Munoz v New York Presbyt.-Columbia Univ. Med. Ctr.
2023 NY Slip Op 31317(U)
April 10, 2023
Supreme Court, New York County
Docket Number: Index No. 805037/2017
Judge: John J. Kelley

SUPREME COURT OF THE STATE OF NEW YORK
NEW YORK COUNTY

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

Justice

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ADONIS MUNOZ,

Plaintiff,

- v -

NEW YORK PRESBYTERIAN-COLUMBIA UNIVERSITY MEDICAL CENTER, MARIA VALERIA SIMONE, M.D., and RACHEL CAMPBELL, M.D.,

Defendants.

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INDEX NO. 805037/2017

MOTION DATE 11/23/2022

MOTION SEQ. NO. 001

DECISION + ORDER ON MOTION

The following e-filed documents, listed by NYSCEF document number (Motion 001) 31, 32, 33, 34, 35, 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, 66, 67, 68, 69, 70, 71, 72

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

I. INTRODUCTION

In this action to recover damages for medical malpractice based on alleged departures from good and accepted practice, the defendants move pursuant to CPLR 3212 for summary judgment dismissing the complaint. The plaintiff opposes the motion. The motion is granted to the extent that the defendants are awarded summary judgment dismissing all of the claims asserted against the defendant resident Rachel Campbell, M.D., and dismissing the claims asserted against the defendant surgeon Maria Valeria Simone, M.D., and the defendant hospital New York Presbyterian-Columbia University Medical Center (NYPH) that sought to recover for (a) the creation or exacerbation of diagnosable psychiatric injuries that allegedly manifested themselves subsequent to the plaintiff's March 26, 2016 discharge from NYPH and (b) the plaintiff's inability to secure employment in the United States Marine Corps or pursue a career in the field of modeling. The motion is otherwise denied.

II. FACTUAL BACKGROUND

The crux of the plaintiff's claim is that, on March 16, 2016, Simone, assisted by Campbell, negligently performed an open umbilical hernia repair procedure, with mesh placement, at NYPH. Specifically, he alleged that the mesh implant was improperly placed and sutured, so that a small loop of his bowel was caught between the mesh and his anterior abdominal wall, leading to diffuse ischemia and necrosis of bowel tissue, thus necessitating both a subsequent exploratory laparotomy on March 18, 2016 and a second surgery on March 21, 2016 to repair the bowel and remove the dead tissue. The plaintiff further alleged that, while recovering from these surgeries at NYPH in late March 2016, he became confused, aggressive, and paranoid, and that, as a consequence of the surgical trauma, he suffered from even more severe psychiatric conditions several years later that caused him to be rejected from the United States Marine Corps and lose the opportunity to pursue a modeling career.

For some time prior to March 1, 2016, the plaintiff complained to one of his relatives, Amarillis Nunez, that he was suffering from pain in his umbilical area. Amarillis Nunez worked at the Charles Rangel Center, a clinic associated with NYPH, and thus assisted the plaintiff in scheduling an appointment with internist Yvette Ortiz, M.D., who worked at that clinic. On March 2, 2016, Dr. Ortiz saw the plaintiff as an outpatient, at which time he repeated his complaints. He reported a score of 17-20 on a PHQ-9 test, which is employed to screen for clinical depression. According to the defendants, that score indicated that the plaintiff was in the moderate-to-severe range for depression. Dr. Ortiz's assessment was that the plaintiff was a depressed, but otherwise healthy, male, who had been followed by a social worker. Dr. Ortiz reported that the plaintiff refused medications and wanted only to exercise and meditate. She formulated a plan for umbilical hernia repair surgery. Dr. Ortiz referred the plaintiff to the NYPH Surgery Clinic for further evaluation, and he was examined there on March 10, 2016. The plaintiff's chief complaint at that time was pain at his umbilical area when lifting weights. His history indicated that he was a 21-year-old male, with no significant past medical history, who

was presenting for evaluation of an umbilical hernia, and reporting an approximately one-year-long history of umbilical pain when lifting weights that compelled him to stop those exercises. The assessment at the Surgery Clinic was of a symptomatic umbilical hernia, with the plaintiff seeking surgical correction, and a recommendation of an open umbilical hernia repair. Upon examination by Simone, who was in charge of the Surgery Clinic at that time, he presented with a small, reducible hernia in the umbilicus. Simone recommended that the plaintiff undergo an open procedure, as compared to a laparoscopic approach, because the plaintiff was athletic, young, and healthy, with good tissue. She also recommended the placement of mesh as part of the repair, in addition to the primary closure of the defect.

NYPH scheduled the surgery for March 16, 2016, and the plaintiff executed a consent for surgery on that date authorizing Simone to perform an open umbilical hernia repair, with placement of mesh. Simone classified the hernia as a symptomatic umbilical hernia that was "non-incarcerated" because it was reducible which, according to the defendants, meant that the contents within the hernia sac could be manually pushed intraabdominally and, thus, presented a transient, but not a permanent, issue.

Simone performed the surgery at NYPH on March 16, 2016, and was assisted by Campbell, who was then a resident at NYPH. As set forth in the operative report, the hernia defect measured one centimeter (cm) by two cm. Simone employed a mesh measuring four cm by four cm to allow for an appropriate overlap. In the course of the dissection, Simone opened the peritoneum constituting the hernia sac, upon which she decided to employ an intraabdominal dual layer Ventralex composite mesh, with an adhesion barrier of hydrogel on the visceral side. According to the defendants, the side of the mesh coated with hydrogel is placed on the visceral side in order to prevent adhesions, while the side that allows tissue ingrowth is meant to abut the peritoneum and the umbilical closure. The defendants did not remember whether Simone or Campbell inserted the mesh, but both of those physicians testified that, if Campbell performed that task, it was under Simone's direct supervision. The

mesh was secured to the fascia in an underlay fashion, with interrupted 2-0 Prolene suturing, which, according to the defendants, meant that each stitch was separate and independently knotted. Simone testified at her deposition that it was her custom and practice to conduct sweep with her finger to ensure correct placement of the mesh and suturing, and to ensure that the mesh was deployed flat and up against the underside of the abdominal wall. The defendants claimed that, after sutures were placed, Simone performed another digital sweep and that a strap that had been employed to "tense up" the mesh was thereafter removed.

According to the intraoperative report, Simone commenced the surgery at 7:57 a.m. on March 16, 2016, completed it at 9:11 a.m., and sent the plaintiff to the post anesthesia care unit (PACU) at 9:25 a.m. On his arrival at the PACU, the plaintiff was noted to be slightly drowsy but arousable and oriented as to person, place, and time, and was administered three liters of oxygen via nasal cannula, with his respirations even and nonlabored. The plaintiff had no complaints of respiratory distress, chest pain, chest pressure, or chest discomfort, and his abdomen was soft, non-distended, and tender to the touch. Upon concluding that the plaintiff evinced an appropriate body temperature and level of consciousness, optimal pain relief, and acceptable blood pressure levels and heart rat, Simone discharged the plaintiff from the PACU at 3:20 p.m. At that time, he was instructed to notify Simone if he experienced fever, chills, increased redness, severe pain, or increased drainage, and to limit his activities for 24 hours.

On March 17, 2016, the plaintiff returned to NYPH, where, in triage, he complained of frequent hiccups since his discharge, with pain at the surgical site, and the absence of a bowel movement since the surgery. He also presented with a fever and abdominal signs that were concerning for peritonitis. The differential diagnosis included bowel obstruction, perforation, and infection. The attending emergency medicine specialist noted the plaintiff's history, and included a note that the plaintiff had no bowel movement, little or no urine output, and presented with a body temperature of 102 degrees Fahrenheit. At that time, the plaintiff was tender in response to minimal palpation in the right lower quadrants, with localized rebound tenderness

near the incision. The attending physician expressed concern that the plaintiff either was bleeding internally, or that there was a perforation of the peritoneum, with evolving peritonitis. NYPH personnel performed a computed tomography (CT) scan of the plaintiff's abdomen and pelvis, which showed the presence of fluid-filled distended loops of small bowel tissue throughout his abdomen that predominantly involved the jejunum, with the tethering of a very short segment of the small bowel along the anterior abdominal well along the midline surgical site. Upon obtaining the plaintiff's consent, NYPH surgeon Jennifer Kuo, M.D., performed an exploratory laparotomy early in the morning of March 18, 2016. During the exploratory laparotomy, Dr. Kuo identified and removed the umbilical mesh. She brought the small bowel into the operative field and examined it. According to the defendants, there was a clear demarcation between healthy and dead bowel tissue, and Dr. Kuo removed approximately 90 cm of ischemic jejunum. Dr. Kuo concluded that a small loop of bowel tissue had been caught between the mesh and the anterior abdominal wall, leading to diffuse ischemia, although Simone testified at her deposition that, at the time that she closed the hernia repair on March 16, 2021, her digital sweep revealed that no bowel tissue had been caught or trapped.

After Dr. Kuo resected the ischemic small intestine segment, she performed a side-to-side anastomosis of the bowel ends. Following the anastomosis, Dr. Kuo examined the small bowel from end to end, noting no other abnormalities or signs of perforation. The plaintiff thereupon was discharged to the PACU. At approximately 2:00 p.m. on March 18, 2016, Dr. Kuo was paged to the PACU after the plaintiff was noted to be tachycardic, as his heart rate measured from 140-169 beats per minute, and hypotensive, as his systolic blood pressure reading was at 90 millimeters of mercury, despite the administration of a phenylephrine drip. The plaintiff's abdomen was noted to be tense on examination, and Dr. Kuo suspected abdominal compartment syndrome. The plaintiff was promptly returned to the operating room for further exploration.

Simone thereupon performed another exploratory laparotomy and noted that the small bowel was swollen and ischemic, with approximately 1.5 liters of fluid in the abdomen. Simone characterized this condition as abdominal compartment syndrome. She drained the fluid, after which she contended that the color of the bowel improved dramatically. In her operative note, Simone indicated that, after decompression of the bowel, the prior resection and anastomosis site were intact. Upon examination of the bowel, Simone concluded that there was no evidence of perforation. Simone permitted the abdominal surgical wound to remain open, with a vacuum-assisted wound closure device (wound VAC) installed at the surgical site.

On March 21, 2016, NYPH surgeon Tracey Arnell, M.D., removed the wound VAC and loosely closed the abdominal wound. On March 22, 2016, the plaintiff was extubated and his central line was removed, at which time his white blood count was measured at 7,000 cells per microliter of blood. NYPH personnel terminated the administration of blood pressure medications upon concluding that they no longer were needed. On March 23, 2016, while recovering at NYPH, the plaintiff progressively become more confused, and indicated that he wanted to leave the hospital. According to the defendants, he became aggressive towards his family, who was visiting with him, he punched furniture, and he asserted that his hospital roommate was planning on sexually abusing him. NYPH personnel contacted hospital security. The plaintiff was administered the antipsychotic medication Haldol, and placed on one-to-one supervision. By March 25, 2016, the plaintiff reported improved pain levels, and, according to the defendants, was doing well. On March 26, 2016, NYPH's physical therapy department reported that the plaintiff was fully functional, safe, and independent in his mobility. NYPH discharged the plaintiff to his home later that day. As the defendants characterized it, since that date, the plaintiff has denied the presence of any gastrointestinal issues, has not seen any gastroenterologists, has not made any complaints of abdominal pain, and has not seen any plastic surgeons in connection with his abdominal scar.

With respect to the plaintiff's psychiatric history, he had initial evaluations at NYPH's pediatric psychiatry department for anger management in 2008, when he was 12 years of age, at which time he had engaged in episodes of punching walls and breaking things in his apartment. As the defendants noted, the plaintiff had academic difficulty in both the first and third grades, and was required to repeat both of those grades. He also did not know his biological father, and only learned of his biological father's identity at age 15, upon which his sisters reported that he became quite sad. After a series of visits to NYPH in 2008, the plaintiff was diagnosed with Axis I problem of parent-child relationship, intermittent explosive disorder, attention deficit hyperactivity disorder, learning disorder, and borderline intellectual functioning.

Although there was no evidence that the plaintiff suffered from any acute psychiatric incidents between his March 26, 2016 discharge from NYPH and January 31, 2018, on the latter date, the plaintiff was brought in by ambulance to NYPH due to complaints of depression and suicidal ideation with a plan, after creating self-inflicted wounds to his left forearm, four of which were new, and several of which were old and scarred. The plaintiff reported cutting his arm and neck with a box cutter prior to intervention by his family, who called 911. Although the plaintiff denied preceding auditory or visual hallucinations, his sister advised NYPH that the plaintiff had in fact told her of hearing voices and that he had threatened people close to him, including his mother. Between 2018 and 2021, the plaintiff was hospitalized on several occasions for treatment of depression, bipolar disorder, alcohol and recreational drug abuse, psychotic events, violent outbursts, and auditory hallucinations, as well as suicidal ideation and self-inflicted cutting wounds. According to the defendants, most of the psychiatrists who treated him during this period of time reported that the plaintiff referred to childhood traumas, including alleged incidents of sexual abuse at the hands of a neighbor, as a partial cause of his current condition, but did not refer to the umbilical hernia repair and mesh replacement surgeries or revisions as having contributed to his mental state.

III. THE PLAINTIFF'S CONTENTIONS

In his complaint, the plaintiff made general allegations that the defendants departed from good and accepted medical practice in treating his umbilical hernia and performing the initial umbilical repair surgery, and that the departures caused physical and emotional injuries.

In the plaintiff's bill of particulars, he asserted that the defendants departed from good and accepted practice in failing to obtain a complete and accurate medical history and in failing to perform a complete physical examination. He asserted that the defendants failed to appreciate and be cognizant of his complaints or pertinent physical findings. In addition, the plaintiff averred that the defendants negligently performed the umbilical hernia repair with mesh on March 16, 2016 by, among other things, negligently and carelessly implanting, inserting, and sewing the mesh in a manner that was contrary to the manufacturer's instructions. He contended that the defendants negligently caused him to sustain a compromised and injured intestine during the March 16, 2016 surgery when they inserted and sewed the surgical mesh laparoscopically and, thus, employed improper surgical techniques during the procedure.

The plaintiff further asserted that the defendants failed to recognize the emergency nature of his condition following umbilical hernia repair surgery and, thus, delayed the diagnosis and treatment of his injured intestine, failed to prevent the deterioration of his condition, and failed to protect him from a compromised and injured intestine. He claimed that the defendants failed to order or perform necessary and indicated diagnostic tests and studies, failed to correctly interpret radiological studies, failed to order, perform, or request additional radiological studies, and failed to address or formulate an indicated and appropriate medical plan.

The plaintiff averred that, as a proximate result of the defendants' malpractice, he was caused to suffer from a compromised and injured intestine, resulting in bowel incarceration, bowel swelling, a necrotic and ischemic jejunum, hemorrhagic ascites (excess abdominal fluid), abdominal compartment syndrome, septic shock and generalized inflammatory response, vasodilatory shock, vasodilatory hypotension, lactic acidosis, acute kidney injury, ischemic liver

injury, ischemic hepatitis, atelectasis, internal adhesions, thrombocytopenia, and coagulopathy. He further alleged that he suffered from postoperative respiratory failure with intubation, an open abdomen, pneumatosis, swelling, infection, induced coma, digestive problems, gastrointestinal issues, tachycardia, acid reflux, weight loss, and bloating, along with abdominal pain, fever, epigastric pain, dizziness, nausea, and vomiting. In addition to alleging generalized emotional distress arising from the initial surgery and additional repair surgery, the plaintiff asserted that the defendants' malpractice caused him to sustain post-traumatic stress disorder and depression.

The plaintiff further asserted that, as a proximate result of the defendants' malpractice, he was caused to undergo several otherwise unnecessary operative procedures. The first unnecessary procedure alleged by the plaintiff was the March 18, 2016 exploratory laparotomy and decompression, with the resection of jejunum, requiring a primary stapled anastomosis and necessitating an abdominal wound VAC placement, with the wound left open. The second unnecessary procedure alleged by the plaintiff was the March 21, 2016 abdominal exploration and wound closure. The third procedure involved the removal of the wound VAC. The plaintiff asserted that, as a consequence of those additional surgeries, he was left with significant and disfiguring surgical scarring, extending approximately from his chest to his groin, and was caused to submit to a prolonged hospital stay. He also contended that he sustained suffered damage to his self-image and to his ability to pursue a planned career in modeling.

IV. THE SUMMARY JUDGMENT MOTION

In support of their motion, the defendants submitted the pleadings, the bill of particulars, relevant medical, hospital, and psychiatric records, transcripts of the parties' and nonparty witnesses' depositions, a statement of facts, an attorney's affirmation, and the expert affirmations of board-certified surgeon Todd Heniford, M.D., and board-certified psychiatrist and neurologist Steven Fayer, M.D. The court notes that, where a court directs the parties to submit a statement pursuant to 22 NYCRR 202.8-g(a), that statement must set forth "material facts as

to which the moving party contends there is no genuine issue to be tried." Although the court did not direct the parties to provide such a statement in this action, the defendants nonetheless elected to do so here, but did not limit their statement to alleged undisputed facts, instead asserting opinions and making several allegations that were clearly in dispute. In connection with this motion, the court only considered the facts set forth in that statement that the defendants clearly intended to characterize as undisputed.

Dr. Heniford opined that Simone's decision to perform an umbilical hernia repair with mesh as an open procedure, versus a laparoscopic approach, was well within the standard of care, and appropriate in the plaintiff's case. Specifically, he averred that long-term activity limitations and discomfort are reduced in patients who undergo open surgery, and that there usually is less scarring in those who submit to open surgery rather than a laparoscopy. He further concluded that the actual performance of the umbilical hernia repair with mesh, the postoperative management in the PACU following the hernia surgery, and all of the collective care and management, including all of the surgeries performed during the plaintiff's March 17, 2016 to March 26, 2016 hospitalization, were within acceptable standards of medical and surgical practice as they existed in 2016. Dr. Heniford asserted that the defendants performed all necessary testing, appreciated the results of such testing, including all radiological and laboratory work, performed the three subsequent procedures, and managed the plaintiff's surgical care from his admission up until his discharge on March 26, 2016 in a proper and timely fashion. Dr. Heniford further opined that nothing that the defendants did or did not do proximately caused any gastrointestinal injuries or limitations on the plaintiff's physical capabilities, including his desire to join the Marines.

Dr. Heniford asserted that Simone, as the attending surgeon, properly supervised Campbell, and that all of Campbell's conduct in the operating room was under Simone's direct supervision and visualization. As he characterized it, that would include the necessary dissection, at which time the peritoneum was opened, or "violated," as the operative report

phrased it. Dr. Heniford concluded that all of the decisions that Simone made during the hernia repair were appropriate, and that "violating" or "opening" the peritoneum during an open hernia repair was neither uncommon nor a departure from accepted surgical practice. He explained that, once the peritoneum was opened, it was proper for Simone to utilize an intraabdominal dual layer mesh with an adhesion barrier to prevent any abdominal contents from adhering to the mesh.

Dr. Heniford went on to opine that, "based on the size of the hernia defect of 1 cm by 2 cm in size, . . . using a 4 cm by 4 cm mesh or even the medium sized mesh, would be an appropriate size to use to allow for tissue mesh overlap." Dr. Heniford further asserted that the mesh was placed in a proper fashion, and that the suturing of the mesh to the anterior abdominal wall was properly considered and performed, in that the 2-0 Prolene sutures that Simone employed were separate and independently knotted. Dr. Heniford approved of Simone's decision to conduct two separate finger sweeps of the surgical area to ensure the correct placement of the mesh and suturing. He further concluded that Simone properly attached straps to the mesh in order to "tense up" against the abdominal wall, and thereafter properly removed them. Dr. Heniford asserted that Simone appropriately took one hour and 14 minutes to complete the initial repair procedure.

Dr. Heniford further concluded that Simone and NYPH properly monitored the plaintiff in the PACU and properly discharged him, with no complaints of respiratory distress, chest pain, or chest discomfort, and that, upon his discharge, his abdomen was soft, non-distended, and tender to the touch. He asserted that Simone provided the plaintiff with proper discharge instructions. Dr. Heniford explained that, when the plaintiff returned to NYPH the day after the initial procedure, with complaints of abdominal pain, and a history of very strong and frequent hiccups, reduced urine output, and a temperature of 102 degrees, NYPH properly and timely performed a CT scan of the abdomen and pelvis, indicating the presence of fluid-filled, distended loops of small bowel tissue throughout the abdomen, predominantly involving the

jejunum, albeit without a definite transition point, which was thus most compatible with a diagnosis of postoperative ileus. He noted that further findings included tethering of the short segment of the small bowel along the anterior abdominal wall along the midline surgical site and an elevated white blood cell count.

Dr. Heniford opined that it was appropriate to bring the plaintiff immediately back to the operating room early in the morning of March 18, 2016 for an exploratory laparotomy, and that this procedure was timely undertaken. Although Dr. Heniford conceded that Dr. Kuo, who performed that exploratory procedure, reported that a small loop of bowel tissue was caught between the umbilical mesh and the anterior abdominal wall, Dr. Heniford concluded that there

> "is no evidence that the mesh used in the hernia repair was placed improperly based upon Dr. Kuo's operative report. There is no evidence that sutures were improperly placed such as sewing the bowel to the mesh or to the abdominal wall. Accordingly, there is no evidence of the hernia repair with mesh placement being improperly performed. The unfortunate complication of the bowel possibly being caught between the mesh and the anterior abdominal wall, as identified by Dr. Kuo in her operative report, causing 90 centimeters of ischemic jejunum to be removed, is not evidence of any departures from accepted practice in the performance of the hernia repair. Rather, this complication would fall within the risks of a hernia repair, which includes injury to nearby structures or intestinal injury. This unfortunate occurrence happened without malpractice or any departures from accepted practice by Dr. Simone, Dr. Campbell Hooper or any other staff in their performance of the hernia surgery."

He opined that, "given the history of extreme frequent and strong hiccups repeatedly suffered by Mr. Munoz immediately from the time of his discharge from the PACU," the hiccups "likely resulted in one side of the patch dipping down and allowing the bowel to get caught between the mesh patch and the underside of the abdominal wall," a conclusion that was appropriate in light of the fact that Dr. Kuo's operative report was silent as to whether any stitches were placed improperly through the bowel or whether the mesh was placed improperly. As he phrased it "[t]he ensuing occurrence and complications *may have been* as a result of his significant frequent and strong hiccups which *likely* allowed for the bowel to become trapped and is through no fault of trauma" (emphasis added).

Dr. Heniford asserted that the small intestine is approximately 23 feet in length on average, and that the plaintiff's loss of approximately 3 feet of intestine should have no future adverse consequences for him, such as compromised digestion or nutrient absorption. He opined that, after Dr. Kuo resected the ischemic small intestine, she performed a proper side-to-side anastomosis of the bowel ends that had been cut, and that, upon completion of her surgery, she properly checked for any other signs of perforation or other abnormalities

Dr. Fayer asserted that he performed an extensive psychiatric examination of the plaintiff on January 6, 2022. He opined that, although the plaintiff did indeed manifest clinically significant psychiatric disturbances, with a history of Bipolar 1 Disorder with psychotic features, the most recent of which was a manic episode, and polysubstance abuse disorder, none of his psychiatric conditions was proximately caused by any of the surgeries at NYPH.

Dr. Fayer noted that, over the years, the plaintiff had experienced several manic episodes that manifested as a distinct period of abnormally and persistently elevated, expansive, or irritable mood, and abnormally and persistently increased goal-directed activity or energy, lasting at least one week. As he explained it,

> "[t]his has included flights of ideas, distractibility, inflated self-esteem, as well as psychotic symptoms including auditory hallucinations and paranoid delusions. His psychiatric hospitalizations have documented a diagnosis of bipolar disorder with psychotic features."

He further asserted that, in addition to the plaintiff's longstanding polysubstance use disorder, he had abused alcohol, marijuana, cocaine, and Ecstasy, and concluded that it was not unusual for individuals with bipolar disorder to have comorbid substance abuse and dependency.

According to Dr. Fayer, the plaintiff's bipolar disorder had largely been controlled by medication, including lithium carbonate, but that he had a poor history of compliance in taking his medications, as noted both in his records and in Dr. Fayer's own examination. As Dr. Fayer explained, although the plaintiff stopped taking his medications as of January 2021, and his bipolar disorder appeared to be stable as of January 2022, the plaintiff nonetheless reported

frequent episodes of depression and alcohol abuse. Dr. Fayer reported that the plaintiff had made multiple suicide attempts, including self-injurious behavior, by cutting himself. As he explained it, the plaintiff applied for induction into the United States Marine Corps, but had failed to written test prior to the 2016 surgeries, and was not accepted for that reason.

Dr. Fayer also reported that, during his examination of the plaintiff, when the plaintiff discussed his 2016 surgeries at NYPH,

> "he was not emotionally upset and showed his scars to.me on his arms and his abdomen. His demeanor was cooperative and forthcoming and was not hostile or angry. He appeared calm and relaxed with no psychomotor agitation or irritability, and he did not appear hyperactive. He spoke in a regularly paced voice with good intonation, and there were no racing thoughts and no flight of ideas during our discussion. He offered no complaints of hypervigilance, flashbacks, nightmares, or any other symptoms consistent with posttraumatic stress disorder as related to his surgeries."

Dr. Fayer concluded that the plaintiff did not suffer from post-traumatic stress disorder, and that the plaintiff's manifest psychiatric disorders, including bipolar disorder, polysubstance use, and mixed personality disorder, were not a result of the hernia repair surgery and its complications. He stated that, "[r]ather, his psychiatric difficulties are multifactorial and secondary to his substantial psychiatric difficulties as a child and adolescent, which are precursors to the development of bipolar disorder and polysubstance abuse." Dr. Fayer thus explained that the plaintiff's multiple suicide attempts, including self-injurious behavior, were a result of his existing psychiatric disorders, and were not proximately caused by the hernia surgeries at NYPH but, rather, arose from his dual diagnosis of bipolar disorder with mixed personality disorder and polysubstance abuse, which included the excessive abuse of alcohol, marijuana, cocaine, and Ecstasy. Dr. Fayer also noted that the plaintiff's significant childhood issues, including the absence of his father and alleged sexual abuse, were precursors of his adult psychiatric condition and, thus, proximately caused his psychiatric disorders with polysubstance abuse.

In opposition to the defendants' motion, the plaintiff relied on the documents submitted by the defendants, and also submitted an attorney's affirmation, a statement of material facts, and the expert affirmation of a board-certified general surgeon.

The plaintiff's expert opined that, although the mesh employed by Simone was appropriately chosen, it was appropriate only for a repair without tension. The expert asserted that, if Simone intended to perform a tension repair, as allegedly was done here, there were other, more appropriate, mesh products that were designed for that purpose. The surgeon stated that, in this case, the Ventralex mesh was not appropriately attached to the plaintiff. Commenting on Simone's deposition testimony, in which she asserted that she employed an "underlay technique," the plaintiff's expert stated that an underlay technique is a type of tension repair, in that it anchors the outer edge of the mesh tightly to the abdominal musculature, several centimeters away from the hernia defect. As the expert explained it, "[i]nstead of being a loose mobile connection, it is a firm connection fixing the edge of the mesh disk tightly to the abdominal wall." The surgeon concluded that

> "[t]his improper technique resulted in crimping or buckling of the mesh and allowed the small intestine to get caught between the tethered mesh and the abdominal wall causing this massive loss of small intestine and near-death surgical catastrophe."

The expert continued that this type of mesh, when placed properly,

> "creates a tension free repair. As such, it is the plastic mesh that fills in the hole, the defect, that represents the hernia. The mesh is attached to the muscle and fascia in a tension free system that does not cause stretching or pulling or distortion of the disc portion of the mesh. The mesh and disk are pulled up into the hole of the hernia defect but do not trap tissue between the mesh and the abdominal wall."

With respect to Simone's testimony that she twice performed a "digital" or "finger" sweep of the surgical area, the plaintiff's expert opined that the finger sweep that she described "would have been precluded by the appropriate use of this mesh. When the mesh is applied properly there is no opportunity to release the sutures and sweep through and make sure the tissue planes are clean and then tighten up the suture." The expert noted that video instructions for

the proper use of the mesh could be found on the manufacturer's website, depicting the method for properly attaching the mesh to the fascia. According to the expert, the technique described by the manufacturer "is not an underlay suture technique" such as the one that Simone performed. As the expert described his or her experience in employing mesh, "once the mesh is properly affixed to the hernia defect, it would not be possible for the bowel to become entrapped as it did here." Therefore, the expert concluded that "if the Ventralex mesh had been appropriately attached to the patient in a tension free repair, this complication would not have occurred."

The plaintiff's expert expressly rejected Dr. Haniford's conclusion that frequent and strong hiccups caused movement and slippage of mesh so as to entrap the tissue therein. Rather, the expert opined that the hiccups were a *symptom* of the bowel ischemia, and not a cause of the "patch dipping down" and entrapping bowel tissue, a conclusion that the expert characterized as "completely speculative." The expert further opined that it was

> "incorrect and unscientific to attribute the complication to hiccups. The complication was clearly caused by improper fixation of the Ventralex mesh which allowed the small intestine to become trapped between the mesh and the abdominal wall as evidenced by the findings described in Dr. Kuo's operative report. This complication simply could not and would not have occurred if the mesh had been properly fixed in place. Hiccups are a common and well-known *symptom* of bowel obstruction, not a *cause* of disruption of a properly placed mesh - an event which I have never heard of and which to the best of my knowledge has never been a reported occurrence in medical literature."

(emphasis added). The plaintiff's expert also asserted that

> "[t]he observation by Dr. Kuo that the ischemic bowel 'was likely caught in between the mesh and the anterior abdominal wall' refers to the time of the repair, and the patient's presentation with ischemic necrotic bowel and the onset of his symptoms is completely consistent with the entrapment occurring at the time of the hernia repair as it would take some time for the entrapment to produce the ischemia, then necrosis."

Ultimately, the plaintiff's expert surgeon concluded that the improper application of the Ventralex mesh during the hernia repair allowed and caused the plaintiff's bowel to become entrapped between the mesh and the bowel wall, that such a result could not have happened if

Simone had employed a proper technique in placing and suturing the mesh, that the use of this improper technique constituted a deviation from accepted standards of care on Simone's part, and that the deviation was the cause of the bowel necrosis and ensuing surgical procedures that otherwise were avoidable.

With respect to the plaintiff's alleged psychiatric injuries, the plaintiff's expert asserted that, although he or she is a surgeon, and not a psychiatrist,

> "it is obvious to me based upon my experience as a surgeon and my medical education and training that the events which occurred after the surgery of March 16 represented a massive emotional trauma in the life of Mr. Munoz and that the physical pain from the several surgical procedures would be likely to exacerbate any pre-existing psychopathology in this young man."

The expert concluded that it was "evident" that the plaintiff experienced immense physical pain, loss of control of his body and his life, scarring, and prolonged fear of death, and such an experience "would only result in increased and extended psychological harm in a young man who was already in a fragile emotional state." The expert surgeon conceded that it was not within the scope of his or her practice formally to diagnose post-traumatic stress disorder. Nonetheless, the expert asserted that, inasmuch as the plaintiff's 2018 discharge diagnoses from Brunswick Hospital included bipolar disorder, post-traumatic stress disorder, generalized anxiety disorder, and substance abuse disorder, and he or she was not "aware of any medical or psychiatric professional having made any of those diagnoses prior to the events underlying this lawsuit," it could be concluded that the malpractice committed during the 2016 surgeries were a significant contributing cause of the "deterioration in his emotional and psychiatric condition as reflected in [the Brunswick Hospital] records."

In reply to the plaintiff's opposition papers, the defendants submitted another attorney's affirmation and a second affirmation from Dr. Haniford, in which he challenged the credentials and qualifications of the plaintiff's expert to render an opinion as to the proper use of mesh in open hernia repair surgeries. According to Dr. Haniford,

> "[t]he underlay technique used to secure the mesh patch is not a tension repair as opined by plaintiff's expert. The underlay technique was properly used for this mesh patch and in fact, the mesh patch was designed to allow a finger sweep after securing the patch with the underlay technique. There are two layers to this patch. The upper layer is present specifically to allow the surgeon to place his/her finger in between the layers for positioning (i.e. finger sweep) and lateral fixation. There is no other reason to have this second layer. Accordingly, plaintiff's expert opinions that the defendants departed from accepted practice in the performance of the hernia repair by using an underlay fashion which they claim is a tension technique to secure the mesh patch is absolutely incorrect."

Dr. Haniford categorically rejected the opinions of the plaintiff's expert that hiccups are a symptom of bowel obstruction, and that they could not have been the cause of the slippage of the mesh and concomitant bowel incarceration. Finally, Dr. Haniford characterized the plaintiff's expert's opinion as "entirely speculative and in fact erroneous."

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]).

The court notes that neither Dr. Heniford nor the plaintiff's expert surgeon are licensed to practice medicine in New York. Although a medical expert need not be licensed to practice medicine in New York for his or her affidavit to be considered by a court in connection with a summary judgment motion (*see Grey v Garcia-Fusco*, 2020 NY Slip Op 32280[U], *20 n 19, 2020 NY Misc LEXIS 3270, *30 n 19 [Sup Ct, N.Y. County, Jun. 16, 2020]; *Solano v Ronak Med. Care*, 2013 NY Slip Op 30837[U], *7, 2013 NY Misc LEXIS 170, *8-9 [Sup Ct, N.Y. County, Apr. 22, 2013]), both Dr. Heniford's affirmation and the affirmation submitted by the plaintiff's expert do not constitute admissible evidence to support or oppose the defendants' summary judgment motion since, as physicians who are not licensed to practice medicine in New York, they may not avail himself of the option to submit an unnotarized affirmation in lieu of a notarized affidavit (*see* CPLR 2106[a] [limiting the option to employ an affirmation to a "physician . . . authorized by law to practice in the state"]). The court, however, exercises its discretion and directs the defendants to submit the content of Dr. Heniford's affirmation in the form of an affidavit and the plaintiff to submit the content of his expert's affirmation in the form of an affidavit (*see* CPLR 2001; *Matos v Schwartz,* 104 AD3d 650, 653 [2d Dept 2013]; *Winslow v Syed*, 2021 NY Slip Op 33230[U], *5-6, 2021 NY Misc LEXIS 9432, *13 [Sup Ct, Dutchess County, Apr. 20, 2021]), each accompanied by a certificate of conformity, as required by CPLR

2309, which may be filed nunc pro tunc (*see Parra v Cardenas,* 183 AD3d 462, 463 [1st Dept 2020]; *Bank of New York v Singh*, 139 AD3d 486, 487 [1st Dept 2016]; *DaSilva v KS Realty, L.P.,* 138 AD3d 619, 620 [1st Dept 2016]; *Diggs v Karen Manor Assoc., LLC*, 117 AD3d 401, 402-403 [1st Dept 2014]; *Matapos Tech., Ltd. v Compania Andina de Comercio Ltda.*, 68 AD3d 672, 673 [1st Dept 2009]).

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]). Moreover, 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).

Even where an adverse outcome is a known risk of a surgical procedure, a plaintiff may raise a triable issue of fact as to whether a physician committed malpractice by showing that the outcome was caused by improper surgical or medical technique, rather than by an unexplained or incidental event (*see Bengston v Wang*, 41 AD3d 625, 626 [2d Dept 2007]; *see also Hoffman*

v Taubel, 2021 NY Slip Op 31523[U], *4-5, 2021 NY Misc LEXIS 2379, *8-9 [Sup Ct, N.Y. County, Apr. 30, 2021] [Kelley, J.], *affd* 208 AD3d 1099 [1st Dept 2022]; *Mathias v Capuano*, 2015 NY Slip Op 32160[U], *5-6, 2015 NY Misc LEXIS 4141, *12-14 [Sup Ct, Suffolk County, Nov. 5, 2015]; *cf. Henry v Duncan*, 169 AD3d 421, 421 [1st Dept 2019] [plaintiff failed to raise triable issue of fact in opposition to physician's showing that injury was a "known risk that may occur despite competent surgical care having been provided"]).

The courts of this State repeatedly have rejected the concept that only a specialist practicing in a defendant's particular specialty is competent to testify that another specialist departed from accepted practice in the specialty (*see Fuller v Preis*, 35 NY2d 425, 431 [1974]; *Bartolacci-Meir v Sassoon*, 149 AD3d 567, 572 [1st Dept 2017]; *Bickom v Bierwagen*, 48 AD3d 1247,1248 [4th Dept 2008]; *Julien v Physician's Hosp*., 231 AD2d 678, 680 [2d Dept 1996]; *Matter of Enu v Sobol*, 171 AD2d 302, 304 [3d Dept 1991]; *Joswick v Lenox Hill Hosp*., 161 AD2d 352, 355 [1st Dept 1990]). Nonetheless, a physician who is put forward by a party as an expert qualified to oppose a summary judgment motion must assert that he or she possesses the necessary knowledge and training in the relevant specialty, or explain how he or she came to it, and also must articulate the standard of care that allegedly was violated (*see Colwin v Katz*, 122 AD3d 523, 524 [1st Dept 2014]).

> "To qualify as an expert, the witness should be possessed of the requisite skill, training, education, knowledge or experience from which it can be assumed that the opinion rendered is reliable. Thus, if a physician possesses the requisite knowledge and expertise to make a determination on the issue presented, he need not be a specialist in the field. The question of whether a physician may testify regarding the standard of accepted medical practice outside the scope of his specialty can be a troublesome one, but appellate courts have rejected claims of error directed at a physician's qualifications to offer an opinion outside the scope of his specialty when the witness's specialty is closely related to the specialty at issue"

(*Matter of Enu v Sobol*, 171 AD2d at 304 [citations omitted]). Thus, although

> "[t]he nonconclusory opinion of a qualified expert based on competent evidence that a defendant departed from accepted medical practice and that that departure was a proximate cause of plaintiff's injury precludes a grant of summary judgment in favor of the defendants (*see Diaz v New York Downtown Hosp.*, 99

> NY2d 542; *Cregan v Sachs*, 65 AD3d 101, 108, 879 NYS2d 440 [1st Dept 2009]), . . . *the affidavit must be by a qualified expert who 'profess[es] personal knowledge of the standard of care in the field of . . . medicine [at issue], whether acquired through his practice or studies or in some other way'* (*Nguyen v Dorce*, 125 AD3d 571, 572 [1st Dept 2015] [pathologist not qualified to render opinion as to whether defendant deviated from the standard of care in the field of emergency medicine]; *see also Atkins v Beth Abraham Health Servs.*, 133 AD3d 491, 20 NYS3d 33 [1st Dept 2015] [osteopath not qualified to render opinion on treatment of a geriatric patient with diabetes and other conditions]; *Udoye v Westchester-Bronx OB/GYN, P.C.,* 126 AD3d 653, 7 NYS3d 59 [1st Dept 2015] [pathologist not qualified to render an opinion as to the standard of care in obstetrics or cardiology]; *Mustello v Berg,* 44 AD3d 1018, 845 NYS2d 86 [2d Dept 2007] [general surgeon not qualified to render opinion as to gastroenterological treatment]).

(*Bartolacci-Meir v Sassoon*, 149 AD3d at 572-573 [emphasis added]).

Contrary to the defendants' contention, the plaintiff's expert---a board-certified surgeon who practices general surgery---practiced in the same specialty as Simone, and averred that he or she had experience in employing mesh for surgical repairs. Hence, the plaintiff's expert is qualified to render an opinion as to the nature of the repair, the propriety of the mesh employed, and the manner in which the mesh was placed and sutured, as well as whether the incarceration of bowel tissue could have been caused in the manner suggested by the defendants. The expert also is qualified to opine on the issue of whether Simone deviated from good practice and whether that deviation caused physical and other immediate post-operative injuries (*see generally Humphrey v Jewish Hosp. & Med. Ctr. of Brooklyn*, 172 AD2d 494, 494 [2d Dept 1991]).

1. Deviation From Good and Accepted Practice

In connection with the claimed deviations from good and accepted practice, the defendants established their prima facie entitlement to judgment as a matter of law with their submissions, including Dr. Haniford's expert affirmation. With respect to Simone, the defendants established that she did not deviate from good practice in the manner in which she placed and sutured the mesh, or in the manner in which she checked the surgical area after completing the suturing. In particular, despite Dr. Kuo's observations that the mesh had

incarcerated a significant portion of bowel tissue, Dr. Haniford asserted that Dr. Kuo was silent as to any misplaced sutures or improperly placed mesh. They further demonstrated, prima facie, that bowel incarceration is a known risk of an open hernia repair procedure. Nonetheless, in light of Dr. Kuo's physical description of the mesh and bowel tissue, as they appeared to her during the first exploratory laparotomy, the defendants' suggestion that the plaintiff's frequent hiccupping caused the mesh to slip and thereupon to incarcerate a portion of his bowel, borders on the speculative (*see generally Hoffman v Taubel*, 208 AD3d 1099 [1st Dept 2022]), and the defendants have propounded no other rational explanation for the bowel incarceration.

In any event, the plaintiff raised a triable issue of fact with the opinions expressed in his expert's affirmation. In that affirmation, the expert opined that Simone engaged in improper surgical techniques in the course of placing and suturing the mesh.

With respect to the plaintiff's claims against Campbell, however,

> "[a] resident who assists a doctor during a medical procedure, and who does not exercise any independent medical judgment, cannot be held liable for malpractice so long as the doctor's directions did not *so greatly deviate from normal practice* that the resident should be held liable for failing to intervene"

(*Soto v Andaz*, 8 AD3d 470, 471 [2d Dept 2004] [emphasis added]; *see Sklarova v Coopersmith*, 180 AD3d 510, 510 [1st Dept 2020]; *Nasima v Dolan*, 149 AD3d 759, 760 [2d Dept 2017]; *Leavy v Merriam* 133 AD3d 636, 638 [2d Dept 2015]; *Poter v Adams*, 104 AD3d 925, 927 [2d Dept 2013]; *Bellafiore v Ricotta*, 83 AD3d 632, 633 [2d Dept 2011]; *Crawford v Sorkin*, 41 AD3d 278, 280 [1st Dept 2007]; *Buchheim v Sanghavi*, 299 AD2d 229, 240 [1st Dept 2002]; *see also Murphy v Drosinos*, 179 AD3d 461, 462 [1st Dept 2020]; *Irizarry v St. Barnabas Hosp.*, 145 AD3d 529, 530 [1st Dept 2016]). This rule is applicable even where the resident "actively participated" in performing a procedure (*see Sklarova v Coopersmith*, 180 AD3d at 510). The defendants established that Campbell did not exercise any judgment independent of that exercised by Simone, that Simone supervised each task that Campbell performed, and that Simone's directions did not so greatly deviate from normal practice that Campbell should be

held liable for failing to intervene. Since the plaintiff's expert did not address this issue, the plaintiff failed to raise a triable issue of fact as to Campbell's purported negligence. Hence, the defendants are entitled to summary judgment dismissing the complaint insofar as asserted against Campbell.

2. Proximate Cause

Although the defendants made a prima face showing that Simone's surgical technique did not cause the incarceration of the bowel tissue itself, the plaintiff's expert raised a triable issue of fact as to whether it did. Other than asserting that Simone did not commit medical malpractice in the first instance, the defendants failed to establish, prima facie, that any such malpractice, if it were indeed committed, did not proximately cause the need for additional surgeries, did not cause additional pain and suffering, and did not cause additional scarring arising from the procedures performed on the plaintiff subsequent to the hernia repair procedure. Even had they made the necessary prima facie showing in this regard, the plaintiff's expert raised a triable issue of fact as to whether Simone's conduct proximately caused the need for those additional procedures and the physical sequellae thereto. In this regard, the expert opined that, despite the fact that the incarceration of bowel tissue is a known risk of employing mesh in a hernia repair procedure, the nature, location, and appearance of the bowel tissue during the March 18, 2016 exploratory laparoscopy, and the fact that the bowel tissue already was ischemic less than one day after the repair surgery, warranted the conclusion that the incarceration occurred during the repair procedure due to improper placement and suturing, and not due to the plaintiff's frequent and severe hiccupping immediately following the repair procedure. In other words, the expert raised a triable issue of fact as to whether the unexpected slippage of mesh, secondary to hiccupping, caused or could cause the mesh to entrap or incarcerate the volume of bowel tissue that was found to be ischemic only one day after the repair surgery. Dr. Haniford's reply simply underscores the sharp difference of opinion with respect to that issue. The plaintiff's expert also raised a triable issue of fact as to whether the

plaintiff's immediate post-surgical outbursts, while he remained an inpatient at NYPH, were caused by those surgeries. Consequently, the court must deny that branch of the motion seeking summary judgment dismissing the complaint against Simone.

The plaintiff's expert is, however, a surgeon, and provided only the barest allegations concerning his or her familiarity with psychiatry, which apparently was limited to a medical school course and a psychiatric rotation. General surgery is a medical specialty far removed from psychiatry, and the plaintiff's expert has made no showing that he or she professes the requisite personal knowledge necessary to qualify as an expert enabling him or her to opine on whether the 2016 surgical procedures caused or contributed to specifically diagnosed psychiatric conditions two years later.

Where, as here, the physician proffering an allegedly expert affirmation demonstrates no explicit familiarity with a particular specialty, the affiant will be deemed not to have the requisite experience, training, and knowledge necessary to render an opinion on the issue of causation (*see Steinberg v Lenox Hill Hosp*., 148 AD3d 612, 613 [1st Dept 2017] [plaintiffs' expert was "not qualified to offer an opinion as to causation[,as h]e specializes in cardiovascular surgery, not neurology or ophthalmology [and] failed to 'profess the requisite personal knowledge' necessary to make a determination on the issue of whether [an arterial] perforation was responsible for plaintiff's visual impairment"]; *see also Vargas v Bhalodkar,* 204 AD3d 556, 557 [1st Dept 2022] ["(p)laintiff's expert, an internist and gastroenterologist with no apparent training or knowledge in cardiology, did not set forth sufficient qualifications to opine on whether [defendant] deviated from the relevant standard of care when she gave cardiac clearance for decedent to temporarily cease taking blood thinners and undergo a colonoscopy"]; *Newell v City of New York*., 204 AD3d 574, 574 [1st Dept 2022] ["an internist who demonstrated no familiarity with surgery in general or abdominal surgery in particular, was not qualified to render an opinion that [defendant] departed from accepted standards of medical care in performing plaintiff's appendectomy"]; *Samer v Desai,* 179 AD3d 860 [2d Dept 2020] [general and vascular surgeon

not qualified to render opinion as to orthopedics or family medicine]; *Bartolacci-Meir v Sassoon*, 149 AD3d at 572 [1st Dept 2017] [general surgeon lacked any experience in gastroenterology sufficient to qualify him as an expert]; *cf. Fuller v Preis*, 35 NY2d at 431 [neurologist was permitted to give an opinion in the closely related specialty of psychiatry on the issue of whether an accident was the proximate cause of a subsequent suicide]; *Humphrey v Jewish Hosp. & Med. Ctr.*, 172 AD2d at 494 [general surgeon was deemed to be qualified to render an opinion in the specialty of obstetrics and gynecology]; *Matter of Sang Moon Kim v Ambach*, 68 AD2d 986, 987 [3d Dept 1979] [opinion testimony of qualified neurosurgeon at a professional misconduct hearing was sufficient to permit a finding of gross negligence or gross incompetence of an orthopedic surgeon committed during spinal surgery]).

Even if the plaintiff's expert were qualified to render an opinion on the causes of the plaintiff's psychiatric condition in 2018, the opinion that the expert rendered was conclusory and unsubstantiated by any medical records or other expert testimony.

Hence, the court must award summary judgment to all of the defendants dismissing so much of the medical malpractice claim as sought to recover for the creation or exacerbation of diagnosable psychiatric injuries that allegedly manifested themselves subsequent to the plaintiff's March 26, 2016 discharge from NYPH.

B. 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]). Since Simone was employed by NYPH, and the court concluded that there are triable issues of fact both as to whether Simone committed

malpractice that caused or contributed to the plaintiff's injuries, that branch of the motion seeking summary judgment dismissing the complaint against NYPH must be denied to the extent that NYPH's liability is premised upon Simone's malpractice.

C. CLAIM FOR LOSS OF CAREER OPPORTUNITIES

To support a claim for lost earnings, a plaintiff must satisfy his burden of proving loss of wages with "reasonable certainty" (*Man-Kit Lei v City Univ. of N. Y.,* 33 AD3d 467, 468 [1st Dept 2006]; *see Tassone v Mid-Valley Oil Co.*, 5 AD3d 931, 932 [3d Dept 2004]). "Recovery for lost earning capacity is not limited to a plaintiff's actual earnings before the accident, however, and the assessment of damages may instead be based upon future probabilities" (*Kirschhoffer v Van Dyke,* 173 AD2d 7, 10 [3d Dept 1991]). The loss, however, must be more than speculative. Hence, a plaintiff who was never employed in the position upon which he or she bases lost earnings, or never obtained the training or credentials necessary to secure such employment, may not seek lost earnings because the proof will be deemed speculative (*see Naveja v Hillcrest General Hosp.*, 148 AD2d 429, 430 [2d Dept 1989]; *cf. Grayson v Irvmar Realty Corp*., 7 AD2d 436, 439-440 [1st Dept 1959] [young person who had begun studies for a career as an opera singer may recover for lost earning capacity caused by injuries arising from defendant's tortious conduct]).

The defendants established, prima facie, that the plaintiff was rejected by the Marine Corps because he failed a written examination before the subject surgeries had even been performed. They also demonstrated that the plaintiff never was employed as a model, never was promised employment as a model, and never trained for employment in the field of modelling. They further established that the 2016 hernia repair and revision surgeries did not cause or contribute to the plaintiff's inability to pursue a career in the Marines or as a model. In opposition to that showing, the plaintiff failed to raise a triable issue of fact. Hence, the court must summarily dismiss the plaintiff's claim to recover for such alleged lost earning capacity.

VI. CONCLUSION

In light of the foregoing, it is

ORDERED that defendants' motion is granted to the extent that the defendants are awarded summary judgment:

(a) dismissing the complaint insofar as asserted against the defendant Rachel Campbell, M.D., and

(b) dismissing those claims that the plaintiff asserted against the defendant Maria Valeria Simone, M.D., and the defendant New York Presbyterian-Columbia University Medical Center that sought to recover for

(1) the creation or exacerbation of diagnosable psychiatric injuries that allegedly manifested themselves subsequent to the plaintiff's March 26, 2016 discharge from New York Presbyterian-Columbia University Medical Center, and

(2) lost earning capacity based on the plaintiff's inability to secure employment in the United States Marine Corps or to pursue a career in the field of modeling,

the complaint is dismissed insofar as asserted against the defendant Rachel Campbell, M.D., and the motion is otherwise denied; and it is further,

ORDERED that the action is severed against the defendant Rachel Campbell, M.D.; and it is further,

ORDERED that the Clerk of the court shall enter judgment dismissing the complaint insofar as asserted against the defendant Rachel Campbell, M.D.; and it is further,

ORDERED that the remaining parties shall appear for a pretrial conference on May 4, 2023, at 10:00 a.m.

This constitutes the Decision and Order of the court.

4/10/2023
DATE

JOHN J. KELLEY, J.S.C.

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