Amitrano v Lorich
2025 NY Slip Op 30418(U)
January 29, 2025
Supreme Court, New York County
Docket Number: Index No. 805341/2019
Judge: John J. Kelley
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SUPREME COURT OF THE STATE OF NEW YORK
NEW YORK COUNTY

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

Justice

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INDEX NO. 805341/2019

RALPH AMITRANO, JR.,

Plaintiff,

MOTION DATE 01/04/2025 01/04/2025

- v -

MOTION SEQ. NO. 005, 006

DEBORAH A. CLARK LORICH, as the Executrix of the Estate of DEAN LORICH, M.D., Deceased, and NEW YORK PRESBYTERIAN HOSPITAL,

Defendants.

DECISION + ORDER ON MOTION

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The following e-filed documents, listed by NYSCEF document number (Motion 005) 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 120, 122, 124, 126, 128, 129, 130, 131, 132, 133, 134, 136

were read on this motion to/for SUMMARY JUDGMENT (AFTER JOINDER).

The following e-filed documents, listed by NYSCEF document number (Motion 006) 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 121, 123, 125, 127, 135, 137

were read on this motion to/for SUMMARY JUDGMENT (AFTER JOINDER).

In this action to recover damages for medical malpractice based on alleged departures from good and accepted medical practice, lack of informed consent, and negligent hiring and supervision, the defendant New York Presbyterian Hospital (NYPH) moves pursuant to CPLR 3212 for summary judgment dismissing the complaint insofar as asserted against it (SEQ 005). The plaintiff opposes that motion. The defendant Deborah A. Clark Lorich (Clark Lorich), as the Executrix of the Estate of Dean Lorich, M.D., Deceased (Lorich), separately moves for summary judgment dismissing the complaint insofar as asserted against her (SEQ 006). The plaintiff opposes that motion as well. NYPH's and Lorich's motions are granted, and the complaint is dismissed in its entirety.

The crux of the plaintiff's claim, as set forth in his bills of particulars, is that Lorich failed properly to treat his fractured left ankle in an appropriately conservative manner between July

21, 2017 and August 22, 2017, when he was 17 years of age, thus requiring him to undergo an unnecessary open reduction procedure with internal fixation at NYPH, which he claimed was itself improperly performed in an unsterile fashion. According to the plaintiff, Lorich also failed to appreciate or recognize that the plaintiff also was suffering from an infection at that time, which he claims that Lorich permitted to go untreated. More specifically, the plaintiff averred that Lorich departed from good and accepted medical practice by failing to immobilize his left ankle fracture with a cast and boot, failing to treat the fracture with rest, avoidance of weight bearing, ice, and compression, and in failing appropriately to stabilize the ankle. He further alleged that Lorich, by failing to prescribe conservative treatment options that would have resolved problems with the fracture as it healed, instead performed an unnecessary open reduction and internal fixation on July 21, 2017, and improperly performed that procedure in any event by, among other things, failing to maintain a sterile surgical site, thus leading to infection.

In addition, the plaintiff alleged in his bills of particulars that Lorich improperly and negligently discharged him from NYPH on July 24, 2017, despite failing to consider signs and symptoms of an infection, including the results of a July 23, 2017 computed tomography (CT) chest scan that reflected the presence of a nodule probable for infection, and despite the nature of the plaintiff's complaints, signs, and symptoms prior to that discharge from his initial admission to NYPH. According to the plaintiff, these complaints, signs, and symptoms included chest pain, left ankle swelling, and an elevated white blood cell count, which the plaintiff alleged that Lorich should have treated with appropriate antibiotics. He also alleged that Lorich should have followed up with a blood culture study and referred him to an infectious disease specialist, and should have scheduled a follow-up visit with Lorich himself within an appropriate time frame as part of an acceptable postoperative plan.

The plaintiff asserted that, as a result of Lorich's departures from good and accepted practice, he underwent an unnecessary open reduction internal fixation procedure on his left ankle. He further averred that he thereafter was required to be readmitted to NYPH with

swelling, diarrhea, and nausea. The plaintiff also alleged that Lorich's departures caused him to develop staphylococcus infections requiring irrigation and drainage, and thus caused him to require a peripherally inserted central catheter (PICC) line to be placed for a period six weeks subsequent to his August 14, 2017 readmission to NYPH, including the eight days between the date of that readmission and his discharge from NYPH on August 22, 2017.

In his bill of particulars as to NYPH, he reiterated the exact same claims as he asserted against Lorich. Specifically, he asserted, in his bill of particulars as to NYPH, that the hospital itself departed from good and accepted practice by

> "improperly and negligently discharging the patient on July 24, 2017; in failing to consider signs and symptoms of an infection including a CT Chest scan of 7/23/17 which found a nodule probable for infection; in failing to consider Plaintiff's complaints, signs, and symptoms prior to discharge including chest pain, left ankle swelling, and elevated WBC; in failing to discharge patient with appropriate antibiotics; in failing to arrange for an appropriate time-frame for a follow up visit; in failing to recommend a blood culture study; in failing to recommend an infectious disease consultation prior to discharge."

He further alleged that NYPH should be held vicariously liable for Lorich's malpractice.

Crucially, in connection with his allegations against NYPH, the plaintiff did not, either in his complaint, or in either of his two bills of particulars, assert that NYPH emergency room personnel should have admitted him as an inpatient on August 5, 2017, when he presented to the NYPH emergency department one day after his first postoperative visit with Lorich, complaining of symptoms that likely were indicative of bacterial infections. Nor did he allege in those documents that NYPH immediately should have commenced the administration of intravenous antibiotics to treat such infections on August 5, 2017. Rather, his bills of particulars limited the allegations of malpractice against NYPH to the alleged determinations of its personnel to discharge him on July 24, 2017, shortly after his July 21, 2017 surgery.

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]). 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 Perez v Fitzgerald,* 115 AD3d 177, 178 [1st Dept 2014]; *Perlin v King*, 36 AD3d 495, 495 [1st Dept 2007]; *see generally 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 Med. Ctr.*, 217 AD2d 98, 101 [1st Dept 1995]).

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).

Nonetheless, where a plaintiff fails to allege a theory of negligence in his or her bill of particulars, that new theory may not be raised for the first time in response to a defendant's motion for summary judgment (*see Rosado v New York City Hous. Auth.,* 194 AD3d 586, 587 [1st Dept 2021]; *Monmasterio v New York City Hous. Auth*., 39 AD3d 354, 355 [1st Dept 2007]).

In support her motion, Clark Lorich submitted the pleadings, the parties' discovery demands and responses, the bills of particulars, the transcripts of the parties' deposition testimony, relevant medical and hospital records, a statement of allegedly undisputed material facts, a memorandum of law, an attorney's affirmation, and the expert affirmation of board-certified orthopedic surgeon Geoffrey I. Phillips, M.D.

With respect to the medical malpractice cause of action asserted against Lorich, Dr. Phillips opined that Lorich did not depart from good and accepted practice in his diagnosis of any infection that the plaintiff may have been suffering while at NYPH, in the manner in which he diagnosed the plaintiff's left ankle fracture, in the determination to treat the fracture with an open reduction and internal fixation procedure, in the manner in which he performed that procedure, or in the manner in which he provided follow-up examinations, treatment, and care, including care related to bacterial infections.

Specifically, Dr. Phillips first noted that the plaintiff, who, at the time of the surgery, was 17 years old, weighed 249 pounds, and was 5' 9" tall, with a body mass index of 35, fractured his left ankle in an automobile accident on July 16, 2017. As Dr. Phillips interpreted the relevant deposition testimony and medical records, the plaintiff was splinted at Peconic Bay Medical Center in Riverhead, New York, and was scheduled to have surgery at Stony Brook University Hospital on July 20, 2017. He explained that the plaintiff's parents sought a second opinion from Lorich, who diagnosed him with a supination external rotation (SER) 4 left ankle fracture, and prescribed the antibiotic Clindamycin, which was administered intravenously as a prophylactic prior to any surgery. According to Dr. Phillips, on July 21, 2017, Lorich successfully performed an open reduction internal fixation procedure at NYPH, employing hardware to fix the relevant bones in place. He noted that Lorich discharged the plaintiff from the hospital on July 24, 2017. Dr. Phillips opined that there was no evidence of infection from an orthopedic perspective that would have warranted retaining the plaintiff in the hospital at that time.

Moreover, Dr. Phillips concluded that the radiographs originally taken of the plaintiff's ankle "clearly indicate that the surgery performed by Dr. Lorich was appropriately indicated, and [a] M[agnetic] R[esonance] I[maging scan] of the left ankle was also performed," which "showed a complex unstable ankle fracture configuration which was deemed to be SER 4 (supination external rotation)." He explained that, depending upon the number of structures involved, the SER grades are scaled from one through four, and that a grade four SER

> "was the highest grade including lateral damage with distal fibula fracture involving the syndesmosis (affecting the distal tibiofibular ligaments---anterior-inferior tibiofibular ligament and posterior inferior tibiofibular ligament) and also medial injury with tears of the deep and superficial fibers of the deltoid."

Dr. Phillips further explained that the radiographs also showed that the plaintiff's ankle mortise was not symmetric and was not appropriately reduced in place, while there was associated widening that was concerning for instability. Hence, he concluded that the "X-rays strongly suggested surgical intervention, which is what the orthopedic surgeon at Stony Brook had also recommended." In this respect, Dr. Phillips expressly opined that the plaintiff's injury was "very appropriate" for surgery, "as there were no other appropriate options available," since the plaintiff was a minor with no significant medical risk factors, and presented with an unstable fracture configuration. He concluded that, without properly addressing the fracture surgically, the plaintiff would have had a poor long-term outcome, with a high incidence of "post-traumatic arthrosis (arthritis that occurs when articular cartilage at the joint surface wears down), swelling, pain, and the need for additional salvage procedures." Contrary to the plaintiff's contention, Dr. Phillips concluded that there were no appropriate conservative options, other than surgery, to achieve a good long-term outcome.

Upon reviewing Lorich's description of the subject procedure in the relevant operative report, Dr. Phillips opined that Lorich's performance of the surgery was "excellent and well within the standard of care," and achieved an "excellent restoration of bony alignment and stability," as evidenced in the postoperative radiographs. Dr. Phillips further asserted that

antibiotics were administered both preoperatively and postoperatively, and that the timing, dosage, and intravenous administration of 900 milligrams (mg) of the antibiotic Clindamycin satisfied the applicable standard of care. In this respect, Dr. Phillips asserted that, inasmuch as there was a question of whether the plaintiff had a penicillin allergy, Clindamycin was an appropriate drug to prescribe. Dr. Phillips opined that there were no records to suggest a breach of the sterile field, nor any to suggest that any of the hardware implants were improperly sterilized. In connection with the postoperative administration of the drug, Dr. Phillips concluded that it was proper for Lorich to employ an injection of 900 mg of Clindamycin in a 5% dextrose solution via a "50 mL infuse over 30min x 2 doses IV Piggy Back every 8 hours," and that the course of antibiotic therapy was completed in an appropriate manner on July 22, 2017, that is, one day after the surgery. Hence, he asserted that "there was no concern whatsoever in terms of pre-operative and post-operative antibiotics prophylaxis in this case," and that there was no reason to place the plaintiff on continued antibiotic therapy immediately before his discharge, as there was no evidence of infection.

With respect to the lung nodule incidentally observed on the July 23, 2017 CT scan of the plaintiff's chest, Dr. Phillips expressly rejected the plaintiff's contention that the nodule was indicative of an infection warranting a delay in discharging him from the hospital. Dr. Phillips opined that it was appropriate and within the standard of care for other specialists treating the plaintiff to determine the significance of his chest pain, including whether or not the lung nodule was an indication of infection necessitating retaining him in the hospital, and what tests to conduct to assess his medical status. He explained that,

> "[f]rom an orthopedic perspective, there was no indication of infection at the surgical site or any other basis not to discharge the patient. The patient was discharged with instructions to look for specific signs and symptoms of infection and to notify Dr. Lorich with any concerns."

Dr. Phillips noted that the plaintiff developed two infections after his discharge from NYPH on July 24, 2017, but explained that one of those infections apparently emanated from his

gastrointestinal tract. He asserted that, "[g]iven that Dr. Lorich was an orthopedic surgeon and not a gastrointestinal expert, it was appropriate and within the standard of care that this infection was treated by other specialists." Dr. Phillips further explained that, although the other infection emanated near the site of Lorich's ankle surgery, the plaintiff was, in fact, readmitted to NYPH on August 14, 2017, at which time Lorich performed an irrigation, debridement, and drainage procedure, without having to remove any surgically implanted hardware.

In connection with the postoperative care that Lorich rendered to the plaintiff, Dr. Phillips asserted that, in accordance with the standard of care, Lorich, upon discharging the plaintiff from NYPH on July 24, 2017, instructed his family and him to follow up with a postoperative appointment by August 4, 2017, as it typically takes two weeks for the early healing process to occur, and two weeks is an appropriate amount of time to allow to pass before conducting a postoperative examination and taking postoperative x-rays to ensure that the hardware was situated in a good position. According to Dr. Phillips, there was no evidence of infection during that two-week postoperative period, inasmuch as the surgical wound was healing well, with no indication of infection observed at the plaintiff's first postoperative visit. Rather, according to Dr. Phillips, at this August 4, 2017 visit, the plaintiff complained of bloody stool and smelly diarrhea.

As Dr. Phillips interpreted Lorich's records and other parties' deposition testimony, Lorich examined the incision site on August 4, 2017, concluded that it appeared fairly "routine," and found no orthopedic problems, upon which Lorich appropriately referred the plaintiff to the NPYH emergency department, where the plaintiff presented on August 5, 2017, and was treated thereat for his gastrointestinal complaints by other specialists. Nonetheless, according to Dr. Phillips, when the plaintiff returned to Lorich's office on August 11, 2017, Lorich appropriately expressed concern that the lateral surgical wound of the plaintiff's ankle continued to drain and was not healing as expected. Dr. Phillips asserted that it was appropriate for Lorich to have waited and watched for any changes in the surgical wound over the eight-day period from August 4, 2017 to August 11, 2017, and that it was within the standard of care to wait to see if

the wound got better. As Dr. Phillips described it, if the wound improved over that period of time, the sutures could be taken out, but if it worsened, "which it did because it continued to drain," then it would be appropriate to perform an irrigation and debridement of the lateral wound. Consequently, Dr. Phillips concluded that, on April 11, 2017, Lorich appropriately decided to undertake an irrigation and debridement of the lateral wound.

According to Dr. Phillips, Lorich appropriately told the plaintiff to return on August 14, 2017, that is, three days later, at which time Lorich would return the plaintiff to the operating room for the irrigation and debridement procedure. Dr. Phillips came to this conclusion because he was of the opinion that, while undertaking an irrigation and drainage was urgent, "it was not emergent." Dr. Phillips concluded that, when the plaintiff was in fact readmitted to NYPH on August 14, 2017, Lorich appropriately performed an irrigation and debridement procedure, and that it was within the standard of care for Lorich to decline the preoperative administration antibiotics, "given that Amitrano was not septic." As Dr. Phillips explained it,

> "[t]he proper course of action was to hold the antibiotics until Amitrano was in the operating room and that way, a wound culture could be obtained that would not be affected by any antibiotics, thus enabling a greater chance to identify the organism if one was present. After performing the irrigation and drainage, Dr. Lorich closed the wound over a drain. Amitrano was kept in the hospital so infectious diseases could wait for the results of the wound culture to come back and adjust antibiotics."

He opined that it was appropriate for Lorich to leave the previously implanted surgical hardware in place, and concluded that, if the culture came back positive, it was within the standard of care to eradicate the infection with antibiotic therapy. According to Dr. Phillips, "[t]he wound culture came back positive but fortunately, it was a low virulent organism which allowed for Dr. Lorich's decision to leave the hardware in to maintain fracture fixation," and that "[u]nder the circumstances, there was nothing to suggest that the hardware needed to be removed acutely. If the hardware came out, the fracture would displace and render the ankle misaligned and unstable."

Dr. Phillips was of the opinion that the plaintiff's hospitalization commencing on August 14, 2017 was extended because of the need for a comprehensive gastrointestinal workup, pursuant to which the plaintiff underwent multiple endoscopic procedures. He asserted that such treatment, with the ankle hardware remaining in place, involved a course of intravenous antibiotics, consisting of a cocktail of Cefazolin and Rifampin that was administered via a PICC line. Dr. Phillips noted that, when the plaintiff returned to see Lorich in October 2017, Lorich found no ankle limitations, reported that the plaintiff was moving quite well, and instructed him to return in three months because he was still on a regimen of oral antibiotic suppression, a course of treatment that was continued for a total of approximately six months in order to eradicate the infection and preserve the surgical fixation until the fracture and ligaments healed. The treatment ultimately was discontinued in January 2018, and, as Dr. Phillips characterized it,

> "[t]he question in January 2018 became whether it was safe to stop the antibiotics and monitor, or to do another surgery, take the hardware out and eliminate the concern that the hardware could still be potentially infected. At that point, the hardware could have been electively taken out. That, however, is not a simple procedure. The procedure would have included going through the same surgical incision so that the tissue that had been traumatized twice before would be traumatized again. More surgical scarring would be created and there are the inherent risks in the removal of the hardware itself, including stripping or breaking a screw."

Hence, Dr. Phillips concluded that Lorich's determination to leave the hardware in was the appropriate one, particularly in light of the fact that the plaintiff reportedly was "doing well."

In support of its motion, NYPH relied on many of the same documents that Clark Lorich had submitted. In addition, NYPH submitted an attorney's affirmation, a statement of allegedly undisputed material facts, the expert affirmations of board-certified orthopedic surgeon Kenneth J. Mroczek, M.D., and board-certified internist and infectious disease specialist Bruce Farber, M.D., and the affidavit of Susan Diaz, its Director of Medical Staff Services.

Diaz averred that, upon her review of the relevant records, she determined that Lorich was not an employee or agent of NYPH at any time in 2017, but merely had attending privileges at NYPH, which allowed him to admit patients and practice orthopedic surgery on his private

patients at the hospital.

Dr. Mroczek opined that Lorich did not depart from good and accepted practice in recommending and performing an open reduction internal fixation procedure upon the plaintiff, that the procedure was fully indicated, that Lorich's surgical technique was well within the standard of care, that his postoperative care was proper, and that he appropriately referred the plaintiff to the NYPH emergency room on August 4, 2017 after the plaintiff presented with signs of a gastrointestinal bacterial infection. He further stated that nothing that NYPH medical or nursing personnel did or did not do caused or contributed to any of the plaintiff's claimed injuries. Dr. Mroczek recounted the plaintiff's experiences and the treatment rendered by Lorich and others at NYPH between July 21, 2017 and his initial discharge from NYPH on July 24, 2017. Dr. Mroczek noted that, prior to that discharge, he was examined by pediatric attending physician Snezana Nena Osorio, M.D., who reported that the plaintiff had remained in the hospital after the surgery as an inpatient for pain control, but that his pain was by then well controlled with oxycodone and Tylenol, and that he was "off" patient-controlled analgesia. She further reported that the plaintiff was able to ambulate with the assistance of physical therapy.

Dr. Mroczek asserted that, at the plaintiff's August 4, 2017 postoperative appointment with Lorich, Lorich examined the surgical wound, which appeared to be healing well, although Lorich documented a blister on the lateral portion of the incision with mild serous drainage, but otherwise observed no obvious signs of infection, erythema, or purulence. Dr. Mroczek averred that an x-ray of the plaintiff's ankle indicated that the hardware was in place and intact as of that date. Nonetheless, Dr. Mroczek asserted that, during this office visit, the plaintiff reported having suffered from foul smelling, bloody diarrhea and night sweats since the date of the procedure, and that, in light of these complaints, Lorich directed the plaintiff to present to the NYPH emergency room for further evaluation. Dr. Mroczek asserted that the plaintiff thereafter presented to the NYPH emergency department on August 5, 2017, at which time the plaintiff reported that he had leg swelling and seven to eight days of diarrhea and bloody stools, and

had experienced a fever of 101 to 102 degrees Fahrenheit five days earlier. Dr. Mroczek noted that, upon examination, NYPH medical staff concluded that the plaintiff's left ankle was swollen and that there was drainage from the surgical site, and that they reported a possible etiology for the diarrhea as including C-difficile bacterial infection. Nonetheless, Dr. Mroczek stated that the left ankle x-ray showed no evidence of hardware complications, and laboratory tests for C-difficile came back negative. Hence, the plaintiff was discharged, with instructions to follow up with "the orthopedic service."

Dr. Mroczek explained that, on August 11, 2017, the plaintiff returned to Lorich's office for removal of the surgical sutures, at which time the plaintiff's ankle evinced continued drainage from the lateral incision, but that he did not have any fevers or chills. According to Dr. Mroczek, Lorich conducted a physical examination that revealed that the plaintiff's medial wound was healed, and the sutures were in place and intact, with the mid-portion of the lateral incision emanating a continued, serous drainage, albeit without any obvious signs of infection, erythema, or purulence. Lorich recommended that, given the continued drainage, it was best to bring the plaintiff back to the operating room for irrigation and debridement of the lateral wound. As Dr. Mroczek recounted it, Lorich discussed the risks and benefits of the procedure with the plaintiff and his father, and formulated a plan for the plaintiff to remain in the hospital until the cultures came back to determine if antibiotics were necessary.

The plaintiff was again admitted to NYPH on August 14, 2017, under Lorich's supervision, to undergo the debridement procedure. As Dr. Mroczek noted, laboratory results from that day showed a normal white blood cell count of 10.8, after which Lorich performed the irrigation and debridement procedure, and removed all infected tissue and tissue that appeared to be non-viable. On August 17, 2017, NYPH's infectious disease team documented that the preliminary wound culture results were consistent with Methicillin-resistant Staphylococcus aureus (MSSA), Staphylococcus Lugdunensis, and Group B streptococcus bacteria, requiring a prolonged course of antibiotic therapy that was appropriate for the treatment of an infection of

an ankle joint in which hardware had been implanted. Thus, on August 18, 2017, the NYPH infectious disease team placed a PICC line for the intravenous administration of antibiotics. On August 22, 2017, the plaintiff was discharged from NYPH, while remaining on the intravenous antibiotics for an additional five weeks, and was provided with home infusion services for continuing the intravenous antibiotic therapy.

As Dr. Mroczek recited the plaintiff's history of treatment, on August 28, 2017, the plaintiff returned to Lorich's office, at which time the plaintiff's father reported that all drainage had ceased four days earlier, while the plaintiff denied suffering from fever, chills, or night sweats. Lorich reported that the plaintiff's wounds had healed, that the plaintiff was neurovascularly intact, and that there were no signs of infection. On September 26, 2017, the plaintiff was evaluated in the Weill Cornell Medicine infectious disease clinic by Maiko Kondo, M.D., who noted that the plaintiff had just completed a six-week course of intravenous antibiotics, and that his ankle hardware was still in place. Dr. Kondo further reported that the plaintiff denied the presence fever, chills, nausea, vomiting, diarrhea, and abdominal pain at that time, while the plaintiff's vital signs were stable, and the physical examination was within normal limits. The plaintiff returned to Lorich's office on October 2, 2017, at which time Lorich reported that the plaintiff had completed his course of antibiotic therapy and was under the care of an infectious disease specialist. Although Lorich reported mild swelling of the plaintiff's ankle, he wrote in his notes that the plaintiff had no significant complaints, that all wounds had healed, that the plaintiff had no physical limitations at that time, and that the plaintiff would continue his antibiotics in accordance with directions given by Dr. Kondo. On January 5, 2018, the plaintiff presented to orthopedic surgeon Jeffrey Richmond, M.D., who concluded that all wounds had healed, and that the physical examination was within normal limits.

Dr. Mroczek opined that it would have been improper for Lorich to have taken a more conservative approach in treating the plaintiff's fractured ankle, and that surgery was the only medical option to treat it properly. He concluded that "the surgery was performed in accordance

with the standard of care. It is noted that the ankle was prepped in a standard sterile fashion. The surgery was successful as the fracture was stabilized and the post-operative x-ray showed good alignment." Dr. Mroczek further opined that,

> "there is no medical evidence that Dr. Lorich did not implement appropriate sterile technique during the plaintiff's surgery on July 21, 2017, and the surgical site infection that plaintiff developed is not a result of negligence. Infection is a risk of any surgery, but especially surgery that involves the use of foreign bodies, such as the hardware that was used here. Dr. Lorich's operative report indicates that the ankle was prepped in standard sterile fashion."

He thus concluded that "the infection that the plaintiff ultimately developed here was not a result of improper sterile technique."

With respect to the plaintiff's admission to NYPH between July 21, 2017 and July 24, 2017, Dr. Mroczek asserted that,

> "[a]s the plaintiff's private attending physician, Dr. Lorich was medically responsible for ordering any indicated consults or lab work at any point during the referenced admission. NYPH and its staff were not medically responsible for ordering any consults or lab work for the plaintiff. Regardless of whose responsibility it was, it is my opinion to a reasonable degree of medical certainty that there were no findings during the plaintiff's July 21, 2017, admission that should have led any staff member to order blood cultures or an infectious diseases consultation."

Dr. Mroczek further averred that the recommendation to follow up with Lorich two weeks after the procedure had been completed was an appropriate recommendation, since that was a proper amount of time to allow the plaintiff's ankle to start healing before a postoperative examination was conducted, and postoperative x-rays taken, to ensure that the hardware remained in place. As he phrased it, even if there had been an earlier follow-up appointment with Lorich, it would not have made a difference with respect to the plaintiff's injuries or when the infection was diagnosed, as the surgical wound was healing well, with no indication of an infection during the plaintiff's August 4, 2017 postoperative appointment with Lorich.

Dr. Farber, NYPH's retained infectious disease specialist, reiterated Dr. Mroczek's recitation of the history of the plaintiff's treatment with Lorich and NYPH medical personnel, and also noted that, on January 25, 2018, Dr. Kondo spoke with Dr. Richmond, who explained that

removal of the hardware that Lorich had installed would cause more trouble than conservative management. Dr. Farber asserted that, at that time, there was no plan to remove the hardware, unless there were evidence of infection, and that Dr. Richmond suggested that the plaintiff discontinue taking oral antibiotics, upon which infectious disease specialist Dr. Kondo called the plaintiff's father and instructed them to stop the administration of oral antibiotics. According to Dr. Farber, since that time, the plaintiff has not had any evidence of recurring infection.

Dr. Farber agreed with Dr. Mroczek that, from July 21, 2017 through August 4, 2017, NYPH personnel did not depart or deviate from good and accepted medical practice in their examinations, treatment, and recommendations to the plaintiff in connection with any existing infection, and that all such examinations, treatment, and recommendations were proper and appropriate. Dr. Farber interpreted the plaintiff's claims against NYPH as being limited to vicarious liability for Lorich's alleged malpractice, and for the determinations of its own personnel to discharge the plaintiff from the hospital on July 24, 2017, that is, only three days after the subject procedure, without placing him on a regimen of antibiotics to treat a chest infection that allegedly spread, or could have spread, to the surgical site on his ankle. In connection with this issue, Dr. Farber was of the opinion that,

> "infection is a well-known and accepted risk of any surgery. All patients who undergo surgery are at risk of developing an infection in the surgical site. There are certain surgeries, such as ones in which a foreign body are used, as was the case here, that carry an even higher risk of post-operative infection. As such, prophylactic antibiotics can be administered post-operatively to reduce the likelihood of a post-operative infection. It is also standard of care treatment to sterilize the surgical site before an incision is made. Unfortunately, it is not possible to completely sterilize the skin because some residual bacteria will survive, even with standard of care disinfection. Therefore, post-operative wound infections are a risk of all surgical procedures, even when all appropriate preventative measures am carried out."

He further concluded that there was no evidence that Lorich failed to maintain a sterile surgical site, particularly because Lorich's operative report stated that the left lower extremity was prepared and draped in the standard sterile fashion, and because there was nothing in that report indicating that the surgery was not performed in accordance with proper sterile care. Dr.

Farber further concluded that Lorich properly and appropriately started the plaintiff on a prophylactic regimen of the intravenous antibiotic Cefazolin following the procedure.

Dr. Farber also concluded that the lung nodule observed on the July 23, 2017 CT scan of the plaintiff's chest was an incidental finding that had no relationship to the plaintiff's subsequent ankle infection. He further opined that the other conditions of which the plaintiff complained should have led to additional work-ups either were not reflected in the relevant medical records, or were normal postoperative findings that were to be expected in the days and weeks immediately following ankle surgery. He concluded by asserting that,

> "[o]f note, when the plaintiff presented to NYPH for the irrigation and debridement procedure on August 14, 2017, his labs showed a normal WBC count of 10.2. This was almost three weeks after the plaintiff's surgery. If his WBC count was not elevated three weeks after discharge during the same admission where he was diagnosed with a surgical site infection, it would not logically follow that it was elevated from that same infection that plaintiff claims was missed on July 24, 2017.
>
> "Given that plaintiff only exhibited normal post-operative findings and did not have any symptoms that plaintiff is claiming such as elevated WBC, chest pain, or ankle swelling, and plaintiff also did not exhibit other symptoms suspicious for infection such as fever, chills, or increased pain at the time of discharge, it is my opinion to a reasonable degree of medical certainty that blood cultures and an I[nfectious] D[isease] consultation was [sic] not indicated at any point during the plaintiff's admission because there were no abnormal findings that should have led the NYPH staff to suspect infection. For those same reasons, it is my opinion to a reasonable degree of medical certainty that antibiotics at discharge were not indicated. It is my opinion to a reasonable degree of medical certainty that there was no evidence of infection at any point during the plaintiff's July 21st admission up through and including the time of discharge on July 24th."

The plaintiff did not expressly oppose Clark Lorich's motion, as he filed no opposition under Motion Sequence 006. The opposition that he filed under Motion Sequence 005 included an expert's affirmation, in which his expert internist and cardiologist explicitly asserted that the affirmation was being submitted "in support of RALPH AMITRANO's opposition to the Defendant, NEW YORK PRESBYTERIAN HOSPITAL's Motion for Summary Judgment," along with an attorney's affirmation that was submitted "in opposition only to Defendant['s], NEW YORK PRESBYTERIAN HOSPITAL's motion." Moreover, the plaintiff's expert did not

specifically identify any act or failure to act on the part of Lorich himself that constituted an alleged deviation or departure from good and accepted medical practice. Nor did the expert opine that anything that Lorich did or did not do caused or contributed to a prolonged bacterial infection and the concomitant need for drainage, debridement, and irrigation of the surgical site, or the prolonged use of a PICC line, which the expert identified as the injuries and items of damage that the plaintiff had sustained. Inasmuch as Clark Lorich established her prima facie entitlement to judgment as a matter of law, and the plaintiff, by declining to address Dr. Phillips's affirmation, failed to raise a triable issue of fact in opposition to that showing, Clark Lorich must be awarded summary judgment dismissing the medical malpractice cause of action insofar as asserted against her.

In opposition to NYPH's motion, the plaintiff relied upon the documentation that both Clark Lorich and NYPH had submitted, and also submitted an attorney's affirmation, as well as the affirmation of an internist and cardiologist with experience in treating infectious diseases. That expert opined that, although the surgery itself "was considered a success," he or she noted that, on the very next day, the plaintiff was transferred to the pediatric floor of NYPH, where he was monitored and underwent a chest x-Ray that "showed interstitial markings and distention of the stomach." The expert opined that interstitial markings are "often times associated with an infection," and that, on the day after that, he evinced "tachycardic signs, another symptomology which could be caused by infection." As the plaintiff's expert continued,

> "[m]ost notably of all on July 23, 2017, the plaintiff's chest CT revealed a nodule in the right middle lobe, 'probably infected.' Nevertheless, because other common infection symptoms or signs were not present, the patient was discharged with instructions to follow up with his surgeon two weeks later."

The plaintiff's expert, however, did not opine that the July 24, 2017 discharge constituted a departure from good practice, and focused almost exclusively on the course of treatment rendered to the plaintiff after his August 4, 2017 postoperative visit with Lorich, concluding that, when the plaintiff presented to the NYPH emergency department on August 5, 2017, NYPH

medical personnel immediately should have administered a new course of antibiotics and immediately admitted him as an inpatient to NYPH during that antibiotic therapy. Specifically, the expert noted that, on August 5, 2017, the plaintiff presented to the NYPH emergency department with a swollen left leg, complaining that he had been suffering from diarrhea and a fever of 101 to 102 degrees Fahrenheit several days prior thereto. The expert noted that drainage continued to emanate from the surgical site at that time. Based upon a reading of the relevant NYPH chart, the expert explained that, although NYPH emergency department staff examined the plaintiff to rule out the presence of deep vein thrombosis, once they did so, they improperly discharged him that day, with instructions only to return to see Lorich. After seeing Lorich on August 11, 2017, the plaintiff was readmitted to NYPH for debridement and irrigation of the surgical wound on August 14, 2017, when NYPH personnel ultimately placed the plaintiff on a prolonged course of antibiotic therapy, via a PICC line, to treat the infection of his ankle joint. According to the plaintiff's expert, he was not discharged from NYPH until August 22, 2017, after having been administered intravenous antibiotics, with instructions to continue supervised home administration thereof for several weeks thereafter.

The plaintiff's expert opined that NYPH deviated from good and accepted medical practice, and departed from the applicable standard of care, in discharging the plaintiff from the emergency department on August 5, 2017, the very same day that he presented with signs of a spreading infection, rather than immediately admitting him to the hospital. The expert further concluded that NYPH deviated from good and accepted medical practice in

> "failing to consider the patient's obvious signs and symptoms of infection prior to discharge. NYPH deviated in failing to recognize that the antibiotics provided prior were not sufficient. NYPH deviated in focusing on ruling out a DVT instead of appropriately treating the patient's infection. NYPH deviated in discharging the patient on August 5, 2017, and allowing the patient's infection to worsen. The presence of drainage from the surgical wound, as well as the fever of 101-102 in the days prior, indicated a significant infection at the wound site. Such an infection requires the benefit of intravenous antibiotics, which have a significantly greater ability to penetrate tissue and treat deeper infections than oral antibiotics. The failure to admit Ralph and treat him with intravenous antibiotics, along with monitoring the effectiveness of the antibiotic therapy with blood testing, was a

> deviation in the standard of care. This deviation in the standard of care was directly responsible for his infection spreading further in his body, resulting in an infection in his bone (osteomyelitis) and more extensively in his tissue. This, in turn, resulted in his need for a more prolonged treatment period for his infection."

The expert further explained that the signs and symptoms of infection were clear both prior to, and upon, the plaintiff's arrival at NYPH on August 5, 2017, noting that the plaintiff's signs of infection had been manifest even prior to his July 24, 2017 discharge from NYPH shortly after the open reduction surgery, including, but not limited to, the CT scan that identified a "likely infected" nodule in his chest. The expert asserted that "[b]acterial infections grow exponentially." As the plaintiff's expert described it,

> "when a patient has evidence of a potential bacterial infection, delay in identifying and treating it results in a rapid worsening of the infection with progressive spreading of that same infection. Time is a critical factor in the medical approach to bacterial infections. Nevertheless, after that discharge Ralph logged complaints of diarrhea, fever, night sweats, and showed consistent sign of drainage from the incision site, evidence of his infection worsening. A patient who undergoes open surgery, such as the O[pen] R[eduction] I[nternal] F[ixation] procedure performed on the Plaintiff is at a significantly increased risk of developing an infection."

The expert ultimately concluded that the appropriate standard of care in treating the plaintiff would have been for NYPH to admit him as an inpatient on August 5, 2017, and immediately to insert a PICC line for the administration of antibiotics to control the infection. The expert stated that, had a PICC line been placed on that day, the plaintiff's infection would have likely been controlled, and would not have worsened over the course of the next nine days, but that the infection instead progressed to the point where a drainage, debridement, and irrigation procedure, and the prolonged employment of a PICC line, were required. Hence, the expert opined that NYPH's delay in seasonably and appropriately treating the plaintiff's infection on August 5, 2017 was the proximate cause of the need for those otherwise unnecessary procedures and the prolonged use of the PICC line.

In reply, NYPH submitted an attorney's affirmation and another affirmation from Dr. Farber, in which the latter noted that the plaintiff had never alleged in his complaint or bills of

particulars that NYPH's specific departures from good practice involved its failure to admit him on August 5, 2017 when he presented to the emergency department, or immediately to commence the administration of intravenous antibiotics at that time, let alone that these were the sole alleged departures claimed by the plaintiff. Dr. Farber further noted that the plaintiff's expert did not address any opinions that Dr. Farber himself had rendered with respect to the plaintiff's initial July 24, 2017 discharge shortly after the ankle surgery. In any event, Dr. Farber asserted that,

> "none of the expert's 'findings' are indicative of infection which should have led to further work-up and/or PICC line insertion. The expert points to two findings that allegedly should have led the NYPH providers to conduct a further work-up such as blood testing to determine the effectiveness of the plaintiff's antibiotic therapy: a fever that had not been present for 4 days and perfectly normal post-operative drainage."

As explained above, inasmuch as Clark Lorich established that Lorich did not depart from good and accepted medical practice, and the plaintiff did not attempt to refute or rebut that showing, the court dismissed the medical malpractice cause of action insofar as asserted against her. Since Lorich has been found not to have committed malpractice, he committed no negligent act for which NYPH could be held vicariously liable, even if it were his employer. Nonetheless, NYPH demonstrated that Lorich was a private attending physician who merely had admission and surgical privileges at NYPH, and that it thus was not Lorich's employer, a showing that the plaintiff did not even attempt to refute. It thus established that it could not be held liable for any malpractice committed by Lorich in any event (*see Mondello v New York Blood Ctr.-Greater N.Y. Blood Program*, 80 NY2d 219, 228 [1992]; *Fiorentino v Wenger*, 19 NY2d 407, 414 [1967]; *Zhuzhingo v Milligan*, 121 AD3d 1103, 1106 [2d Dept 2014]).

With respect to allegations of malpractice by NYPH's medical staff and employees, NYPH established, prima face, that those staff members and employees did not depart from good and accepted medical practice in connection with all of the alleged deviations and departures enumerated by the plaintiff in his complaint and bills of particulars. In opposition to

that showing, the plaintiff's expert did not address those issues and, hence, did not attempt to refute the opinions of Drs. Mroczek and Farber in this regard. Instead, the only opinion rendered by the plaintiff's expert involved a new theory of negligence and malpractice, consisting of NYPH's failure immediately to admit the plaintiff to NYPH when he appeared at its emergency department on August 5, 2017 with complaints of recent fevers, diarrhea, and ankle swelling, and immediately to commence the administration of intravenous antibiotics at that time. A plaintiff may not raise a triable issue of fact in opposition to a defendant's prima facie showing on a summary judgment motion by submitting evidence that supports only a new theory of liability that had not been alleged in his or her bill of particulars (*see Rosado v New York City Hous. Auth.,* 194 AD3d at 587; *Monmasterio v New York City Hous. Auth*., 39 AD3d at 355). The specific theories of liability that the plaintiff alleged in his bills of particulars cannot be stretched or distended to encompass the theory propounded by his expert in opposition to NYPH's summary judgment motion (*cf. Lawi v Complete Wellness Med., P.C.,* 2020 NY Misc LEXIS 47975, *9 [Sup Ct, N.Y. County, Oct. 29, 2020] [plaintiff's expert affirmation did not assert new theories of liability that had not been asserted in the bill of particulars, but only a "more detailed picture" of those prior allegations, using information obtained during discovery]). Since the plaintiff failed to raise a triable issue of fact in opposition to NYPH's prima facie showing of entitlement to judgment as a matter of law, summary judgment must be awarded to NYPH dismissing the medical malpractice cause of action insofar as asserted against it.

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]). "'[T]his showing of qualitative insufficiency of the consent [is] required to be supported by expert medical testimony'" (*King v Jordan*, 265 AD2d 619, 620 [3d Dept 1999], quoting *Hylick v Halweil*, 112 AD2d 400, 401 [2d Dept 1985]; *see* CPLR 4401-a; *Gardner v Wider*, 32 AD3d 728, 730 [1st Dept 2006]). Nonetheless, "expert testimony concerning what a reasonable person would have done in plaintiff's position is not necessary to maintain a cause of action premised upon lack of informed consent" (*Gray v Williams*, 108 AD3d 1085, 1087 [4th Dept 2013]; *see Hugh v Ofodile*, 87 AD3d 508, 509 [1st Dept 2011]; *Andersen v Delaney*, 269 AD2d 193, 193 [1st Dept 2000]).

"'The mere fact that the plaintiff signed a consent form does not establish the defendants' prima facie entitlement to judgment as a matter of law'" (*Huichun Feng v Accord Physicians*, 194 AD3d 795, 797 [2d Dept 2021], quoting *Schussheim v Barazani*, 136 AD3d 787, 789 [2d Dept 2016]; *see Godel v Goldstein*, 155 AD3d 939, 942 [2d Dept 2017]). Nonetheless, a defendant may satisfy his or her burden of demonstrating a prima facie entitlement to judgment as a matter of law in connection with such a claim where a patient signs a detailed consent form, and there is also evidence that the necessity and benefits of the procedure, along with known risks and dangers, were discussed prior to the procedure (*see Bamberg-Taylor v Strauch*, 192 AD3d 401, 401-402 [1st Dept 2021]).

"A failure to diagnose cannot be the basis of a cause of action for lack of informed consent unless associated with a diagnostic procedure that 'involve[s] invasion or disruption of the integrity of the body'" (*Janeczko v Russell*, 46 AD3d 324, 325 [1st Dept 2007], quoting Public Health Law § 2805-d[2][b]; *see Lewis v Rutkovsky*, 153 AD3d at 456). In addition to invasive diagnostic testing arising from a failure properly to diagnose a medical condition, the

administration of nonindicated medications arising from a misdiagnosis may also be the basis for a lack of informed consent cause of action (*see Lyons v Vassar Bros. Hosp*., 30 AD3d 477, 478 [2d Dept 2006]).

It is unclear as to whether the plaintiff's lack of informed consent cause of action, as asserted in his complaint, was meant to address Lorich's alleged failure to inform him of the risks and benefits of an open reduction internal fixation procedure on his ankle, or of risks and benefits of the mode of treatment rendered in connection with his infections. Regardless of the specifics of his claim, however, both Clark Lorich and NYPH established their prima facie entitlements to judgment as a matter of law in connection with that cause of action, and the plaintiff failed to raise a triable issue of fact in opposition thereto, inasmuch as his expert did not address the issue in the expert affirmation.

According to Dr. Phillips, the plaintiff and his parents spoke with pediatric orthopedist Wesley Carrion, M.D., at Stony Brook University Hospital, and later with Lorich about the risks and benefits of the proposed surgical procedure, as documented in both the Stony Brook and NYPH charts, and the plaintiff and his parents were made aware of the risk of infection. The plaintiff's parents signed a written informed consent form for both Drs. Carrion and Lorich. In fact, Dr. Phillips noted that Lorich documented, in his own handwriting, that the plaintiff and his parent were fully informed that infection was a risk of the surgery.

Although Lorich could not legally have relied upon the sufficiency of the information provided to the plaintiff and his family by Dr. Carrion at Stony Brook prior to the family's meeting with Lorich (*see Sangiuolo v Leventhal,* 132 Misc 2d 680, 682-683 [Sup Ct, N.Y. County 1986] [each physician has independent obligation to inform patient of risks, benefits, and alternatives, even where another physician has informed the patient thereof]), the court notes that Dr. Carrion's records indicated that Dr. Carrion informed the plaintiff and his parents that the risks of an open reduction internal fixation procedure included "nerve damage, tendon damage, infection, failure to resolve symptoms, need to re-operate, loss of range of motion, loss of

strength, loss of sensation, chronic pain syndrome such as reflex sympathetic dystrophy, loss of function, blood vessel damage, and fracture." In any event, Dr. Phillips asserted that a reasonable patient in the plaintiff's position would not have declined to undergo such surgery because the risks of foregoing surgery were far greater than the risks inherent in the surgery. Moreover, Dr. Mroczek also expressly refuted the plaintiff's contention that Lorich did not obtain the plaintiff's fully informed consent to the surgical procedure.

By failing to address the opinion of Drs. Phillips and Mroczek is this regard in any manner whatsoever, the plaintiff failed to raise a triable issue of fact and, hence, those branches of both Clark Lorich's and NYPH's motions seeking summary judgment dismissing the lack of informed consent cause of action insofar as asserted against each of them must be granted.

NYPH demonstrated that it neither "knew, [n]or should have known," of their employees' "propensity for the sort of conduct which caused the [patient's] injury" (*Sheila C. v Povich*, 11 AD3d 120, 129-130 [1st Dept 2004]; *see Kuhfeldt v New York Presbyt./Weill Cornell Med. Ctr.*, 205 AD3d 480, 481-482 [1st Dept 2022]). Clark Lorich established that Lorich was not responsible for hiring any personnel involved in the plaintiff's surgery or postoperative care who engaged in any of the tortious conduct complained of by the plaintiff. Inasmuch as the plaintiff did not address this issue in his opposition papers, he failed to raise a triable issue of fact in opposition to these defendants' prima facie showings in this regard. Hence, those branches of both NYPH's and Clark Lorich's motions seeking summary judgment dismissing the negligent hiring, training, supervision, and retention cause of action insofar as asserted against each of them must be granted.

In light of the foregoing, it is,

ORDERED that the motion of the defendant New York Presbyterian Hospital for summary judgment dismissing the complaint insofar as asserted against it (SEQ 005) is granted, and the complaint is dismissed insofar as asserted against New York Presbyterian Hospital; and it is further,

ORDERED that the motion of the defendant Deborah A. Clark Lorich, as the Executrix of the Estate of Dean Lorich, M.D., Deceased, for summary judgment dismissing the complaint insofar as asserted against her (SEQ 006) is granted, and the complaint is dismissed insofar as asserted against Deborah A. Clark Lorich, as the Executrix of the Estate of Dean Lorich, M.D., Deceased; and it is further,

ORDERED that, on the court's own motion, the action against New York Presbyterian Hospital is severed from the action against Deborah A. Clark Lorich, as the Executrix of the Estate of Dean Lorich, M.D., Deceased; and it is further,

ORDERED that the Clerk of the court shall enter judgment dismissing the complaint insofar as asserted against the defendant New York Presbyterian Hospital; and it is further,

ORDERED that the Clerk of the court shall enter judgment dismissing the complaint insofar as asserted against the defendant Deborah A. Clark Lorich, as the Executrix of the Estate of Dean Lorich, M.D., Deceased.

This constitutes the Decision and Order of the court.

1/29/2025
DATE

JOHN J. KELLEY, J.S.C.

MOTION 005:	X	**CASE DISPOSED**			**NON-FINAL DISPOSITION**		
	X	**GRANTED**		**DENIED**	**GRANTED IN PART**		**OTHER**
APPLICATION:		**SETTLE ORDER**			**SUBMIT ORDER**		
CHECK IF APPROPRIATE:		**INCLUDES TRANSFER/REASSIGN**			**FIDUCIARY APPOINTMENT**		**REFERENCE**
MOTION 006:	X	**CASE DISPOSED**			**NON-FINAL DISPOSITION**		
	X	**GRANTED**		**DENIED**	**GRANTED IN PART**		**OTHER**
APPLICATION:		**SETTLE ORDER**			**SUBMIT ORDER**		
CHECK IF APPROPRIATE:		**INCLUDES TRANSFER/REASSIGN**			**FIDUCIARY APPOINTMENT**		**REFERENCE**