SUPREME COURT OF THE STATE OF NEW YORK
NEW YORK COUNTY

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

Justice

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RAQUEL MAURO and VINCE MAURO

Plaintiff,

- v -

MEMORIAL SLOAN KETTERING CANCER CENTER, also known as MEMORIAL HOSPITAL FOR CANCER AND ALLIED DISEASES,

Defendant.

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INDEX NO. 805152/2021

MOTION DATE 10/15/2024

MOTION SEQ. NO. 001

DECISION + ORDER ON MOTION

The following e-filed documents, listed by NYSCEF document number (Motion 001) 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 33, 34, 35, 36, 37, 38, 40, 41, 42

were read on this motion to/for SUMMARY JUDGMENT.

In this action, inter alia, to recover damages for medical malpractice, the defendant moves pursuant to CPLR 3212 for summary judgment dismissing the complaint. The plaintiffs oppose the motion. The motion is denied.

The crux of the plaintiffs' claim is that, while the plaintiff Raquel Mauro (the patient) was being treated for lymphoma at the defendant hospital with radiation and chemotherapy, the side effects of the treatment made her dizzy and lightheaded, and, as a consequence of the defendant's failure properly to provide her with assistance in getting dressed after finishing a radiation treatment, she fell to the floor and sustained injuries.

In their complaint, the plaintiffs alleged that the patient, who was then 87 years old, began treating with the defendant hospital in late 2017 and early 2018, at which time she was diagnosed with follicular lymphoma, and began treatment for that cancer. They asserted that, in the months leading up to May 31, 2018, the patient was administered intravenous rituximab as a chemotherapeutic agent for treatment of the lymphoma. According to the plaintiffs, rituximab causes multiple side effects, including dizziness, lightheadedness, and fainting, especially after

a patient gets up from a lying or sitting position. They averred that, while still receiving rituximab, the patient also was prescribed radiation therapy as part of the treatment protocol and that, on May 31, 2018, she underwent her first radiation therapy session. In their complaint, the plaintiffs asserted that, after the patient's radiation therapy session had concluded, the patient was directed to dismount from a treatment table and walk to the dressing area to change back into her street clothes, but was unassisted by any doctor, nurse, or other hospital personnel. They alleged that she was unsteady on her feet due to her advanced age and medical condition and that, while standing and dressing herself, she became dizzy, faint, and lightheaded, fell onto the floor, and sustained a left femoral neck fracture, after which she was discovered by nursing personnel, examined, and placed on a stretcher.

In their complaint, the plaintiffs further alleged that, immediately after the fall, the patient's radiation oncologist, Joachim Yahalom, M.D., and a nurse, Catherine Adams, both of whom were employed by the defendant, evaluated her complaints of acute left hip pain and the inability to move her left leg. The plaintiffs contended that the patient was removed from the defendants' radiation therapy department on the stretcher and taken to the defendant's urgent care center, where she was placed under the care of Daniel Eduardo Prince, M.D., who diagnosed a left proximal femoral neck fracture, and performed a percutaneous closed reduction and internal fixation of the injury on June 1, 2018. They further alleged that the patient remained in the defendant hospital until her discharge on June 23, 2018, after which she underwent physical therapy and regularly followed up with Dr. Prince for continued orthopedic care, up to and including October 16, 2019. According to the complaint, the patient continues to receive treatment at the defendant hospital for her lymphoma and physical disabilities related to her left hip injury.

In their bill of particulars, the plaintiffs reiterated, virtually verbatim, the allegations set forth in their complaint. They further asserted that the defendant departed from good and accepted medical care by failing to treat and care for the patient in a sufficiently careful and

skillful manner, failing properly to monitor, supervise, and assist her during ambulation and dressing after a medical procedure, failing to take into account her weakened and debilitated state as a result of her lymphoma, cancer treatment, and advanced age, and failing safely and properly to assist her as she got dressed in the radiation therapy department after the radiation procedure, thus failing to prevent her fall. As a consequence of these alleged departures from good practice, and the consequent fall, the plaintiffs alleged that the patient sustained a fracture of the left proximal femoral neck, and was compelled to undergo percutaneous closed reduction and internal fixation surgery, all of which resulted in pain, suffering, arthritis, loss of range of motion, ambulatory difficulties, and gait disturbance, further necessitating a regimen of physical therapy, home nursing care, and the need to use assistive devices for ambulation. They further alleged that she sustained depression, anxiety, emotional distress, mental anguish, and limitations in her activities of daily living as a consequence of her physical injuries.

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]).

"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 Foster-Sturrup v Long,* 95 AD3d 726, 727 [1st Dept 2012]; *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]). Proof that a hospital failed to follow its own established protocols that had been established to prevent or minimize injury to patients will support a cause of action sounding in medical malpractice (*see Lang-Salgado v Mount Sinai Med. Ctr., Inc.,* 157 AD3d 532, 533 [1st Dept 2018]; *Pacio v Franklin Hosp*., 63 AD3d 1130, 1132-1133 [2d Dept 2009]).

To make a prima facie showing of entitlement to judgment as a matter of law, a defendant physician moving for summary judgment must establish 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]; *Barry v Lee*, 180 AD3d 103, 107 [1st Dept 2019]; *Frye v Montefiore Med. Ctr*., 70 AD3d at 24) or establish that the plaintiff was not injured

by such treatment (*see Pullman v Silverman,* 28 NY3d 1060, 1063 [2016]; *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 this 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, as noted, 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).

The defendant established its prima facie entitlement to judgment as a matter of law by submitting the pleadings, the bill of particulars, relevant medical records, and the transcripts of the parties' deposition testimony, along with the expert affirmation of oncologist Mark Farrugia, M.D., and the affidavit of expert radiation oncology nurse Caitlin Morgante, R.N.

Dr. Farrugia opined that none of the defendant's medical or nursing personnel departed from good and accepted medical practice in the manner in which they monitored the patient after her radiation therapy, and that nothing that they did or failed to do caused or contributed to the patient's injuries.

Dr. Farrugia first explained that, after the patient had been diagnosed with stage IV follicular lymphoma, the defendant's medical staff informed her that the recommended course of treatment was the administration of the drug rituximab, followed by radiation therapy. As he described it, rituximab is an antibody medication that attaches to cancer cells, and helps the body destroy them, and that a common side effect of rituximab is immunosuppression, which causes some patients to become more susceptible to infections. Dr. Farrugia asserted that some, but not all, patients experience an "infusion reaction" following rituximab treatment, and might experience side effects that manifest themselves in the period immediately following the administration of the drug. He opined that, although these side effects may include lightheadedness, dizziness, and fainting, they are not expected to appear as far into the future as weeks or months following administration, and that the patient was not susceptible to infusion-related side effects in any event, based, in part, on her own reports that she was tolerating the immunotherapy treatment well, without associated dizziness. Inasmuch as April

26, 2018 was the last time prior to the patient's fall that she was administered rituximab, and she fell on May 31, 2018, Dr. Farrugia opined that, even if she had experienced any infusion-related side effects from rituximab, those side effects "would have resolved well before [she] started radiation therapy over one month later."

With respect to the effect of radiation therapy upon the patient, Dr. Farrugia asserted that, after the patient completed the immunotherapy on April 26, 2018, Dr. Yahalom informed her that she would be administered radiation therapy to the left pelvis and right humerus. According to Dr. Farrugia's review of relevant medical records and deposition testimony, he asserted that Dr. Yahalom advised the patient that possible side effects of the radiation included fatigue, mild dermatitis, diarrhea, and bladder irritation. Dr. Yahalom formulated a plan to administer radiation on two dates, for a total dosage of 4 Grays (Gy) of radiation, which is equal to 400 rads. Dr. Farrugia opined that 4 Gy is a very low dose of radiation, noting that typical breast cancers are treated with 50 Gy of radiation over a period of five weeks, while head and neck cancer is treated with 70 Gy of radiation over a period of seven weeks. He concluded that "a total dose of 4 Gy of radiation has little to no side effects. In this instance, on May 31, 2018, plaintiff was treated with 2 Gy of radiation," and "2 Gy of radiation would not have caused plaintiff to feel any lightheadedness, weakness, or dizziness immediately following treatment."

Dr. Farrugia further explained that "radiation therapy elicits its effects by causing DNA damage. Cells are affected by the damage after they undergo cellular division. Most cells do not divide daily. For this reason, . . . the effects of radiation are not manifested until days after treatment." He further noted that effects from radiation therapy are cumulative and that, consequently, it would take several treatments until a patient experienced any side effects. Dr. Farrugia thus concluded that,

> "[g]iven that it would take several treatments, or at a minimum several days, before a patient would experience any side effects from radiation therapy, and this patient received a very low dose of radiation on May 31, 2018, it is my opinion to a reasonable degree of medical certainty that the May 31, 2018

> radiation treatment did not increase the likelihood of plaintiff feeling dizzy, lightheaded, or in any way more inclined to fall over as a consequence of the radiation."

He noted that, on May 31, 2018, the patient was lying down on a treatment table for approximately one hour while she received radiation therapy, and that one hour of radiation was within the standard timeframe for radiation therapy. He opined that that this one hour of radiation therapy would not, in and of itself, have warranted additional assistance after the treatment ended. In this respect, Dr. Farrugia concluded that the patient's fall in the dressing room while putting on her pants "was in no way related to, nor caused by, either the immunotherapy or radiation therapy she had received" at the defendant hospital.

In her expert affirmation, Morgante opined that all nursing personnel at the defendant hospital satisfied the applicable standard of care in monitoring the patient during her radiation therapy and immediately thereafter, and that nothing that any nurses there did or did not do caused or contributed to the patient's fall. In this regard, she asserted that, while some patients experience fatigue following rituximab treatment, the patient herself had stated that she did not experience any side effects from rituximab during the time that is was being administered to her, and that it was unlikely that she would have been experiencing rituximab-associated fatigue or weakness on May 31, 2018, more than one month after the last dosage of rituximab had been administered. Moreover, she opined that the side effects of radiation therapy are cumulative and that, as such, if a patient were to feel fatigue or weakness from radiation, he or she would only begin to experience these symptoms after several sessions of radiation therapy, not immediately after the initial session.

As Morgante explained it, prior to the patient's first radiation treatment on May 31, 2018, Adams saw and evaluated her. She stated that, during Adams's fall-risk assessment, the patient had reported that she had fallen outside of the hospital twice in the year preceding that date. According to Morgante, the patient told Adams that she had a visual impairment that affected her mobility, and weakness in her legs that affected one side of her body. As Morgante

described it, when Adams inquired of the patient, the patient responded that she did not need assistance in ambulating, getting into a chair, or placing herself on a table for examination, and that, based on patient's self-reported history of falls, Adams determined that, although the patient had some risk of falling, the patient did not require assistance in ambulating on that day. Morgante opined that not every patient who is deemed to have some risk of falling will automatically require assistance with ambulation, especially when he or she expressly declines assistance. She stated that a nurse must consider the totality of the patient's condition to determine whether intervention nevertheless is required, and that, based on the totality of the patient's presentation here, Adams appropriately respected the patient's declination of assistance. In this respect, Morgante noted that the patient had walked into the radiology treatment room without any assistance, was alert and interactive, and had reported that she was not experiencing any fatigue, diarrhea, dehydration, nausea, vomiting, or nutritional problems. She further noted that, as of May 31, 2018, the patient was living and ambulating independently, and that the patient testified that, in the days leading up to May 31, 2018, she walked her dogs three times per day for 30 minutes to one hour each time, did not use a cane or walker, did not have any difficulty navigating stairs, and did not need help getting dressed. Morgante additionally explained that, with respect to the two prior falls that the patient identified, the patient herself attributed one fall to trouble with walking her dog and the other to an abrupt stop by a bus driver when she was a bus passenger. Hence, Morgante concluded that a knowledge of the patient's prior falls, standing alone, did not warrant intervention in ambulating or dressing.

Morgante opined that, when an elderly cancer patient has a history of falls but does not require the aide of an assistive device, is not accompanied by a home health aide, is mentally competent, does not have self-reported symptoms of fatigue, and declines assistance, the nursing staff must respect the patient's authority and autonomy. She thus concluded that the appropriate intervention for the patient here was to provide her with "education," and advise her to ask for assistance as needed, which Adams appropriately provided by informing the patient to

request help if she needed it and to stay on the treatment table to make sure she did not feel dizzy before standing up. Morgante further asserted that the defendant followed its own Nursing Policies and Procedures by properly evaluating the patient's risk, inasmuch as its nursing staff asked the patient all of the requisite and appropriate questions, and thereafter provided the patient with "education" as to the prevention of falls. In this respect, she further concluded that the defendant's staff properly determined that, although the patient presented some risk for falls, she was not at a high risk for falls, since she was not confused, did not have cords, Foleys catheters, or intravenous lines attached to her, and was not physically impaired due to a diagnosis that physically limited her ability to ambulate. Morgante explained that, inasmuch as the patient was alert and oriented as to person, place, and time, ambulated independently, and denied the need for any assistance, she was not a "high risk" patient.

Morgante further opined that the defendant's treatment was not the proximate cause of the patient's injuries. With respect to that opinion, Morgante noted that, immediately prior to the patient's first radiation treatment on May 31, 2018, she walked unassisted down a hallway to a dressing room, and undressed without any assistance or difficulty. She further explained that, after changing, the patient walked unassisted to the treatment table, and only asked for assistance in getting onto the table, and then only because she did not know which way to lie down, while, after treatment, the patient did not ask for any help, and walked unassisted back to the dressing room. Hence, Morgante concluded that the "patient's conduct and condition in no way indicated to the providers that the patient would or should need help getting dressed," and that, given the patient's level of independence and mental capacity, "it was incumbent upon the patient to request help if it was needed at any time before or after the treatment." Morgante pointed out that, at her deposition, the patient testified that she did not know exactly why she fell in the dressing room, asserting instead that she "must have felt dizzy and blacked out."

In opposition to the defendant's prima facie showing, the plaintiffs raised triable issues of fact both as to whether Yahalom and Adams departed from good and accepted practice, and

whether their departures caused or contributed to the patient's injuries. The plaintiffs raised these triable issues of fact with their submissions, which included a response to the defendant's statement of uncontested facts, an attorney's affirmation, the expert affirmation of a board-certified radiation oncologist, and the expert affirmation of a registered nurse.

The plaintiffs' expert radiation oncologist asserted that Yahalom and Adams departed from good and accepted medical practice by violating the defendant's own hospital protocols, and that these departures proximately caused the patient's injuries. As a general matter, this expert opined that the defendant failed to treat and care for the patient in a sufficiently careful and skillful manner, failed properly to monitor, supervise, and assist the patient during ambulation and dressing immediately after the radiation treatment, and failed to take into account her weakened and debilitated state as a result of her lymphoma, cancer treatment, and advanced age of 87 years. The expert asserted that the defendant's staff should properly have assisted the patient as she got dressed in the radiation therapy department.

The plaintiff's medical expert expressly disagreed with both Dr. Farrugia and Morgante that the patient was not at a high risk for falling. Rather, the expert characterized the patient as a "documented High Fall Risk and who required assistance at all times while she was in the Memorial Sloan Kettering facilities, including following her radiation therapy." As this expert explained it,

> "[a]ccording to Memorial Sloan protocols, a 'Yes' to any of the questions on the fall risk assessment indicates the patient is at high risk for falling; here, in the 'Falls Risk Assessment' it says: Patient reports falling in the past year: Yes. Patients states they have fallen: More than one time. Plaintiff states their last fall was Outside,"

The expert noted that the patient had been injured as a result of a prior fall, which had been documented on a May 9, 2018 positron emission tomography (PET) scan. The plaintiffs' expert radiation oncologist further concluded that the patient was a high fall risk because she reported that she had a visual impairment that affected her mobility and had weakness in her legs that affected one side of her body. In addition, the expert noted that Adams, who was the nurse

assisting in the administration of radiation therapy, knew that the patient was a high fall risk. The plaintiffs' medical expert further noted the patient's history of an unsteady balance, and her deposition testimony, in which she asserted that she needed assistance not only when she was getting onto the examination table on May 31, 2018 to permit health-care providers to make a mold, but also at appointments prior to that date, when she would sometimes have difficulty climbing onto the examination table by herself. The expert concluded that all of these factors should have triggered the interventions described in the defendant's protocols. Additionally, the expert adverted to Adams's deposition testimony that fatigue is a common side effect from radiation, no matter what portion of the body is being treated.

In support of the opinion that intervention was required, the plaintiffs' medical expert quoted from the defendant's own protocols, as follows:

> "[p]atients are assessed for the following fall risk factors; the presence of one risk factor makes patient high risk for falling:
>
> "i. Patient factors (history of falls, needs help transferring to commode or toilet, needs help moving from bed to chair or requires a complete transfer)
>
> "ii. Sensory deficits (visual or auditory impairment affecting mobility, peripheral neuropathy affecting mobility)…
>
> "Assessment for falls risk is included in all outpatient nursing assessments.
>
> "Patients are assessed for the following fall risk factors. Review and update CIS
>
> "Header as indicated with each assessment.
>
> "A "YES" response to any of these questions indicates the patient is at high risk for falling:
>
> "i. Have you fallen at any time in the past year?"

The expert noted that those protocols further provided that, if a patient were a high fall risk:

> "Along with the standard safety interventions for all patients, the following interventions should be implemented for those patients at high risk for fall:
>
> "1. Interventions for all high-risk in- and outpatients:
>
> "a. Communicate relevant information regarding patient condition, risk factors, and interventions to patient and family.

> "b. Document relevant risk factors in CIS under the "Health Issues" tab to notify interdisciplinary team members.
>
> "c. Institute appropriate high-risk care plan as applicable to setting.
>
> "d. Position high-risk patients in rooms/treatment areas with best visual access to staff whenever possible.
>
> "e. Reinforce activity limits/safety precautions with patient/family. Encourage patient/family to notify staff for assistance prior to toileting.
>
> "f. Reorient confused patients as necessary.
>
> "g. Evaluate safety by frequent rounding on patient and addressing environmental hazards, toileting needs, comfort, and personal requests.
>
> "h. Assist and supervise patient while toileting. Do not leave patient alone while in bathroom or on the commode.
>
> "i. Assist patient with activities of daily living specifically transfer out of bed, ambulation, and personal hygiene, as applicable to care setting."

The plaintiffs' expert radiation oncologist thus concluded that the defendant departed from the standard of care by failing to adhere to its own protocols, and was of the opinion that, in this case, compliance required the defendant's staff to "[a]ssist and supervise patient while toileting," to not "leave patient alone while in bathroom or on the commode," and to "[a]ssist patient with activities of daily living specifically transfer out of bed, ambulation, and personal hygiene, as applicable to care setting." The expert thus opined that it was a departure from the standard of care for the defendant's personnel to fail to provide the patient with assistance and supervision on May 31, 2018 when she was in the dressing room, that the interventions articulated in the defendant's protocol should have been implemented, and that the defendant's personnel thus should not have permitted the patient to be left alone while in the bathroom, the dressing room, or on the toilet.

The plaintiff's medical expert expressly disagreed with Dr. Farrugia's opinion that the patient would not have felt any lightheadedness or dizziness from the administration of 2Gy of radiation. The expert asserted that the patient already was in a weakened state given her age,

the totality of her symptoms, and the administration of chemotherapy weeks earlier with rituximab, “which is known to cause tiredness, dizziness and fatigue.”

The expert also disagreed with Dr. Farrugia’s conclusion that the patient’s fall was not related to or caused by a lack of assistance in the dressing room or by the treatment that the defendant’s personnel rendered to her. In this respect, the plaintiffs’ expert referred to the patient’s deposition testimony, in which she stated that, when she sat up from the treatment table, she felt very dizzy and disoriented, but that she nonetheless was told to get up and retrieve her clothing from the dressing room, despite having lain on the examination table for more than one hour. Notwithstanding the patient’s dizziness at that time, the plaintiffs’ medical expert asserted that no one assisted her when she needed to get down from the examination table. The expert noted that nurse Kathleen Logan reported in the relevant chart that the patient had fallen in the female changing area, was found lying with her back on the floor, with legs bent at the knees, and immediately complained of intense pain to her left groin and hip area and left wrist. The plaintiffs’ expert concluded that the defendant’s staff, by failing to assist the patient in arising from the examination table, and in failing to accompany her to the dressing room, not only departed from accepted practice, but caused the patient to lose her best chance of avoiding a fall and that, consequently, such a departure was a substantial factor and proximate cause of the fall and concomitant injuries. Specifically, the medical expert asserted that the patient’s fall would not have happened had she been provided assistance in walking to the dressing room and while she was in the dressing room attempting to get dressed.

The plaintiffs’ retained radiation oncologist asserted that, as a consequence of the patient’s fall, she was caused to undergo left hip closed reduction surgery with percutaneous pinning and screws for a valgus impacted femoral neck fracture on June 1, 2018. The expert further asserted that the patient additionally required physical therapy following her fall and surgery, and that the patient had testified that, since the fall and the surgery, she has not been able to go out on her own or go places in the without someone accompanying her.

The plaintiffs' expert registered nurse essentially reiterated the opinions of their retained radiation oncologist, albeit in connection with the issue of whether the defendant's nursing staff departed from good and accepted nursing practice in failing to deem the patient as one with a high risk for falling, and in failing to implement the defendant's protocols for intervention in connection with such a patient by having a nurse or other health-care employee both assist and accompany the patient to the dressing room, and assist her in dressing while she was in the dressing room. The expert nurse further reiterated the opinions of the plaintiffs' radiation oncologist that these departures caused or contributed to the patient's fall and injuries.

In reply, the defendant submitted an attorney's affirmation, in which counsel asserted that Adams in fact complied with the defendant's protocols for assessing and treating patients who might be at some risk for falling, and that the opinions of the plaintiffs' experts were speculative and conclusory.

"'In general, under the doctrine of respondeat superior, a hospital may be held vicariously liable for the negligence or malpractice of its employees acting within the scope of employment, but not for negligent treatment provided by an independent physician, as when the physician is retained by the patient himself'" (*Valerio v Liberty Behavioral Mgt. Corp*., 188 AD3d 948, 949 [2d Dept 2020], quoting *Seiden v Sonstein*, 127 AD3d 1158, 1160 [2d Dept 2015]; *see Hill v St. Clare's Hosp*., 67 NY2d 72, 79 [1986]; *Dupree v Westchester County Health Care Corp*., 164 AD3d 1211, 1213 [2d Dept 2018]). Both Yahalom and Adams were employed by the defendant when they allegedly engaged in the omissions complained of here. Hence, to the extent that there are triable issues of fact with respect to whether Yahalom and Adams departed from good and accepted practice, there would be triable issues of fact as to the defendant's vicarious liability with respect to those claims. Inasmuch as the court concludes that the plaintiffs raised triable issues of fact as to whether Yahalom and Adams departed from good and accepted medical and nursing practice, respectively, and whether those departures caused or contributed to the patient's fall and resulting injuries, the defendant's motion must be denied.

The affirmation of the plaintiffs' expert radiation oncologist was signed and acknowledged in North Carolina. Although CPLR 2106 was amended, effective January 1, 2024, to authorize the use of an affirmation in lieu of an affidavit by "*any person* wherever made," as long as the statement set forth therein had been "affirmed by that person to be true under the penalties of perjury" (L 2023, ch 559) (emphasis added),[1] the Legislature did not repeal or amend CPLR 2309(c), which continues to require the submission of a certificate of conformity to accompany a written "oath or affirmation taken without the state." A certificate of conformity is a written instrument, pursuant to which a person qualified by the laws of the state in which an affidavit or affirmation is executed and notarized, or by the laws of New York, certifies that the out-of-state affidavit or affirmation has indeed been drafted, executed, and notarized in conformity with the laws of that state. The absence of the certificate of conformity, however, does not require the court to disregard or reject the sworn affirmation of the plaintiffs' expert radiation oncologist, as the failure to include a certificate of conformity is a mere irregularity that may be cured by the submission of the proper certificate nunc pro tunc (*see Khurdayan v Kassir*, 223 AD3d 590, 591 [1st Dept 2024]; *Parra v Cardenas,* 183 AD3d 462, 463 [1st Dept 2020]; *Bank of New York v Singh*, 139 AD3d 486, 487 [1st Dept 2016]; *DaSilva v KS Realty, L.P.,* 138 AD3d 619, 620 [1st Dept 2016]; *Diggs v Karen Manor Assoc., LLC*, 117 AD3d 401, 402-403 [1st Dept 2014]; *Matapos Tech., Ltd. v Compania Andina de Comercio Ltda.*, 68 AD3d 672, 673 [1st Dept 2009]).

Accordingly, it is,

ORDERED that the motion is denied; and it is further,

ORDERED that that the parties shall appear for an initial pretrial settlement conference before the court, in Room 204 at 71 Thomas Street, New York, New York 10013, on December

[1] The court notes that the written submission of the plaintiffs' expert radiation oncologist, although styled as an "affirmation," nonetheless was notarized and acknowledged.

18, 2024, at 11:00 a.m., at which time they shall be prepared to discuss resolution of the action and the scheduling of a firm date for the commencement of jury selection.

This constitutes the Decision and Order of the court.

11/18/2024
DATE

JOHN J. KELLEY, J.S.C.

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