateral breast reduction procedure. Dr. Engler noted that the plaintiff presented with asymmetrical breasts and that, although Rowe attempted to produce symmetry with the breast reduction, slight differences in breast symmetry are common even after the procedure and can occur, as it did here, in the absence of negligence. Dr. Engler rejected the plaintiff's contention that Rowe employed excessive tension on suture lines, in that tension is needed on suture lines to obtain a good aesthetic result. He opined that any scarring was not due to excessive tension on the suture lines, but to a normal post-inflammatory response to incisions generally, and, more specifically, to those for which a certain degree of tension is required in order to achieve a desirable aesthetic result. Dr. Engler further explained that, contrary to the plaintiff's contention, Rowe did not depart from good practice in failing to correct scarring of the areola intraoperatively, as

hypertrophic scarring typically does not present until approximately one to two months following an insult to the skin, while keloid scarring typically develops months to years thereafter.

Dr. Engler opined that Rowe properly performed the abdominoplasty, also known as a "tummy tuck," as well as the umbilical and a ventral hernia repair. He noted that evidence of an improper umbilical hernia repair could include loss of the belly button, which the plaintiff did not experience. Dr. Engler asserted that Rowe properly and timely removed the drains that had been placed. He explained that

> "drains are placed because there are two large raw surfaces that are in apposition with each other; namely, the undersurface of the flap (abdominal skin and fat) and the external surface of the underlying muscles. These surfaces rub against each other with movement, even including breathing. As part of the healing these two surfaces adhere (stick) to each other but until they do (a process which can take several weeks), serous fluid is generated by each of the surfaces. This fluid is absorbed by the body to some extent but the remainder is typically evacuated (removed) by drains that are inserted during surgery, as Dr. Rowe did in this case. The drainage is monitored and when it has decreased to an acceptable level (about 30 ml per day) the drains are removed, typically in a sequential manner (i.e., not both on the same day)."

Dr. Engler opined that the drainage amounts in the plaintiff's case were "well below that level" and, hence, Rowe properly discontinued the left drain once the fluid collection had decreased to 20 ml per day, properly continued to have plaintiff monitor the right drain output for one week, and properly removed the drain at the end of that week due to diminished serous fluid output. He thus disagreed with the plaintiff's allegation that she sustained unabating fluid output, and concluded that she instead developed seroma formation, which is a known risk of an abdominoplasty and/or hernia repair. As he described it, a seroma "is a collection of straw-colored fluid that accumulates under the healing skin before the repositioned skin of the stomach adheres sufficiently to the abdominal wall." Dr. Engler noted that engagement in activities that cause shearing of the abdominal wall increase the likelihood of seroma formation and that, if a seroma did develop, the proper treatment was aspiration where, as here, the plaintiff evinced no infection in the affected area. Dr. Engler explained that, in properly performing the respective aspirations, Rowe documented that serous and/or clear fluid was

aspirated, that there was no indication that the fluid was cloudy or foul smelling and, thus, no findings suggestive of infection. He noted that, in any event, Rowe's records reflected that Rowe properly prescribed the plaintiff a two-week course of prophylactic antibiotics to minimize the risk of infection, thus contradicting the plaintiff's contention that Rowe failed to do so.

Dr. Engler explained that, notwithstanding several aspirations of fluid, the May 12, 2015 abdominal CT scan revealed the presence of a subcutaneous seroma. Dr. Engler concluded that, after Rowe aspirated additional clear fluid on July 18, 2015, he made appropriate recommendations for follow-up radiological testing in both August and September 2015 since, although the plaintiff's abdomen was soft and without distention, there may have been a collection of fluid that was not observable or could not be apprehended on examination. In light of the fact that the plaintiff's complaints of abdominal discomfort ultimately resolved, Dr. Engler concluded that Rowe properly drained the plaintiff's seroma formations. In this regard, Dr. Engler noted that, following the plaintiff's last visit with Rowe, the plaintiff presented to internists Dr. Catha, Dr. Bhatt, and Dr. Bezozo and gastroenterologist Dr. Finklestein on no less than 16 occasions between January 2016 and May 2019, and consistently denied abdominal pain, after which those physicians consistently documented that the plaintiff's abdomen was soft, non-tender, and non-distended on examination. Hence, he concluded that there was no basis for the plaintiff's claim of supraumbilical hardness or severe abdominal swelling of any significance.

Dr. Engler rejected the plaintiff's contention that she sustained keloid scarring. As he explained it,

> "[k]eloid scars typically appear as raised, thickened scars that extend beyond the boundaries of the original injury or incision. Conversely, hypertrophic scars typically appear as raised scars, that may widen but do not extend beyond the original boundaries of the injury/incision. Here, based on my review of plaintiff's post-operative photographs, I do not observe scarring extending beyond the boundaries of the original injury, and thus, it is my opinion that while she has some hypertrophic scarring on her breasts and abdomen, she does not have keloid scars."

Dr. Engler opined that Rowe properly recommended to the plaintiff that, during the immediate post-operative period, she use scar massage, collagenase, and silicone sheeting to minimize potential scarring at the breast and abdominal incisions, as these are known to assist in preventing the development of unsightly post-operative scars. He noted, however, that even when a surgery is performed properly and scar-prevention treatment is utilized, a patient may still develop scars that heal in an unfavorable manner. Dr. Engler concluded that, when such circumstances arise, it would be proper to try steroid injections, such as Kenalog, to diminish the appearance of the scar.

Dr. Engler explicitly rejected the plaintiff's contention that Rowe abandoned the plaintiff, inasmuch as Rowe properly referred her for consultations with Lenox Hill Radiology and a general surgeon and instructed her to return after those consults, noting that she failed to schedule those consults or return to Rowe.

Finally, Dr. Engler opined that nothing that Rowe did or failed to do caused or contributed to the plaintiff's claimed injuries, including any hypertrophic scarring of the left breast, abdomen, and flanks or fluid collection in the abdomen, let alone tissue ischemia of the breasts, abdomen and flanks, for which he claimed there was no evidence in any event.

In opposition to the Rowe defendants' motion, the plaintiff relied on the same documentation that they submitted, and also submitted her attorney's affirmation and her own affidavit, in which she made conclusory allegations that Rowe improperly performed the various procedures upon her and caused unnecessary and excessive scarring, as well as excessive fluid build-up. She did not submit an affirmation or affidavit of any physician, let alone a plastic surgeon.

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]).

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).

"'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 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 at 368 [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]).

The Rowe defendants established, prima facie, that they did not depart from good and accepted medical practice, as Dr. Engler unambiguously concluded that they comported with applicable standards of care in recommending the several procedures that they performed upon the plaintiff, properly performing the surgeries, and provided appropriate post-surgical care and recommendations. Since the plaintiff did not oppose the motion with an expert affirmation or affidavit, she has failed to raise a triable issue of fact in opposition to the Rowe defendants' showing. Consequently, that branch of the Rowe defendants' motion seeking summary judgment dismissing the medical malpractice cause of action must granted.

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]).

"'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]).

The Rowe defendants established, prima facie, that the consent that they obtained from the plaintiff was qualitatively sufficient, in that Rowe both explained the risks, benefits, and alternatives in detail to the plaintiff, and obtained her signature on numerous consent forms that reiterated, in detail, the relevant information concerning the risks, benefits, and alternatives. Since the plaintiff did not oppose the motion with an expert affirmation or affidavit, she has failed to raise a triable issue of fact in opposition to the Rowe defendants' showing in this regard (*see* CPLR 4401-a; *Gardner v Wider*, 32 AD3d 728, 730 [1st Dept 2006]).

VI. REMAINING DEFENDANTS

On or about January 5, 2018, the plaintiff discontinued the action against the defendants Daniel Rosen, M.D., and Jennifer Capla, M.D.

On April 14, 2017, the plaintiff served process upon the defendant CSC by delivering two copies of the summons and complaint to the Secretary of State. CSC thus was required to answer, appear, or move with respect to the complaint on or before the first business day (*see* General Construction Law § 25-a) after the lapse of 30 days following service of process (*see* CPLR 320[a], 3012[c]), or until May 15, 2017. CSC did not do so and, hence, was in default as of May 16, 2017.

CPLR 3215(c) provides that:

> "[f]f the plaintiff fails to take proceedings for the entry of judgment within one year after the default, the court shall not enter judgment *but shall dismiss the complaint as abandoned, without costs, upon its own initiative* or on motion, unless sufficient cause is shown why the complaint should not be dismissed. A motion by the defendant under this subdivision does not constitute an appearance in the action."

(emphasis added). The plaintiff failed to take any proceedings for the entry of a default judgment against CSC on or before May 16, 2018. "The language of CPLR 3215(c) is not

discretionary, and a claim for which a default judgment is not sought within the requisite one-year period will be deemed abandoned" (*Wells Fargo Bank, N.A. v Martinez*, 181 AD3d 470, 471 [1st Dept 2020]; *see HSBC Bank USA, N.A. v Slone*, 174 AD3d 866, 867 [2d Dept 2019]). Consequently, the complaint must be dismissed against CSC.

Inasmuch as the action now has been resolved against all of the defendants, it must be marked disposed.

In light of the foregoing, it is

ORDERED that the motion of the defendants Norman Rowe, M.D., and Rowe Plastic Surgery for summary judgment dismissing the complaint insofar as asserted against them is granted, and the complaint is dismissed insofar as asserted against the defendants Norman Rowe, M.D., and Rowe Plastic Surgery; and it is further,

ORDERED that the action is severed as against the defendants Norman Rowe, M.D., and Rowe Plastic Surgery; and it is further,

ORDERED that the Clerk of the court shall enter judgment dismissing the complaint insofar as asserted against the defendants Norman Rowe, M.D., and Rowe Plastic Surgery; and it is further,

ORDERED that, on the court's own motion, the complaint is dismissed insofar as asserted against the defendant Center for Specialty Care.

This constitutes the Decision and Order of the court.

3/22/2023
DATE

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