At an IAS Term, Part MMESP-7 of the Supreme Court of the State of NY, held in and for the County of Kings, at the Courthouse, at 360 Adams Street, Brooklyn, New York, on the 16th day of May 2024.

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF KINGS
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SAMIRA MAMEDOVA,

Plaintiff,

-against-

SANATH DHARMASENA, M.D., JOHN S. LYONS, M.D., SAMUEL DAVIDOFF, M.D., SCANWELL DIAGNOSTICS, GASTROENTEROLOGY NUTRITION, P.C., NEW YORK COMMUNITY HOSPITAL, CONEY ISLAND HOSPITAL and NEW YORK CITY HEALTH AND HOSPITALS CORPORATION,

Defendants.
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DECISION & ORDER

Index No. 512178/2016
Mo. Seq. 4, 5 & 6

HON. CONSUELO MALLAFRE MELENDEZ, J.S.C.

Recitation, as required by CPLR §2219 [a], of the papers considered in the review:

NYSCEF #s: 134-216

Defendants Sanath Dharmasena, M.D. ("Dr. Dharmasena") and New York Community Hospital move (Seq. No. 4) for an Order, pursuant to CPLR 3212, granting summary judgment to said defendants, dismissing all claims against them, and deleting them from the caption of this action.

Defendant John S. Lyons, M.D. ("Dr. Lyons") separately moves (Seq. No. 5) for an Order, pursuant to CPLR 3212, granting summary judgment in his favor, dismissing all claims against him, and amending the caption.

Defendants New York City Health and Hospitals Corporation ("HHC") and Coney Island Hospital separately move (Seq. No. 6) for an Order, pursuant to CPLR 3212, granting summary judgment to said defendants and dismissing the complaint against them in its entirety.

Plaintiff opposes the motions with respect to her claims against Dr. Lyons and HHC/Coney Island Hospital only. There is no opposition to Dr. Dharmasena and New York Community Hospital's motion (Seq. No. 4) and their motion is accordingly **GRANTED** without opposition.

Plaintiff commenced this action on July 15, 2016, asserting claims of medical malpractice and lack of informed consent against the moving defendants and others, in connection to diagnosis and treatment of stomach cancer and a gastrointestinal bleed.

On January 7, 2015, Plaintiff presented at the emergency department of New York Community Hospital with complaints of epigastric pain for two days. She was examined by Dr. Dharmasena and prescribed medication for epigastric pain and reflux gastritis. No ultrasound or CT scan was ordered at that time.

The following day, Plaintiff underwent an ultrasound of the abdomen and retroperitoneum at Scanwell Diagnostics. The ultrasound report listed "Dr. Metwally" as the referring provider and "abdominal pain" under clinical history. Plaintiff testified that she never treated with Dr. Metwally, and that she went to the radiology office because her sister worked there in a non-medical position (Plaintiff deposition tr, at 63-64, 101). Plaintiff's sister, Esmira Mesh, testified that the ultrasound was arranged by her manager and performed by a technician without any apparent order or referral from a doctor (Mesh deposition tr, at 28).

Plaintiff's ultrasound images were reviewed and interpreted by Dr. Lyons on January 8, 2015, from a remote location. Dr. Lyons testified that he accessed Plaintiff's study digitally through the PACS system, and he "had no reason to doubt" that it was Dr. Metwally who ordered the ultrasound and who would also receive his report (Dr. Lyons deposition tr, at 51-52, 74-75). He further testified that he would ordinarily receive an email with patient information including their clinical history/complaints, but he did not retain this email or recall its contents (*id.*, at 38).

From the ultrasound study, Dr. Lyons reported normal and unremarkable findings of the liver, gallbladder, common bile duct, pancreas, kidneys, spleen, and abdominal aorta. He concluded with the impression "negative study," finding no evidence of lesions, cysts, gallstones, or renal stones. He noted that a CT scan should be performed if renal stones were suspected (Exhibit T). Plaintiff's sister testified that Dr. Lyons's report was given to her by her manager (Mesh deposition tr at 30, 32).

On April 27, 2015, Plaintiff arrived at the emergency department of Coney Island Hospital with worsening epigastric and abdominal pain. She reported pain since the beginning of the year, difficulty swallowing, lost weight, and episodes of nausea, vomiting, and diarrhea. An abdominal ultrasound revealed masses in the liver, likely to be a malignant tumor or metastatic disease. An abdominal CT scan the same day revealed a large lesion in the left upper quadrant, suspected to be a gastrointestinal stomal tumor. She was admitted to the medicine unit.

On April 28, she had a gastroenterology consult with Francis Steinheber, M.D. ("Dr. Steinheber"). A liver biopsy was performed on April 29, and an upper endoscopy was performed by Dr. Steinheber on April 30. During the endoscopy, an "oozing, large, friable mass" was observed in the cardia of the stomach, which began bleeding on contact. Dr. Steinheber cauterized the bleeding. He was only able to take brushings and not a tissue sample due to the risk of rebleeding.

Plaintiff remained hospitalized and underwent further testing for possible metastatic spread to the breasts, bone, and lungs. On May 6, only the pathology results from the liver biopsy had not returned. The attending physician, Lotus Ahmed, M.D. ("Dr. Ahmed"), deemed Plaintiff "hemodynamically stable for discharge" with a plan to follow up on her liver biopsy results. According to a nursing note, Plaintiff reported sharp abdominal pain in the early morning hours of May 6 and was given Toradol shortly before she was discharged. Plaintiff was discharged from Coney Island Hospital at approximately 2:13 p.m. on May 6.

Hours after returning home, Plaintiff returned to Coney Island Hospital by ambulance at approximately 10:00 p.m. with symptoms of blood in her stool, weakness, dizziness, and seizure. She received blood transfusions and was diagnosed with a major gastrointestinal bleed. An upper endoscopy was performed on

May 7 at 5:05 a.m., which revealed "a large, fungating mass with massively oozing bleeding," with signs of recent bleeding and blood clots in the cardia, gastric body, and anterior wall of the stomach. The bleeding could not be localized or controlled endoscopically.

Plaintiff was ultimately transferred to Kings County Hospital Center, where Francesco Serafini, M.D. ("Dr. Serafini") performed an exploratory laparotomy on May 8. The amount of blood throughout her gastrointestinal tract necessitated a total gastrectomy (removal of the stomach) and resection of the distal esophagus. Her diagnosis was a severe upper gastrointestinal hemorrhage from a tumor in the stomach.

Plaintiff alleges that radiologist Dr. Lyons departed from good and accepted medical standards in his review and report of the January 8, 2015 ultrasound, and these departures proximately caused Plaintiff's alleged injuries by delaying her cancer diagnosis. Plaintiff also alleges that HHC/Coney Island Hospital departed from good and accepted medical standards, and those departures were a proximate cause of her gastrointestinal hemorrhage and total gastrectomy.

Generally, "[i]n determining a motion for summary judgment, the court must view the evidence in the light most favorable to the nonmoving party" (*Stukas v Streiter,* 83 AD3d 18, 22 [2d Dept 2011]). In evaluating a summary judgment motion in a medical malpractice case, the Court applies the burden shifting process as summarized by the Second Department:

> "The elements of a medical malpractice cause of action are a deviation or departure from accepted community standards of practice, and that such departure was a proximate cause of the plaintiff's injuries. When moving for summary judgment, a defendant provider has the burden of establishing the absence of any departure from good and accepted medical practice or that the plaintiff was not injured thereby. In order to sustain this burden, the defendant must address and rebut any specific allegations of malpractice set forth in the plaintiff's bill of particulars. In opposition, the plaintiff must demonstrate the existence of a triable issue of fact as to the elements on which the defendant has met his or her initial burden. General allegations of medical malpractice, merely conclusory and unsupported by competent evidence tending to establish the essential elements of medical malpractice, are insufficient to defeat a defendant's summary judgment motion. Although summary judgment is not appropriate in a medical malpractice action where the parties adduce conflicting medical expert opinions, expert opinions that are conclusory, speculative,

or unsupported by the record are insufficient to raise triable issues of fact" (*Barnaman v Bishop Hucles Episcopal Nursing Home,* 213 AD3d 896, 898-899 [2d Dept 2023] [internal quotation marks and citations omitted].

In support of his motion for summary judgment, Dr. Lyons submits an expert affirmation from Karen Fried, M.D. ("Dr. Fried"), a physician certified in diagnostic radiology, as well as medical records and deposition transcripts.

Based on her review of the records, including the radiological images, Dr. Fried opines that Dr. Lyons did not depart from good and accepted standards in his interpretation and report of the January 8 ultrasound. Dr. Fried opines that the radiologist's role is only "to review the ultrasound images, interpret them, and prepare an ultrasound report on their findings." She opines that it was the duty of the Scanwell Diagnostics facility to maintain its records and pass on his report to the alleged referring physician. She also opines that it is ultimately the referring physician's duty to "make any determinations on further care and treatment based upon the patient's symptoms," and that treatment is not directed by the radiologist.

Dr. Fried notes that Plaintiff's ultrasound was *not* ordered by any physicians she saw the prior day at New York Community Hospital. Due to the fact Dr. Lyons did not retain email records and they were not sought from Scanwell Diagnostics by any party, it is unclear what clinical history or other information was sent to Dr. Lyons. The ultrasound was obtained through Plaintiff's sister and one or more other Scanwell Diagnostics employees, circumventing the usual process of a physician ordering the ultrasound and reviewing the report.

Dr. Fried reviewed the images from the January 8 ultrasound and opines that Dr. Lyons's interpretation and report was accurate and proper for the type of ultrasound that was performed. In her view, the images "clearly depict the liver, gallbladder, common bile duct, pancreas, bilateral kidneys, spleen, and abdominal aorta." She opines that Dr. Lyons appropriately assessed each of these elements in detail, and the study revealed "absolutely no abnormalities in these structures." At the time the ultrasound was taken, Plaintiff had no visible metastatic disease in her liver or any other irregularities visible from the study, and therefore, Dr. Fried opines that Dr. Lyons

appropriately concluded it was a "negative study."

Dr. Fried further opines that the standard of care does not impose a duty on the radiologist to recommend further testing or contact the referring provider on a normal/negative study. She opines that while a radiologist *may* recommend further testing, it is ultimately the treating physician who decides whether to follow that recommendation. In this case, there was no referring physician to order such tests. Therefore, Dr. Fried opines there is no causal link between Dr. Lyons's report and any subsequent care and treatment to Plaintiff.

Based on these submissions, Dr. Lyons has established a prima facie case that his interpretation and report of the January 8 ultrasound was within good and accepted radiology standards, and that he did not have a duty under the applicable standard of care to make further recommendations or contact Plaintiff's physician.

In opposition to Dr. Lyons's motion, Plaintiff submits an expert affirmation from a physician certified in diagnostic radiology, (name of expert redacted) and an expert affirmation from a physician certified in internal medicine and medical oncology and hematology, (name of expert redacted). The Court was presented with both signed, unredacted affirmations for *in camera* inspection.

Plaintiff's radiology expert opines that Dr. Lyons departed from the standard of care by failing to recommend additional imaging studies, specifically a CT scan of the abdomen. The expert viewed the radiographic images from January 8, 2015, and opines that these images were of poor quality, "grainy," and did not adequately show the organs to determine it was a "negative study," as Dr. Lyons wrote in his impression.

Plaintiff's radiology expert also opines that it is a departure from the standard of care to interpret an ultrasound "in a vacuum" without taking clinical history and symptoms into account. The expert opines that "abdominal pain" as listed on Dr. Lyons's report is too broad a category to interpret the ultrasound properly. If a patient's primary complaint was *epigastric pain,* as in Plaintiff's case, then the abdomen and retroperitoneum ultrasound was an inadequate diagnostic tool. The expert opines that even lower abdominal complaints should prompt "an abdominal and pelvic ultrasound followed by a CT scan of the abdomen and pelvis if an ultrasound does not yield a diagnosis." According to the expert, if a diagnosis cannot be made based on the initial ultrasound, the standard of care is for an interpreting radiologist to recommend a CT scan, either by including

that recommendation in his report or attempting to contact the referring physician. A CT scan "offers superior contrast image quality to assess abdominal structures" including the presence of tumors in the stomach.

Plaintiff notes that Dr. Lyons did recommend a CT scan to detect the presence of renal stones, but he did not otherwise comment on the "poor diagnostic quality" of the images in identifying the source of Plaintiff's symptoms. The expert opines that in these circumstances, simply concluding it was a "negative study" was erroneous and a departure from the standard of care, and this report offered a false reassurance to Plaintiff. The expert further opines based on the record that if an abdominal CT scan was performed in January 2015, it would have revealed the gastric mass in the stomach and resulted in an earlier diagnosis.

On the issue of proximate causation, Plaintiff's oncology expert opines that the delay in diagnosis from January 2015 to April 2015 "led to a worse prognosis, more extensive surgery, and diminished life expectancy." Plaintiff was eventually diagnosed with high grade poorly differentiated synovial sarcoma, a rare type of tumor that originated in the soft tissue of her gastrointestinal tract. The oncology expert explains that with high grade sarcoma, it takes approximately 2-4 months for the mass to double in volume. Based on this rate of growth, the expert opines that Plaintiff's gastric tumor was significantly smaller in January 2015 than in April/May 2015 when she was diagnosed and experienced the gastrointestinal bleed and total gastrectomy. Thus, the oncology expert opines that her overall prognosis and extent of surgical resection would have been greatly improved by earlier diagnosis. Additionally, the expert notes that at the time of the January 8 ultrasound, there was no evidence of lesions or abnormalities in the liver. By April 27, an ultrasound of the same area showed that the disease had spread to her liver. The expert opines that Plaintiff's metastatic spread would have been "substantially reduced" by earlier discovery of the gastric tumor.

Plaintiff's radiology expert raises issues of fact as to Dr. Lyons's departures from the standard of care. "When experts offer conflicting opinions, a credibility question is presented requiring a jury's resolution" (*Stewart v. North Shore University Hospital at Syosset*, 204 AD3d 858, 860 [2d Dept. 2022], citing *Russell v. Garafalo,* 189 A.D.3d 1100, 1102, [2d Dept. 2020]). Plaintiff's expert expressly counters Dr. Fried's opinion that the radiologist had no duty under the standard of care to make testing recommendations, either within their

report or by contacting the referring physician. Plaintiff's expert opines that it is good and accepted radiological practice to review the patient's clinical symptoms and comment on the allegedly poor diagnostic quality of the images. Plaintiff also raises issues of fact as to proximate causation by submitting the oncology expert's opinion that a CT scan recommendation would have led to an earlier diagnosis and better outcome. For these reasons, Dr. Lyons's motion for summary judgment is denied as to the medical malpractice cause of action.

Notwithstanding, Plaintiff's complaint asserts a second cause of action for "lack of informed consent" against all defendants, which is not applicable to Dr. Lyons under these facts. The theory of lack of informed consent is limited to cases involving performance of a "non-emergency treatment, procedure or surgery" or "a diagnostic procedure which involved invasion or disruption of the integrity of the body" (*Deutsch v Chaglassian,* 71 AD3d 718, 720 [2d Dept 2010], quoting Public Health Law § 2805-d [2]). This cause of action does not arise where, as here, there is no assertion that the physician performed any procedure or "affirmative violation of the plaintiff's physical integrity" during the treatment and care at issue (*Samer v Desai,* 179 AD3d 860, 864 [2d Dept 2020]). Plaintiff's claims against Dr. Lyons are limited to his review and report of the radiology images. Therefore, Dr. Lyons's motion for summary judgment is granted to the extent of dismissing Plaintiff's claims on lack of informed consent only.

Turning to the summary judgment motion of HHC/Coney Island Hospital (Seq. No. 6), the movant submits an expert affirmation from Michael Frank, M.D. ("Dr. Frank"), a physician certified in internal medicine and gastroenterology; an expert affirmation from Ronald Blum, M.D. ("Dr. Blum"), a physician certified in internal medicine and medical oncology; and an expert affirmation from Steve Salzman, M.D. ("Dr. Salzman"), a physician certified in internal medicine and critical care medicine. The movant also submits medical records and deposition transcripts.

Based on the records and his expertise in gastroenterology, Dr. Frank opines that the treatment rendered to Plaintiff at Coney Island Hospital was in accordance with good and accepted medical standards. Specifically, Dr. Frank opines on the acts of Dr. Steinheber, who performed Plaintiff's upper endoscopy on April 30. Dr. Frank opines that the friable mass at the cardia of Plaintiff's stomach began bleeding on contact and Dr.

Steinheber properly cauterized the bleeding and refrained from taking a biopsy sample. Dr. Frank opines that it was within good and accepted standards to take brushings instead of a tissue sample due to the risk the friable mass would "bleed more actively."

Dr. Frank also opines that there was no reason for a repeat endoscopy to be performed before Plaintiff's discharge on May 6. Dr. Frank opines that the standard of care is not to perform a second endoscopy after a bleed "unless there is a reason to suspect the bleed has become active again." Dr. Frank states that because Plaintiff's "vital signs remained unchanged," the risk of the endoscopy itself causing another bleed outweighed any benefit at that time.

Additionally, Dr. Frank opines that due to the location and size of the mass observed in the endoscopy, there was no option for Plaintiff but a total gastrectomy, and the fact there was a major gastrointestinal hemorrhage did not change or cause this outcome.

Next, the movant's internal medicine expert, Dr. Salzman, opines that Plaintiff was appropriately monitored throughout her admission, and that it was not a departure from the standard of care to discharge Plaintiff on May 6. Dr. Salzman opines that Plaintiff was medically stable for discharge after her endoscopy on April 30, but she remained at the hospital for a complete metastatic work-up so her staging and initiation of treatment could begin sooner. Her attending physician Dr. Ahmed testified that Plaintiff was discharged "with a plan for outpatient follow-up" because her liver biopsy results were still pending. Dr. Salzman opines that this was not outside the standard of care.

Dr. Salzman also opines that Plaintiff did not exhibit any symptoms of a gastrointestinal bleed before being discharged. She had no evidence of tachycardia, vomiting blood, or blood in stool. Her blood pressure was in the low-normal range when she was discharged, but Dr. Salzman opines this was not an acute development or uncommon for a woman in her 20s. Dr. Salzman opines that there was no need to provide further blood checks after April 30, because the drop in her H&H levels was not a "significant change" for a patient receiving IV fluids, and there were no other clinical symptoms that she had significant bleeding as opposed to being "borderline anemic." Dr. Salzman further opines that even if her H&H were checked prior to

her discharge, the absence of other symptoms suggests that they would have been stable, and she did not have signs of "significant bleeding for days." Dr. Salzman opines that her complaints of abdominal pain on May 6 were consistent with having a large stomach tumor and liver metastasis. Therefore, Dr. Salzman opines Plaintiff was not inappropriately discharged on May 6, and this discharge had no effect on her hemorrhage.

Finally, the movant's oncology expert Dr. Blum opines that Plaintiff had cancer for months before her admission to Coney Island Hospital April 27. Her initial ultrasound and CT scan on April 27 revealed masses in the abdomen and near the stomach, which was correctly determined to be a likely tumor. He opines that she timely received a gastroenterology consult, liver biopsy, and upper endoscopy in the days that followed. He further opines that because she had a rare type of tumor, it was within good and accepted standards for the pathology results on the liver sample to take several days, requiring serial special stains and markers.

Dr. Blum opines that Plaintiff's discharge on May 6 had no effect on her cancer or the extensiveness of her surgery. He states that she was ultimately diagnosed with Ewing's sarcoma, a "rare and aggressive cancer," which would have indicated a total gastrectomy to excise the tumor regardless of any treatment or care she received at Coney Island Hospital. He opines that Ewing's sarcoma is "not as responsive to chemotherapy" as other tumors, and therefore there was no option for neoadjuvant chemotherapy to shrink the tumor before surgery. Therefore, he specifically opines that no departures from the standard of care by Coney Island Hospital were a proximate cause of her total gastrectomy, and that procedure would have been necessary regardless of the extent of her hemorrhage.

Based on the record and three expert affirmations, HHC establishes a prima facie case that the physicians and employees of Coney Island Hospital did not depart from good and accepted medical standards in Plaintiff's treatment from April 27 to May 6. The movant also establishes that any alleged departures of HHC did not proximately cause Plaintiff's claimed injuries, including her total gastrectomy, which the experts opine was an unavoidable outcome of her cancer.

In opposition to HHC's motion, Plaintiff submits an expert affirmation from a physician certified in internal medicine and gastroenterology, (name of expert redacted); an expert affirmation from a physician

certified in surgery with experience in partial and total gastrectomies, (name of expert redacted); and an expert affirmation from a physician certified in medical oncology and hematology, (name of expert redacted). The Court was presented with the signed, unredacted affirmations of all experts for *in camera* inspection.

Firstly, Plaintiff's internal medicine and gastroenterology expert opines that Coney Island Hospital departed from the standard of care by failing to monitor Plaintiff for signs of bleeding between April 30 and May 6. The expert opines that anemia, evidenced by low H&H levels, is a common symptom of gastrointestinal bleeding. The upper endoscopy performed by Dr. Steinheber on April 30 revealed a friable mass, i.e., a "mass that easily bleeds when palpated or manipulated." The mass was so unstable that he could not take biopsy tissue sample. Plaintiff's expert opines that a mass of that nature was "highly prone to re-bleed," and the standard of care required Plaintiff's H&H levels to be monitored daily while she was hospitalized.

On her April 27 admission, Plaintiff's blood draw revealed hemoglobin levels which were already low but within normal range, according to Plaintiff's expert. Her H&H levels then dropped below normal range and continued to decrease on April 28, April 29, and April 30. The last recorded results were hemoglobin 11.5 (12-15.8 normal) and hematocrit 34.0 (35.9-48.7 normal). The attending physician, Dr. Ahmed, testified that she discontinued daily blood draws after April 30 due to the potential for bleeding, pain, thrombosis, or infection at the injection site. Plaintiff's expert addresses this explanation as "absurd and contrary to the accepted standard of care," and opines that the high risk of a gastrointestinal hemorrhage should have "far outweighed" those considerations.

Plaintiff's expert also counters Dr. Salzman's opinion that further blood tests were not indicated because Plaintiff had no other clinical symptoms such as vomiting blood, blood in the stool, or tachycardia. Plaintiff's expert opines that "a physician does not need to wait" for those extreme symptoms to check H&H levels, and that the standard of care was to continue those blood labs when a patient is known to have a friable mass.

From a gastroenterology standpoint, Plaintiff's expert opines that under the standard of care, a repeat upper endoscopy should have been performed to ensure that the bleeding had effectively been cauterized. In the expert's opinion, another endoscopy was "necessary, indicated, and warranted" by the April 30 findings of a

friable mass with a high likelihood of re-bleeding. The expert opines that Coney Island Hospital's gastroenterologists were negligent in failing to further examine her after April 30 or perform another endoscopy before she was discharged. Based on the records and her subsequent massive hemorrhage, Plaintiff's expert opines that a repeat endoscopy in this case "would have undoubtedly demonstrated that the mass continued to bleed," and interventions such as cauterization or embolization could have been undertaken sooner.

The expert counters Dr. Salzman's opinion that Plaintiff's complaints of sharp abdominal pains of May 6 were normal symptoms of her tumor. She was given Toradol, which the expert opines is "a very strong pain medication which only masked her clinical symptoms." The expert opines that it was a departure from the standard of care not to perform a blood test, abdominal CT scan, gastroenterology consult, and repeat upper endoscopy to rule out bleeding.

Plaintiff's expert notes that by the time Plaintiff was readmitted to the hospital on the evening of May 6, her hemoglobin was 5.6 and hematocrit was 17.2, numbers dangerously below the normal range, and she required multiple blood transfusions to be stabilized. The expert counters Dr. Salzman's opinion that there were no earlier signs of "significant bleeding" until after she was discharged. Plaintiff's expert opines that this sharp decrease from her last recorded H&H levels would have taken "days, not hours." The expert opines that Plaintiff's H&H levels had likely been dropping before her discharge, and her symptoms of severe abdominal pain "were consistent with her abdominal cavity filling up with blood." Had the bleeding been diagnosed and treated sooner, the expert opines that Plaintiff's gastrointestinal hemorrhage would not be as massive.

Plaintiff's surgery expert opines on the issue of proximate causation as related to Plaintiff's gastrectomy. The expert opines that the May 8 surgery was a direct result of her "inappropriate and premature discharge" on May 6, and the alleged failure of Coney Island Hospital to timely diagnose and control her gastrointestinal bleed. Countering the opinion of Dr. Frank, Plaintiff's expert opines that a total gastrectomy was not the only option to treat Plaintiff's form of cancer. She arrived at Kings County Hospital with an active hemorrhage, requiring "massive blood transfusions to improve her hemodynamics," and surgeon Dr. Serafini's primary goal was to locate the source of the bleeding and save her life, which took precedence over "sparing organs."

Plaintiff's surgery expert opines that at least "a portion of the stomach could have been salvaged" if the surgery did not take place in the context of an emergency to stop a massive hemorrhage. The expert opines that if Plaintiff's bleeding had been treated sooner, the tumor could have been shrunk with neoadjuvant therapy prior to surgery, "permitting for less radical surgical intervention." The expert opines, based on the gastric mass found in Dr. Steinheber's initial upper endoscopy, Plaintiff could have "undergone a sub-total gastrectomy or hemi-gastrectomy that would have spared a portion of her stomach" had it been performed under non-emergency conditions. Plaintiff's surgery expert opines that Plaintiff's quality of life has suffered due to undergoing a total gastrectomy rather than a partial gastrectomy.

Finally, Plaintiff's oncology expert opines that Plaintiff could have been able to receive neoadjuvant chemotherapy to shrink the tumor before surgery and preserve a portion of her stomach. The oncology expert counters the opinion of Dr. Blum that Plaintiff's initial diagnosis of Ewing's sarcoma would have inevitably indicated a total gastrectomy. With further analysis, Plaintiff's diagnosis was a synovial sarcoma variant, not Ewing's sarcoma, which the oncology expert opines would have made her a candidate for neoadjuvant chemotherapy to shrink the tumor. The expert opines that her uncontrolled bleed deprived her of any chance of receiving this treatment prior to surgery, and therefore her total gastrectomy was proximately caused by Coney Island Hospital's departures from the standard of care.

Based on these submissions, Plaintiff's experts raise clear issues of fact precluding summary judgment as to HHC/Coney Island Hospital. They also raise conflicting opinions to HHC's experts on the issue of proximate causation and whether her total gastrectomy was unavoidable. Therefore, HHC's motion is denied with respect to the medical malpractice claims.

Notwithstanding the above, Plaintiff submits no opposition to the branch of HHC's motion seeking summary judgment on the issue of informed consent. HHC argues that the lack of informed consent is a new theory of liability that was not asserted in Plaintiff's notice of claim against HHC and Coney Island Hospital. It is also not applicable based on Plaintiff's allegations of malpractice against said defendants, e.g., premature

discharge and failure to diagnose a gastrointestinal bleed. For these reasons, HHC's motion is granted to the extent of the lack of informed consent claims only.

Accordingly, it is hereby:

ORDERED that Dr. Dharmasena and New York Community Hospital's motion (Seq. No. 4) for an Order, pursuant to CPLR 3212, granting summary judgment to said defendants, dismissing all claims against them, and deleting them from the caption of this action, is **GRANTED** without opposition; and it is further

ORDERED that Dr. Lyons's motion (Seq. No. 5) for an Order, pursuant to CPLR 3212, granting summary judgment to Dr. Lyons is **GRANTED TO THE EXTENT** of dismissing any claims for lack of informed consent against him, and the motion is otherwise **DENIED;** and it is further

ORDERED that HHC and Coney Island Hospital's motion (Seq. No. 6) for an Order, pursuant to CPLR 3212, granting summary judgment to the movants, is **GRANTED TO THE EXTENT** of dismissing any claims for lack of informed consent against them, and the motion is otherwise **DENIED.**

The parties are directed to appear for a settlement conference on September 5, 2024.

The Clerk is directed to enter judgment in favor of SANATH DHARMASENA, M.D. and NEW YORK COMMUNITY HOSPITAL.

This constitutes the decision and order of this Court.

ENTER.

Hon. Consuelo Mallafre Melendez

J.S.C.