SUPREME COURT OF THE STATE OF NEW YORK
NEW YORK COUNTY

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

Justice

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ANNE M. BURNS,

Plaintiff,

- v -

DARRICK E. ANTELL, M.D., MICHELLE KOZLOWSKY, RN, LENNOX HILL AMBULATORY SURGERY, P.C. (A/K/A COLUMBIA EAST SIDE SURGERY A/K/A MANHATTAN RECONSTRUCTIVE SURGERY A/K/A DARRICK E. ANTELL, M.D., P.C.),

Defendants.

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INDEX NO. 450950/2019

MOTION DATE 02/14/2023

MOTION SEQ. NO. 005

DECISION + ORDER ON MOTION

The following e-filed documents, listed by NYSCEF document number (Motion 005) 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 250, 251, 252, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 295

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 medical practice and insufficient recordkeeping, and for lack of informed consent, fraud, gross negligence, and violation of the Education Law, the defendants Darrick E. Antell, M.D., Lenox Hill Ambulatory Surgery, P.C. (LHAS), also known as Columbia East Side Surgery, also known as Manhattan Reconstructive Surgery, and Darrick E. Antell, M.D., P.C. (collectively the Antell 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 to the extent that the Antell defendants are awarded summary judgment dismissing, insofar as asserted against them, the lack of informed consent, fraud, gross negligence, and Education Law causes of action, and so much of the medical malpractice cause of action as alleged that Antell improperly performed breast reduction surgery upon the plaintiff, improperly maintained his ambulatory surgery facilities and surgical equipment in an

unclean manner, and improperly maintained his office records. The motion is otherwise denied, inasmuch as there are triable issues of fact as to whether the Antell defendants committed malpractice in failing timely to recognize, diagnose, and treat an infection that caused necrotic tissue to develop and spread, necessitating further surgical intervention, and causing the plaintiff to lose the entirety of her left nipple-areola complex.

II. FACTUAL BACKGROUND

The crux of the plaintiff's claims is that Antell, a plastic surgeon, departed from good and accepted medical practice when, in the course of performing an August 10, 2016 breast reduction procedure upon her at LHAS, he sutured the entirety of a thick clump of eschar, specifically, dead skin from the nipple-areola complex region, to surrounding healthy skin, and permitted the eschar to remain sutured to the healthy skin for two weeks following the surgery, thus allowing an infection to spread that resulted gross deformity in the nipple-areola complex, which, in turn, required the whole complex to be removed. The plaintiff further alleged that Antell's recordkeeping protocols were so insufficient that it prevented her from obtaining information necessary for her to secure appropriate follow-up treatment. She also suggested that the uncleanliness of his ambulatory surgical facilities may have been the source of the infection. In addition, the plaintiff claimed that Antell failed to obtain her fully informed consent to the procedure, inasmuch as he did not provide her with information concerning all of the risks and benefits of the procedure, or reasonable alternatives thereto.

In 2014, the plaintiff consulted with plastic surgeon David Rapaport, M.D., to discuss a possible breast reduction procedure, but decided not to pursue surgery with Dr. Rapaport at that time. She first met with Antell on April 30, 2015, complaining that the large size and concomitant weight of her breasts caused her to experience neck, back, and shoulder pain, and she informed Antell that conservative treatment with diet and exercise had been unsuccessful. Antell concluded that breast reduction surgery was medically and surgically indicated. She returned to see Antell on December 1, 2015, at which time he documented that he and the

plaintiff discussed of a number of plastic surgery procedures, including breast reduction, as well as cosmetic procedures on the plaintiff's face, chin, and eyelids. On that same date, the plaintiff executed a consent form authorizing Antell to perform the surgeries.

On April 20, 2016, the plaintiff returned to Antell at LHAS for cosmetic plastic surgery on her face, chin, and eyelids, which he performed on that date.

On July 20, 2016, the plaintiff spoke with Antell by telephone to plan a breast reduction procedure that would remove 800 grams of tissue from each breast. She next saw Antell on or about August 9, 2016, at which time he prepared a diagram of the contemplated breast surgery that depicted, in a general fashion, how the procedure would be performed, and what the breast would look like postoperatively if the graft of the nipple-areola complex were not successful.

Antell performed the breast-reduction surgery on August 10, 2016 at LHAS in Manhattan, and also performed liposuction on the plaintiff's arms. The operative report noted that the blood supply to the nipple-areola complex was evaluated, but did not describe either the mode of evaluation or the results thereof. After the procedure, the plaintiff was moved to a recovery room, where the Antell defendants' nurse, the defendant Michelle Kozlowsky, RN, managed her care. That same day, the plaintiff, who resided in Ithaca, New York, was discharged to a nearby hotel room for post-operative care, overseen by Patty Kendrick, a registered nurse and acquaintance of the plaintiff who Kozlowsky described as a "chaperone." At 6:39 p.m. on August 10, 2016, Kozlowsky made an evening checkup call to the plaintiff at her hotel room. According to Kendrick, the plaintiff complained of *right* breast pain, as well as that there was substantial drainage coming from both arms, and that the breast dressings were dry, but "scruntched up." Kendrick conceded that she had no nursing experience in connection with breast reduction surgery, and that she never looked at or examined the plaintiff's breasts.

On August 11, 2016, the plaintiff reported to Antell that she was alarmed by the dark color of the left nipple-areola complex, but that he reassured her that "everything looked good," and that the discolored, dark nipple-areola complex was a "scab" that would fall off, revealing

"viable tissue." Antell, however, made no record of the darker nipple in the plaintiff's chart on August 11, 2016. Antell nonetheless prescribed the plaintiff silver sulfadiazine (Silvadene), a topical antibiotic cream, and directed her to apply it twice daily to treat the dark tissue to prevent infection, an also prescribed oral antibiotics. On August 12, 2016, Antell discharged the plaintiff to her home, and directed her to make an appointment for stitch removal. The plaintiff returned to her home in Ithaca that day.

On August 16, 2016, Kozlowsky memorialized a telephone call that she had with the plaintiff, in which the plaintiff allegedly reported that she was "doing much better," with "some stinging . . . some discomfort [, and] no other problems." On August 17, 2016, the plaintiff and Kozlowsky had another telephone conversation, in which Kozlowsky asked the plaintiff to provide her with a photograph depicting the left breast to assess concerns about bleeding. In response, the plaintiff emailed Kozlowsky, with four photo attachments, and asserted that her left breast was "bleeding a little." At least one of the photographs depicted discoloration and possible scabbing around the left nipple-areola complex, which, according to the plaintiff depicted full thickness necrosis of the left nipple-areola complex, with surrounding erythema and ecchymosis. The plaintiff and Kozlowsky spoke again on the telephone on August 18, 2016. The plaintiff asserted that the necrotic nipple was allowed to remain in place without further treatment until Antell saw her on August 25, 2016, at which point he removed the suturing at the nipple-areola complex, characterized the condition of the plaintiff's left breast as a "necrotic layer on top of L nipple-areola," and memorialized a plan to "[e]xcise necrotic left breast tissue [with] . . . [a]djacent tissue transfer flap repair." Antell also determined to apply Nitropaste ointment to the nipple-areola complex, but he did not perform any further procedures on the area at that time.

In an August 29, 2016 telephone conversation with the plaintiff, Antell mentioned that he saw the post-operative photographs that the plaintiff had taken of herself, and commented that that they looked "pretty much status quo." He personally instructed the plaintiff to return to see

him at his office on the next day. According to Kozlowsky, Antell discussed the possibility of opening up the left breast area, probably debriding it, cleaning out whatever tissue didn't look like it survived, closing it up, and washing it out. The defendants contend that Antell then discussed with the plaintiff the possibility that, if the nipple needed to be removed, it could be rebuilt upon her return from scheduled travel plans. On August 30, 2016, the plaintiff returned to Antell's office and met with Kozlowsky, who purportedly discussed the protocols for the additional surgery. According to Kozlowsky, the plaintiff had indicated that she had not really showered after the August 10, 2016 surgery.

On August 31, 2016, and again between September 9, 2016 and September 15, 2016, Antell performed a series of surgical procedures and debridements upon the plaintiff's left breast at various ambulatory surgery facilities to address necrotic and infected breast tissue.

In connection with the August 31, 2016 procedure, which was performed at Manhattan Reconstructive Surgery, Antell reported that he undertook the excision of necrotic left breast tissue with adjacent tissue transfer, and the repair of a flap that was 10 centimeters in length, which essentially entailed the complete removal of the left nipple-areola complex. As Antell described it in his August 31, 2016 post-operative report, in the period immediately following the August 10, 2016 surgery, although the plaintiff initially was healing well, the left nipple-areola complex darkened and eventually turned black. He noted that "[o]n physical exam, it appeared that there was a necrotic layer on the top and we felt that we should debride it." He prescribed a regimen of the oral antibiotic Azithromycin. Kozlowsky called the plaintiff that evening at 7:04 p.m. to follow up. On September 1, 2016, the plaintiff was seen at Antell's office for a follow-up examination and a dressing change, was given a refill prescription for Azithromycin, and was directed to return on September 6, 2016.

On September 6, 2016, the plaintiff returned to Antell's office, at which time he examined her and found her to be without fever, without any discharge from the surgical sites, and without any foul odor. He changed the administration of antibiotics from Azithromycin to Doxycycline.

On September 9, 2016, Antell again saw the plaintiff, debrided her left breast, secured a swab to be cultured, and changed the dressing. After the September 9, 2016 debridement, the plaintiff, who had been taking several antibiotics since August 11, 2016, was referred to infectious disease specialist Elmela Zlatanic, M.D. Tissue cultures that had been collected on September 9, 2016 and provided to Dr. Zlatanic grew enterococcus faecalis bacteria.

Antell saw the plaintiff for debridements and dressing changes twice on September 10, 2016, and spoke with her by telephone to report his contact with both the pathology laboratory and Dr. Zlatanic. Based on the results of the culture and his discussion with Dr. Zlatanic, he changed the antibiotic prescription to Augmentin. Antell again saw and treated the plaintiff on September 11, 2016, and spoke again with Dr. Zlatanic. On September 12, 2016, Antell again saw and treated the plaintiff, and collected another tissue specimen for culturing. Those additional cultures grew gram-positive cocci bacteria in pairs and chains, as well as gram-negative bacteria. The plaintiff returned to Antell's office on both September 13, 2016 and September 14, 2014, and additional tissue samples were taken on the latter date. According to Kozlowsky, those culture results revealed the presence of no organisms and no white blood cells. On September 15, 2016, Antell spoke with the plaintiff by telephone, and reported his plan to close up the left breast surgical wound site that same day. He reported the results of the September 14, 2016 culture and expressed his opinion that the plaintiff needed to continue on antibiotics. Antell broached the topic of future reconstruction of the left breast. Later that day, the plaintiff returned to see Antell, who performed a final debridement of the left breast.

Kozlowsky and the plaintiff spoke by telephone on September 16, 2016, and the two exchanged both emails and telephone calls, pursuant to which Kozlowsky scheduled the plaintiff for a return office visit on September 20, 2016. Antell examined the plaintiff on September 20, 2016, and concluded that there was a minimal discharge from the left breast, and that the plaintiff had no fever. Antell instructed the plaintiff to continue taking antibiotics and to return for

a follow-up visit. Other than some additional phone contacts and texts between Antell and the plaintiff, the plaintiff had no further communication with Antell.

According to the plaintiff, the August 10, 2016 surgery caused not only the need to remove her left nipple-areola complex, but a breast asymmetry that is characterized by a left breast that is 20% smaller than the right breast, and persistent fat necrosis present in the central and lateral regions of her left breast.

On January 24, 2020, the plaintiff presented to Jefferson Plastic Surgery in Philadelphia for a medical evaluation, at which photographs were taken. According to the plaintiff, all of her breast scars were mature and no open wounds were present, while her left breast remained noticeably smaller than the right by approximately 20%, with an absent nipple-areola complex. Additionally, significant and easily palpable regions of persistent fat necrosis were noted in the central and lateral regions of the left breast, which also had been noted on recent breast imaging studies. Although the plaintiff discussed various options with Jefferson Plastic Surgery medical personnel to improve breast symmetry and correct the resulting deformity, she was, at the time that the instant motion was submitted, undecided as to when she wished to proceed with any corrective surgical procedures.

III. THE PLAINTIFF'S CONTENTIONS

In her complaint, the plaintiff asserted, as relevant here, that Antell performed breast reduction surgery upon her on August 10, 2016, that he failed to install drains, and discharged her to a nearby hotel for recovery. She further alleged that the dressing that he and Kozlowsky applied to the surgical wounds was placed too tightly on her breast, but that Kozlowsky declined to change the dressings post-operatively despite repeated requests. The plaintiff asserted that Antell departed from good and accepted medical practice by permitting necrotic tissue to develop at the incision site on her left breast, suturing the necrotic tissue to adjacent healthy tissue, and allowing the sutures to remain in place for a significant period of time before removal, thus causing infection and necrosis to spread. She asserted that this, in turn,

necessitated revision surgery in which her left nipple-areola complex had to be completely removed, leaving a significant disfigurement. Specifically, the plaintiff alleged in her complaint that Antell deviated from the standard of care in the course of the August 10, 2016 breast reduction surgery by cutting her left breast in a negligent manner, resulting in a loss of proper blood flow to the left nipple-areola complex and/or causing a blood spurt that created an septic condition in the operating room that led to infection and necrosis. The plaintiff also averred in her complaint that Antell departed from accepted standards of practice by failing properly to treat her left nipple on the day after the surgery, despite the fact that it was unusually dark in color, and thus left it to turn increasingly "necrotic, festering, diseased, decomposing and gangrenous for more than three weeks." In addition, the plaintiff asserted that Antell committed medical malpractice by failing properly to maintain appropriate and complete medical records, and misrepresented in those records her actual condition, as well as the nature of the revision surgeries that were necessary to stem the spread of infection. She also included copies of photographs of the deformed breast as exhibits to her complaint.

The plaintiff alleged that, as a result of Antell's negligence, she experienced physical and emotional pain and suffering, including self-image related issues, depression, fear of intimacy, and fear of breast cancer, and sought to recover for all related surgical costs for the numerous office procedures she had to undergo, as well as the costs of future surgery needed to rehabilitate the deformity and mutilation. She also made a claim to recover psychotherapy-related costs, along with all travel-related costs for her various trips between her home in Ithaca and Manhattan subsequent to the August 10, 2016 surgery, and all related hotel, restaurant, and incidental travel costs.

The plaintiff's initial bill of particulars mostly provided a narrative of the plaintiff's communications and interactions with Antell, her disagreements with Antell, Antell's failure to keep a full and appropriate medical chart, and her own attempts to secure a full and appropriate medical record from Antell. As to specific allegations as to how Antell departed from good and

accepted medical practice, the plaintiff's initial bill of particulars asserted that he "deviated from the standard of care . . . when he decided, for whatever reasons, to leave full thickness 'eschar' of the NAC region sutured to the surrounding healthy tissue for the next 20 days." It further alleged that "Antell and staff were simply disregarding any other possible cause of the infection" other than self-infection at home, "despite the left nipple showing clear signs of necrosis at the first post op check-up, on August 11, 2019." In addition, she suggested that Antell departed from accepted practice when he failed to hospitalize her during her recovery period, instead discharging her to a local hotel and then to home, thus requiring her to travel between Ithaca and Manhattan while her breast was supposed to be healing.

The plaintiff's amended bill of particulars more specifically described the departures that Antell allegedly committed than did her initial bill of particulars. In her amended bill of particulars, the plaintiff alleged that Antell neglected to treat her "with the requisite knowledge and skill that is used by the average member of medical profession, and most particularly he failed to apply that body of knowledge and skill possessed and used by the average plastic surgeon conducting breast reduction surgery in Manhattan, NY." She further alleged that Antell failed to check on her before her discharge from recovery, despite her complaints of extreme pain. In addition, the plaintiff claimed that Antell was negligent in failing to inform her at either her August 11, 2016 or August 12, 2016 post-operative examinations that necrosis was forming, and in misrepresenting to her that the darkened color of her left nipple-areola complex constituted a mere scab, thus failing timely to treat her for "obvious" infection and necrosis. In connection with the treatment that Antell did provide for the darkened left breast, the plaintiff claimed that Antell negligently misrepresented the purpose of applying Silvadene ointment. She averred that Antell not only failed properly to diagnose her infection, but also failed to admit that she had suffered from an infection even after it had been diagnosed by Dr. Zlatanic.

With respect to her claims of lack of informed consent, the plaintiff asserted that, at his initial consultation with her, Antell failed properly to advise her as to the risks of breast reduction

surgery, including the risk of nipple loss, and that he continued fail to advise her of that risk at every consultation with her, both prior to and following the August 10, 2016 breast reduction surgery. She further asserted that, following that surgery, Antell "failed to provide" her with "critical information in his notes," including a failure to make mention of any complications in his August 10, 2016 operative report, despite later testifying that he had reason to be concerned about the circulation of the plaintiff's blood during surgery.

Moreover, the plaintiff alleged in her amended bill of particulars that Antell failed to keep records that accurately reflected his evaluation and treatment of her throughout the course of her breast reduction and follow-up remedial treatments, procedures, and surgeries, including three revision procedures in late August and early September 2016. She also asserted that Antell improperly failed to photograph post-operative examinations, despite his admission that it was his routine practice to take such photographs. The plaintiff further faulted Antell because he failed to tell her that her in-office conversations and telephone calls were being recorded without her knowledge. In addition, she asserted that Antell violated accepted record-keeping practices by failing to note the loss her left nipple-areola complex in his August 31, 2016 operative report, and in failing to report the four unanticipated sequelae of the August 10, 2016 surgery--- necrosis, revisionary surgery to remove the left nipple-areola complex, continued infection, and seven days of deep tissue removal and chemical treatments---either directly to the American Association for the Accreditation of Ambulatory Surgical Facilities (AAAASF) or to Kozlowsky, to whom he had delegated the responsibility of communicating with the AAAASF.

Finally, the plaintiff alleged in her amended bill of particulars that Antell and his affiliated practices invoiced her insurance company, Excellus, for numerous unauthorized charges, including double-charging for a facility fee, first in the sum of $1,900.00 by the defendant Darrick Antell, M.D., P.C., which was fully paid, and thereafter by the defendant Manhattan Reconstructive Surgery, another of Antell's entities, in the sum of $50,000.00 fee for the use of

the same facility, on the same day, at the same time, and during the same surgeries, for which Excellus paid $32,000.00.

IV. THE SUMMARY JUDGMENT MOTION

In support of their motion, the Antell defendants submitted the pleadings, the plaintiffs' bills of particulars, the transcripts of the parties' depositions, relevant hospital and medical records, discovery orders, the note of issue, and the expert affirmation of board certified general surgeon/plastic and reconstructive surgeon Paula A. Moynahan, M.D., who based her affirmation, among other things, on a report of her examination of the plaintiff.

Dr. Moynahan concluded that, inasmuch as the loss that the plaintiff ultimately sustained was the loss of the nipple-areola complex on the left breast, the outcome of the August 10, 2016 procedure was "not so much a complication of the breast reduction surgery but is more a failure of the procedure to achieve the desired result." In this regard, she explained that breast reduction surgery involves a dramatic reduction of the size of the breast that requires the nipple-areola complex to be completely repositioned and relocated higher on the breast, so as to obtain the correct cosmetic appearance following surgery. She further asserted that a surgeon cannot guarantee that the grafted nipple-areola complex will always survive its relocation, and agreed with Antell's deposition testimony, in which he stated that a significant percentage of patients will sustain some necrosis of the tissue of the breast as a consequence of the surgery. Dr. Moynahan opined that the reason why a patient might lose a nipple to necrosis during breast reduction surgery is that circulation to the grafted nipple-areola complex is subject to compromise during the healing process, and a risk of loss of the nipple-areola complex exists regardless of which surgical procedure is performed, regardless of the skill of the operating surgeon, and regardless of the surgeon's "depth of experience" with the procedure.

Dr. Moynahan averred that the entries contained in the August 10, 2016 operative report that Antell had prepared described the inferior pedicle technique that he used, which she opined was appropriate to address the conditions presented by the plaintiff. She reiterated the report's

conclusions that the plaintiff underwent standard observation in the recovery room following an uneventful procedure that accomplished the goal of surgically reducing the size and volume of both breasts. As Dr. Moynahan characterized it, the plaintiff's post-operative course, including her expected discomfort, the drainage from the incision, and the dressings applied to the area of the surgery, were all consistent with "a course entirely within the spectrum of postoperative findings of patients who undergo this extensive surgical procedure." She expressly rejected the plaintiff's contention that there was a compromise of blood circulation to the nipple-areola complex, either during surgery or during the postoperative care, and asserted that the records of treatment and the testimony of the parties did not support that claim. Although Dr. Moynahan recognized that the plaintiff characterized her left breast as appearing darker than her right breast one day after the August 10, 2016 surgery, she adverted to Antell's examination notes for that day, which reflected "no problem" with the left breast, as well as the plaintiff's deposition testimony to the effect that "everything was okay" with the appearance of her breast on the night of August 10, 2016.

Dr. Moynahan further noted that, at the plaintiff's August 12, 2016 visit with Antell, despite the fact that she complained that her left nipple was darker than her right, Antell informed the plaintiff that there was "viable tissue," and that the plaintiff credited that opinion in determining not to contact Antell immediately upon her return home to Ithaca. Dr. Moynahan concluded that the plaintiff's condition during the first several days following the August 10, 2016 procedure reflected a normal post-operative course, and that there was no evidence that Antell caused any injury to the plaintiff or that his treatment fell below the standard of care. In this regard, Dr. Moynahan opined that it is difficult to predict, and not possible to control, the healing process, which will either incorporate the nipple-areola complex into its new location, or result in the partial or total loss of the nipple and areola.

Dr. Moynahan further asserted that, regardless of whether the plaintiff did or did not apply topical Silvadene cream or Nitropaste during the post-operative period, those products do

not restore circulation to the nipple-areola complex when the body is unable to restore the blood supply to the nipple during the healing process. She accepted Kozlowsky's explanation that Silvadene is an antibiotic ointment that is used on some breast reduction patients who do not tolerate other more routinely used antibiotic ointments.

In addition, Dr. Moynahan asserted that the plaintiff's August 16, 2016 telephone call with Kozlowsky, as well as the photographs transmitted to Antell's office on August 17, 2016, "continued to support the existence of a normal postoperative course," and referred to Kozlowsky's deposition testimony, in which the nurse averred that there was no sign of infection or other complication of the surgery, and that the photographs were consistent with a normal healing progress. She rejected the plaintiff's contention that the uncleanliness of the operating room or the presence of bacteria on her skin in the immediate post-operative period caused the plaintiff to become infected, inasmuch as "there is no evidence that this patient ever had an infection in the operated upon areas or that infection contributed to the failure of the nipple areolar on the left breast." Dr. Moynahan asserted that bacteria are normally present on the skin of the breast, and will be found there if laboratory tests are performed. Although she conceded that infection at the surgical site is an entirely different matter, she nonetheless concluded that the plaintiff did not develop a post-operative infection in the immediate aftermath of the surgery, but that, despite Kozlowsky's contention that the plaintiff was "doing a great job tending her postoperative wounds," she instead "developed bacteria in the grafted tissue as a normal consequence of its necrosis after it failed to become incorporated at its new site." Dr. Moynahan adopted Kozlowsky's testimony that the small amount of wound drainage at that time was not a matter of concern, and concluded that wound drainage, including a small amount of blood, would be a common post-operative consequence of the surgery. She further asserted that, although the nipple had turned black by August 24, 2016, that appearance was "consistent with the type of venous congestion which will gradually reduce the circulation to the nipple graft and cause the graft to become necrotic over days to weeks after surgery."

Dr. Moynahan further explained that, during the plaintiff's September 2016 visits with Antell, he cleaned the wound edges to allow the skin to close the defect that remained following the removal of the left nipple-areola complex, and asserted that "[t]here was the normal bacteria population of the skin in the area of the breast surgery." She further noted that, although the plaintiff evinced necrosis of the skin at the left nipple-areola complex, "[t]here was no infection which contributed to the complication or caused injury to the patient."

With respect to the issue of whether Antell and his entities obtained the plaintiff's fully informed consent to perform breast reduction surgery, Dr. Moynahan asserted that the plaintiff executed detailed consent forms that were derived from "standard templates" that had been circulated to members by the American Society of Plastic Surgery, and that they more than complied with the standard of accepted plastic surgery practice in New York City during 2015 and 2016 as to their discussion of risks and complications of surgery. Dr. Moynahan averred that, in the field of plastic surgery, it is recognized as being important that patients approach surgical procedures with reasonable expectations, and that it was "clear" that the plaintiff was given the appropriate information to allow her to provide a fully informed consent to each of the procedures that Antell performed upon her. Dr. Moynahan further noted that the diagram that Antell sketched and reviewed with the plaintiff prior to August 10, 2016 depicted "the very complication this patient later experienced," and that he employed such an example precisely "in order to obtain her informed consent to the breast surgery." She opined that both the consent form and the consent process that Antell employed made "clear" that there was a small chance of graft failure. Dr. Moynahan compared both Antell's notes and his testimony, in which he respectively memorialized and later confirmed that he discussed this risk with the plaintiff on the telephone prior to the surgery, with the plaintiff's deposition testimony, in which she stated that she did not recall that telephone conversation. In his office notes, Antell quoted the plaintiff as acknowledging that "I know I can lose my nipple and all that" if she underwent breast reduction surgery.

Dr. Moynahan concluded that, based on her review of the records in this action, the plaintiff had reviewed and understood the standard consent forms that she executed, including the statement that "[i]n rare circumstances the nipple may be lost entirely." She noted that the plaintiff never stated or testified that she was unaware of this potential complication, but only that she never thought that she would be among the small percentage of patients undergoing surgery who would lose her nipple. Dr. Moynahan asserted that approximately 2% of patients who undergo breast reduction surgery each year lose a nipple as a consequence of surgery. She thus opined that Antell and his entities obtained appropriate, fully informed consent from the plaintiff to perform breast reduction surgery, as they provided the plaintiff with information concerning all of the risks and benefits of the procedure, and the alternatives thereto. She further asserted that a reasonable patient in the plaintiff's situation would indeed have elected to undergo the procedure despite the disclosed risk of losing a nipple-areola complex.

Dr. Moynahan further opined that Antell's pre-operative notes, consent forms, and records of the procedure performed on August 10, 2016, are "all in good order, reflecting treatment which was within the prevailing standard of care." She further concluded that the debridements that Antell performed in September 2016 "do not always result in operative reports, as they are measures taken in the course of routine wound care," and that while the plaintiff may have taken exception to Antell's use of the term "enhancement" in connection with the wound care that he provided in September 2016, those procedures merely contributed to the closing of the wound site following the loss of the nipple-areola complex.

In conclusion, Dr. Moynahan asserted that

> "[i]t is not easy to determine exactly when the left nipple-areola complex became non-viable tissue, but that is the nature of this complication which can occur to any patient and any surgeon who becomes involved in this procedure regardless of the level of care exercised, the skill of the surgeon, or the otherwise good health and compliance of the patient."

She further opined that

> "there is no evidence that there were any points at which the treatment fell below the standard of care. There is likewise no evidence that acts or omissions on the part of the medical care providers caused the patient to have the complication or made the effects of the complication worse than they otherwise would have been."

Dr. Moynahan continued that the loss of the left nipple-areola complex "is an unavoidable and recognized complication of the breast reduction surgery" and that there was "no evidence to support the claim that malpractice on the part of the defendants caused any injury" to the plaintiff.

In the memorandum of law that the Antell defendants submitted in support of their motion, they argued that there was no basis for any claims of recklessness or gross negligence, and no basis for any claims of fraud, which were based on the plaintiff's allegations that that Antell's operative reports were misleading, that he failed to report her complications to the AAAASF, that he falsely directed a "self-infection narrative," that he fraudulently advertised his services, and that he fraudulently billed her medical insurance carrier.

In opposition to the Antell defendants' motion, the plaintiff relied on the same documentation that those defendants had submitted, and also submitted an attorney's affirmation, as well as Antell's billing records and appointment calendar, photographs of the plaintiff's breast, and the expert affirmation of board-certified general surgeon/plastic and reconstructive surgeon Patrick J. Greaney, Jr., M.D. Dr. Greaney opined that the breast reduction surgery resulted in an inadequate blood supply to the left nipple-areola complex, and that while this condition "may have been evident intraoperatively," it "certainly was noticeable even to the patient on the first post-operative day based not only on the patient's clear descriptions but also by very early photographs." According to Dr. Greaney, "[t]he frankly necrotic tissue was misidentified as viable tissue by the surgeon and furthermore misidentified as a minor issue to the patient." As he explained it, the medical terminology that Antell utilized appears "meaningfully contradictory," as there was not a necrotic "layer," but rather a full-thickness necrosis that required a complete excision of the nipple-areola complex. Dr. Greaney

concluded that had there been only a partial thickness loss of the tissue, "the skin could have been excised tangentially," but that "[t]his would be a medically incorrect decision for clearly dead tissue." He noted that Nitropaste cream would only have had an opportunity to work on live tissue that merely was "venous congested," but that it was not and could not be effective on completely necrotic tissue.

Dr. Greaney opined that Antell inappropriately delayed in treating "the frankly necrotic tissue," and that this delay constituted a deviation from standard of care that increased the plaintiff's chances of complications such as infection, "which she unfortunately progressed to acquire." He concluded that the early identification of nipple-areolar ischemia would have allowed conversion to a free nipple graft technique, thereby preserving the tissue and preventing additional deformity. In addition, Dr. Greaney asserted that the infections that the plaintiff incurred, in turn, resulted in increased tissue loss and significant fat necrosis of the left breast that required repeat operative debridements, which were misidentified to the plaintiff as "enhancing" operations. He concluded that the result of this departure from good medical practice resulted in a complete loss of the plaintiff's left breast nipple-areola complex, breast asymmetry, decreased breast volume, and persistent fat necrosis that continues until the present. He thus reiterated the conclusions set forth in his prior opinion letter that

> "applying ineffective creams such as Silvadene and Nitropaste to eschar increased her chances of complications such as infection, which she unfortunately progressed to acquire . . . which in turn caused the repeat operative debridements which resulted in increased tissue loss and therefore increased deformity and asymmetry."

Dr. Greaney rejected Dr. Moynahan's opinion that it was "not easy to determine exactly when the left nipple areola complex became non-viable tissue," concluding instead that, as early as August 11, 2016, or one day after the reduction surgery, the darkening left nipple should have forewarned that the tissue might well be becoming non-viable, and that full thickness necrosis was clear in the August 17, 2016 photograph, thus reflecting complete non-viability by that date. He also disagreed with Dr. Moynahan's opinion that there was no evidence that

Antell's treatment fell below the standard of care, and came to the contrary conclusion that there was sufficient evidence of necrosis to warrant a much earlier diagnosis and treatment. Specifically, Dr. Greaney opined that Antell's delay in diagnosing and treating the necrotic tissue was a deviation from accepted community standards of practice, and was a proximate cause of the plaintiff's injuries. Dr. Greaney also concluded that Antell further departed from good care when, even after he observed the clearly necrotic tissue firsthand on August 25, 2016, he discharged the plaintiff to her home for yet another week, thus leaving dead tissue untreated, which led to infection and the need for further surgical procedures that resulted in the complete loss of the plaintiff's left nipple-areola complex and increased tissue loss of the lest breast.

Dr. Greaney did not address Dr. Moynahan's opinion that the consent that the Antell defendants obtained from the plaintiff in connection with the breast reduction procedure was qualitatively sufficient and, thus, constituted fully informed consent. Moreover, although he noted that, according to the plaintiff,

> "omissions appear to exist in the patient's medical record including but not limited to phone calls and conversations between the patient and surgeon/staff expressing concern regarding the appearance/color of the left nipple region (e.g. to Ms. Kozlowsky, August 11 appointment discussions between the patient and physician regarding alarm regarding color of the tissue, etc),"

he rendered no opinion as to whether these purported omissions constituted a deviation from accepted standards of surgical and medical care, whether the Antell defendants' recordkeeping was deficient in general, or whether any such deficiency caused or contributed to the plaintiff's injuries or inability to pursue timely corrective treatment. Nor did Dr. Greaney render an opinion as to whether the Antell defendants failed to maintain their ambulatory surgery facilities or their surgical equipment in a good and clean condition, or whether any such uncleanliness caused or contributed to the plaintiff's infection and necrosis.

In the attorney's affirmation submitted in opposition to the motion, the plaintiff's attorney raised new allegations that the Antell defendants violated Education Law § 1630 and committed various species of fraud.

In reply, the Antell defendants submitted an additional attorney's affirmation, in which they argued that the plaintiff failed to raise a triable issue of fact in opposition to any of their prima facie showing. They further asserted that necrosis and concomitant loss of the nipple-areola complex is a known risk of surgery. In addition, counsel contended that there was no basis for the plaintiff's claim that the Antell defendants violated any provision of the Education Law, and that the billing records did not raise a triable issue of fact as to whether they committed any fraud, let alone that such fraud caused damages to the plaintiff.

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]).

1. MEDICAL MALPRACTICE BASED ON DEPARTURES FROM GOOD AND ACCEPTED PRACTICE

"To sustain a cause of action for medical malpractice, a plaintiff must prove two essential elements: (1) a deviation or departure from accepted practice, and (2) evidence that such departure was a proximate cause of plaintiff's injury" (*Frye v Montefiore Med. Ctr*., 70 AD3d 15, 24 [1st Dept 2009]; *see Roques v Noble*, 73 AD3d 204, 206 [1st Dept 2010]; *Elias v Bash*, 54 AD3d 354, 357 [2d Dept 2008]; *DeFilippo v New York Downtown Hosp*., 10 AD3d 521, 522 [1st Dept 2004]). Where a physician fails properly to diagnose a patient's condition, thus providing less than optimal treatment or delaying appropriate treatment, and the insufficiency of or delay in treatment proximately causes injury, he or she will be deemed to have departed from good and accepted medical practice (*see Zabary v North Shore Hosp. in Plainview,* 190 AD3d 790, 795 [2d Dept 2021]; *Lewis v Rutkovsky*, 153 AD3d 450, 451 [1st Dept 2017]; *Monzon v Chiaramonte*, 140 AD3d 1126, 1128 [2d Dept 2016] ["(c)ases . . . which allege medical malpractice for failure to diagnose a condition . . . pertain to the level or standard of care expected of a physician in the community"]; *O'Sullivan v Presbyterian Hosp. at Columbia Presbyterian Medical Ctr.*, 217 AD2d 98, 101 [1st Dept 1995]).

A defendant physician moving for summary judgment must make a prima facie showing of entitlement to judgment as a matter of law by establishing the absence of a triable issue of fact as to his or her alleged departure from accepted standards of medical practice (*Alvarez v Prospect Hosp*., 68 NY2d 320, 324 [1986]; *Frye v Montefiore Med. Ctr*., 70 AD3d at 24) or by

establishing that the plaintiff was not injured by such treatment (*see McGuigan v Centereach Mgt. Group, Inc.*, 94 AD3d 955 [2d Dept 2012]; *Sharp v Weber*, 77 AD3d 812 [2d Dept 2010]; *see generally Stukas v Streiter*, 83 AD3d 18 [2d Dept 2011]). To satisfy the burden, a defendant must present expert opinion testimony that is supported by the facts in the record, addresses the essential allegations in the complaint or the bill of particulars, and is detailed, specific, and factual in nature (*see Roques v Noble*, 73 AD3d at 206; *Joyner-Pack v. Sykes*, 54 AD3d 727, 729 [2d Dept 2008]; *Koi Hou Chan v Yeung*, 66 AD3d 642 [2d Dept 2009]; *Jones v Ricciardelli*, 40 AD3d 935 [2d Dept 2007]). If the expert's opinion is not based on facts in the record, the facts must be personally known to the expert and, in any event, the opinion of a defendant's expert should specify "in what way" the patient's treatment was proper and "elucidate the standard of care" (*Ocasio-Gary v Lawrence Hospital,* 69 AD3d 403, 404 [1st Dept 2010]). Stated another way, the defendant's expert's opinion must "explain 'what defendant did and why'" (*id*., quoting *Wasserman v Carella*, 307 AD2d 225, 226 [1st Dept 2003]). 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/or 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 Antell defendants established their prima facie entitlement to judgment as a matter of law with respect to the medical malpractice cause of action with, among other things, Dr. Moynahan's affirmation, in which she concluded that Antell did not deviate from good and accepted practice in the manner in which he performed the surgery, the post-operative care that he provided, or the manner in which he operated his ambulatory surgical facilities. In opposition to that showing, the plaintiff, through her expert's affirmation, raised a triable issue of fact only in connection with her claim that Antell committed malpractice in failing timely to recognize, diagnose, and properly treat her developing infection and concomitant necrosis subsequent to the August 10, 2016 surgery, and that such a failure proximately caused her to develop an infection, required her to undergo additional surgery and debridements, and caused her ultimately to lose her left nipple-areola complex. Although, contrary to Dr. Moynahan, Dr.

Greaney opined that the plaintiff's necrosis arose because she lost blood circulation to her left nipple-areola complex during the breast reduction surgery, he did not opine that the loss of circulation was caused by any deficiency in Antell's surgical technique or Antell's failure to observe the plaintiff's condition intra-operatively. Moreover, as noted above, he did not address Dr. Moynahan's opinion that Antell properly maintained his ambulatory surgery facilities in good order, or provide his own opinion as to the likely source of the infection. He thus did not rebut Dr. Moynahan's opinion that the plaintiff became infected after she was discharged from the ambulatory surgery facility.

The court recognizes that medical malpractice may also arise from a provider's failure properly and timely to maintain medical records, where that failure prevented that provider or other providers from rendering appropriate follow-up treatment (*see generally Henry v Sunrise Manor Ctr. for Nursing & Rehabilitation*, 147 AD3d 739, 740-741 [2d Dept 2017]). Nonetheless, in response to Dr. Moynahan's opinion that Antell's chart was in good order, Dr. Greaney merely noted that the plaintiff had complained about certain omissions from those records. As explained above, he did not conclude that Antell's record keeping practices deviated from the accepted standard of care, nor did he opine that the omissions from the medical record that were cited by the plaintiff prevented Antell or any other physician from providing appropriate follow-up treatment.

Hence, the Antell defendants must be awarded summary judgment dismissing so much of the medical malpractice cause of action as alleged that Antell improperly performed breast reduction surgery upon the plaintiff, improperly maintained his ambulatory surgery facilities and surgical equipment in an unclean manner, or improperly maintained his office records. In connection with this ruling however, the court expresses no opinion as to whether aspects of the allegations of improper reporting and recordkeeping may be admissible at trial in connection with Antell's recollections and credibility.

The court, however, denies that branch of their motion seeking summary judgment dismissing the claim that Antell committed malpractice by failing timely to recognize, diagnose, and treat the infection that caused the necrosis and ultimate need to remove the left nipple-areola complex, and whether those failures caused or contributed to the plaintiff's injuries and losses. Those issues must await determination by a finder of fact at trial.

2. LACK OF INFORMED CONSENT

The elements of a cause of action to recover 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]).

In opposition to the Antell defendants' prima facie showing that the consent that Antell obtained in connection with the plaintiff's breast reduction surgery was qualitatively sufficient, the plaintiff's expert did not address that issue (*see* CPLR 4401-a; *Gardner v Wider*, 32 AD3d 728, 730 [1st Dept 2006]). Hence, the plaintiff failed to raise a triable issue of fact, and the Antell defendants must be awarded summary judgment dismissing the lack of informed consent cause of action insofar as asserted against them.

3. FRAUD

To state a claim to recover for fraud, one must allege a "misrepresentation or a material omission of fact which was false and known to be false by defendant, made for the purpose of inducing the other party to rely upon it, justifiable reliance of the other party on the misrepresentation or material omission, and injury" (*Lama Holding Co. v Smith Barney*, 88 NY2d 413, 421 [1996]; *KS Trade LLC v International Gemological Inst., Inc*., 190 AD3d 556, 556 [1st Dept 2021]). Fraud must be pleaded with sufficient particularity (see CPLR 3016[b]; *Pludeman v Northern Leasing Sys., Inc.,* 10 NY3d 486, 491 [2008]). The Antell defendants established, prima facie, that they either did not commit any fraudulent acts, that any alleged "misrepresentations" complained of by the plaintiff were at most medical misrepresentations that implicated only malpractice in any event, that those statements were true and, hence, not misrepresentations, let alone material misrepresentations, and that any representations that Antell made, even if false, do not give rise to a fraud cause of action. In opposition to that showing, the plaintiff failed to raise a triable issue of fact. Hence, Antell must be awarded summary judgment dismissing the fraud claim insofar as asserted against him.

4. RECKLESSNESS AND GROSS NEGLIGENCE

Gross negligence consists of "conduct that evinces a reckless disregard for the rights of others or 'smacks' of intentional wrongdoing" (*Colnaghi, U.S.A. v Jewelers Protection Servs*., 81 NY2d 821, 823-824 [1993]; *Ambac Assur. UK Ltd. v J.P. Morgan Inv. Mgt., Inc*., 88 AD3d 1, 8 [1st Dept 2011]). Gross negligence thus is "different in kind as well as degree" from ordinary negligence (*Sutton Park Dev. Corp. Trading Co. v. Guerin & Guerin Agency*, 297 AD2d 430, 431 [3d Dept 2002]; *Green v Holmes Protection of N.Y*., 216 AD2d 178, 178-179 [1st Dept 1995]). The element of culpability is, in gross negligence, magnified to a high degree as compared with that present in ordinary negligence (*see Sharick v Marvin,* 1 AD2d 284, 286-287 [3d Dept 1956]). Gross negligence thus can be defined as conduct of an aggravated character that discloses a failure to exercise any diligence whatsoever (*see Civil Service Employees Assn,*

Inc. v Public Employment Relations Bd., 132 AD2d 430, 435 [3d Dept 1987]). Conclusory allegations of gross negligence, however, are insufficient to state a cause of action (*see Mancuso v Rubin*, 52 AD3d 580, 583 [2d Dept 2008]; *Porter v Forest Hills Care Center, LLC*, 2018 NY Slip Op 33439[U], 2018 WL 6976728 [Sup Ct, Queens County, Nov. 28, 2018]). Where a plaintiff fails to allege any facts whatsoever describing any type of behavior beyond ordinary negligence, the plaintiff cannot be said to have fulfilled the pleading requirements applicable to claims of gross negligence (*see Mancuso v Rubin,* 52 AD3d at 583; *see also Gold v Park Ave. Extended Care Ctr. Corp*., 90 AD3d 833, 834 [2d Dept 2011]; *Baker v Andover Assoc. Mgt. Corp*., 2009 NY Slip Op 52788[U], *26, 30 Misc 3d 1218[A] [Sup Ct, Westchester County, Nov. 3, 2009] [Scheinkman, J.]).

The Antell defendants established, prima facie, that all of the claims that the plaintiff characterizes as constituting instances of recklessness or gross negligence are simply allegations of medical malpractice that do not evidence conduct of an aggravated character. In opposition to that showing, the plaintiff has made no compelling argument that Antell's alleged departures from good and accepted practice constituted reckless behavior or gross negligence. Consequently, summary judgment must be awarded to Antell dismissing the recklessness and gross negligence causes of action insofar as asserted against him.

5. VICARIOUS LIABILITY

Where a physician working for a professional corporation renders medical care to a patient "within the scope of his or her employment" for that corporation, the corporation may be held vicariously liable for the negligence of the physician (*Petruzzi v Purow*, 180 AD3d 1083, 1084-1085 [2d Dept 2020]). Inasmuch as this court has concluded that there are triable issues of fact as to whether Antell committed malpractice in failing to diagnose and timely treat the plaintiff's infection and resultant necrosis, Lenox Hill Ambulatory Surgery, P.C., also known as Columbia East Side Surgery, also known as Manhattan Reconstructive Surgery, and Darrick E.

Antell, M.D., P.C., as his joint employers, may be held vicariously liable for that malpractice. Hence, summary judgment is awarded to those defendants only to the extent that this court is awarding summary judgment to Antell, that is, to the extent of dismissing, insofar as asserted against them, the lack of informed consent, fraud, and gross negligence causes of action, and so much of the medical malpractice cause of action as was premised upon the performance of breast reduction surgery itself, the allegedly improper maintenance of ambulatory surgery facilities and surgical equipment, and the allegedly improper maintenance of medical charts and office records. The motion is otherwise denied as to those defendants

VI. CONCLUSION

The plaintiff's remaining claims, including any claims that the plaintiff purportedly seek to assert under the Education Law, are without merit.

Accordingly, it is

ORDERED that the motion of the defendants Darrick E. Antell, M.D., Lenox Hill Ambulatory Surgery, P.C., also known as Columbia East Side Surgery, also known as Manhattan Reconstructive Surgery, and Darrick E. Antell, M.D., P.C., is granted to the extent that those defendants are awarded summary judgment dismissing, insofar as asserted against them, the lack of informed consent, fraud, gross negligence, and Education Law causes of action, and so much of the medical malpractice cause of action as alleged that Darrick E. Antell, M.D., improperly performed breast reduction surgery upon the plaintiff, improperly maintained his ambulatory surgery facilities and surgical equipment in an unclean manner, and improperly maintained his office records, those causes of action are dismissed insofar as asserted against those defendants, and the motion is otherwise denied; and it is further,

ORDERED that the remaining parties to this action shall appear for a pretrial conference on August 8, 2023 at 9:00 a.m.

This constitutes the Decision and Order of the court.

6/13/2023
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