

**Donnelly-Friedmann v Edwards**

2025 NY Slip Op 31410(U)

April 9, 2025

Supreme Court, New York County

Docket Number: Index No. 805047/2020

Judge: Kathy J. King

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**SUPREME COURT OF THE STATE OF NEW YORK  
 NEW YORK COUNTY**

**PRESENT: HON. KATHY J. KING PART 06**

*Justice*

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KATHLEEN DONNELLY-FRIEDMANN and STANLEY  
 FRIEDMANN,

Plaintiffs,

- v -

ERIC EDWARDS, M.D., PETER TAUB, M.D., MOUNT  
 SINAI HOSPITAL and ICAHN SCHOOL OF MEDICINE AT  
 MOUNT SINAI,

Defendants.

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INDEX NO. 805047/2020

MOTION DATE 11/13/2023

MOTION SEQ. NO. 002

**DECISION + ORDER ON  
 MOTION**

The following e-filed documents, listed by NYSCEF document number (Motion 002) 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113

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

Upon the foregoing papers, and oral arguments having been heard, Defendants Eric Edwards, M.D. (“Dr. Edwards”), Peter Taub, M.D. (“Dr. Taub”), Mount Sinai Hospital, and Icahn School of Medicine at Mount Sinai (“Mount Sinai Defendants”) (collectively “Defendants”) move, pursuant to CPLR 3212, for summary judgment dismissing the Plaintiffs’ amended complaint. Plaintiffs oppose the motion.

**BACKGROUND**

On January 29, 2018, Plaintiff Kathleen Donnelly-Friedmann (“Plaintiff”) underwent abdominal surgery at Mount Sinai Hospital. The abdominal surgery, performed by Defendants Dr. Edwards and Dr. Taub, included a takedown of two enterocutaneous fistula (ECF), a small bowel resection, a small bowel anastomosis procedure, and abdominal wall reconstruction. Prior

to the surgery, Plaintiff signed a Consent Form attesting that the risks of the procedure were disclosed to her by Dr. Edwards.

Plaintiff alleges that during the surgery, Dr. Edwards and Dr. Taub were negligent and deviated from acceptable medical practice when they failed to detect a 1 cm small bowel perforation which they inadvertently created during the procedure. Instead of detecting and repairing the perforation, they closed the abdominal fascia and surgical incisions without properly inspecting the surgical field.

Two days later, on January 31, 2018, Plaintiff became septic. An abdominal x-ray revealed free air escaping into her peritoneum, prompting an emergency surgery, during which Dr. Edwards discovered the 1cm perforation in her small bowel “just distal” to the anastomosis created during the abdominal surgery. Dr. Edwards repaired the perforation, but the surgical incision ultimately did not heal properly. As a result, Plaintiff claims to have suffered from an open abdominal wound with continuous drainage, the need for constant dressing changes, and frequent infections at the surgical site necessitating emergent surgery, due to the Defendants failure to detect the perforation during the surgery.

The Plaintiffs, Mrs. Donnelly-Friedmann, and her husband, Stanley Friedmann, who sues derivatively for loss of consortium, commenced this instant action on February 12, 2020, through the filing of a Summons and Verified Complaint, alleging medical malpractice. The gravamen of Plaintiffs’ case is that Dr. Edwards and Dr. Taub created and failed to detect a perforation during her abdominal surgery, caused infection and the need for emergency surgery, which required reopening of the surgical incisions, and damaging her skin integrity to such a degree that the wound could not heal. The Defendants joined issue by service of a Verified Answer on May 13, 2020. The Defendants now move for summary judgment dismissing the Plaintiffs’ amended complaint.

## DISCUSSION

A defendant physician moving for summary judgment must make a prima facie showing of entitlement to judgment as a matter of law by establishing the absence of a triable issue of fact as to his or her alleged departure from accepted standards of medical practice, or by establishing that the plaintiff was not injured by such treatment (*see Alvarez v Prospect Hosp.*, 68 NY2d 320, 324 [1986]; *Frye v Montefiore Med. Ctr.*, 70 AD3d 15 [1st Dept 2009]; *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 204, 206 [1st Dept 2010]; *Joyner-Pack v. Sykes*, 54 AD3d 727 [2d Dept 2008]; *Koi Hou Chan v Yeung*, 66 AD3d 642 [2d Dept 2009]; *Jones v Ricciardelli*, 40 AD3d 935 [2d Dept 2007]). Furthermore, 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]). When no opposing evidence is submitted, the Court must still deny summary judgment if the moving party does not meet its burden (*Liberty Taxi Mgt., Inc. v Gincheran*, 32 AD3d 572 [2d Dept 2007]).

In moving for summary judgment, defendants rely on the opinion of two experts, Dr. Jerald Wishner ("Dr. Wishner"), a board-certified Colorectal Surgeon, and Dr. Jeffrey Ascherman ("Dr. Ascherman"), a board-certified Plastic Surgeon, both of which opine, within a reasonable degree of medical certainty, that: the Plaintiff's abdominal surgery, a high-risk patient with multiple

comorbidities and a history of non-healing abdominal wounds, to address her ECFs, was appropriate; the subsequent bowel perforation was a known risk likely resulting from a gradual breakdown of a partial thickness injury during adhesion dissection rather than an immediate surgical error; and her persistent post-operative wound complications were attributable to her pre-existing conditions and the chronic state of her abdominal cavity, not the Defendants' surgical procedures.

Dr. Wishner notes that at the time of the abdominal surgery, Plaintiff was 62 years old, obese, with a history of diabetes, cirrhosis of the liver, many prior abdominal surgeries, and two draining ECFs that had been present for several years and were unlikely to heal on their own. Dr. Wishner opines that considering Plaintiff's condition, Dr. Edwards' decision to perform the abdominal surgery to take down the two ECFs and to reconstruct the abdominal wall was appropriate and indicated. Dr. Wishner further opines that a perforation of the small bowel (also known as an "enterotomy") is a known and accepted risk of this type of procedure and that the medical records document that Plaintiff was well advised and aware of such risk. Dr. Wishner states that a perforation of the small bowel can occur (1) as a result of a direct incision to the bowel during surgery (as Plaintiffs allege) or (2) because of a partial thickness injury to some of the layers of the bowel wall that subsequently develop into a complete perforation. Dr. Wishner opines that in this particular case, Plaintiff's perforation on January 31, 2018, resulted from a partial thickness bowel injury during the dissection of extensive adhesions, which weakened over time and subsequently perforated. According to Dr. Wishner, had the perforation been created during the abdominal surgery, Dr. Edwards and Dr. Taub would have observed the perforation prior to closing the abdominal fascia and surgical incisions.

Dr. Wishner further opines that Plaintiff's post-operative course indicates that the perforation was not present when Dr. Edwards and Dr. Taub closed the abdominal fascia and surgical incisions upon completion of the surgery. Dr. Wishner contends that Plaintiff's normal post-operative abdominal examinations and ability to ambulate without significant pain in the days following the surgery on January 29, 2018, strongly suggest that an enterotomy was not present at the time of the surgery's completion, as the presence of a bowel perforation would have resulted in immediate signs of leakage and significant discomfort. Furthermore, the serosanguinous drainage from the JP drain, rather than fecal matter, supports the conclusion that a perforation did not exist immediately post-operatively. To this end, Dr. Wishner opines that Dr. Edwards timely diagnosed and treated the perforation during the January 31, 2018, emergency surgery and that Plaintiff's abdomen was appropriately left open at the conclusion of that surgery because there was a tension in the abdomen due to blood volume requirements to support her vitals.

Despite an initially good post-operative course, Plaintiff required a return to the operating room on February 2, 2018, for drainage and wound care, followed by an exploratory laparotomy on February 6, 2018, with primary fascial closure, a surgical approach Dr. Wishner deemed appropriate to prevent complications like infection, wound breakdown, and life-threatening intra-abdominal compartment syndrome, while also maximizing the chances of proper wound healing. Dr. Wishner explains that according to her medical records, Plaintiff's abdominal wound thereafter continued to reopen with multiple sinus tracts and recurrent infections because subsequent surgeries failed to completely close the wound. According to Dr. Wishner, Plaintiff's persistent failure of her abdominal wound to heal, including reopening, drainage, and infection, was not caused by the surgery on January 29, 2018, but rather by her pre-existing medical conditions and

the nature of her extensive scar tissue and adhesions from prior surgeries, which made wound closure inherently difficult.

In his affidavit, Dr. Ascherman concurs with Dr. Wishner's assessment and expert opinions. Dr. Ascherman emphasizes that Plaintiff was a very high-risk patient to undergo any surgery due to her medical and surgical histories and co-morbidities. According to Dr. Ascherman, Plaintiff's post-operative complications, including the persistent reopening, draining, and infection of her abdominal wound, were not caused by the January 29, 2018, surgery performed by the Defendants. Instead, he opines that these issues were a continuation of a pre-existing process stemming from her medical comorbidities and the chronically inflamed and infected state of her abdominal cavity, evidenced by the fact that her abdominal wound had not fully healed since 2014. Therefore, Dr. Ascherman opines that the subsequent procedures after the January 29<sup>th</sup> abdominal surgery were necessitated by these chronic underlying conditions rather than the Defendants' surgical interventions.

Based on the expert affirmations, the Court finds that the Defendants satisfied their prima facie burden of showing that the care and treatment rendered by Dr. Edwards and Dr. Taub were within the standard of care in rendering treatment to Plaintiff, and did not proximately cause any of the injuries as alleged by the Plaintiffs in this matter. Once the defendant meets their burden, the plaintiff must rebut the defendant's prima facie showing (*see Alvarez v Prospect Hosp.*, 68 NY2d 320, 324 [1986]). "Generally, the opinion of a qualified expert that a plaintiff's injuries were caused by a deviation from relevant industry standards would preclude a grant of summary judgment in favor of the defendants" (*Murphy v Chinatown Cardiology, P.C.*, 220 AD3d 539, 540 [1st Dept 2023] [quotation marks and citations omitted]). However, an expert affirmation "that sets forth general conclusions, misstatements of evidence, and unsupported assertions, and which

fails to address the opinions of defendant's expert, is insufficient to defeat summary judgment" (*Cabrera v Golden*, 231 AD3d at 155). Here, in opposition, the Plaintiffs submit the affidavit of Dr. David A. Mayer ("Dr. Mayer"), a board-certified general surgeon.

Dr. Mayer opines, with a reasonable degree of medical certainty, that the Defendants' failure to detect the 1 cm perforation during Ms. Donnelly-Friedmann's abdominal surgery represented a departure from the standard of medical practice, a critical untimely finding made by Dr. Edwards during the ensuing emergency surgery. Dr. Mayer highlights that Donnelly-Friedmann's hospital records repeatedly document a "missed enterotomy," including Dr. Edwards' discharge summary, which contradicts the Defendants' claim that the perforation occurred after the surgery. Dr. Mayer states that Dr. Edwards discovered the bowel perforation immediately adjacent to the anastomosis in an area where both he and Dr. Taub, who participated in the initial surgery, were required by the standard of care to inspect for bowel defects. While inadvertent perforations can be a risk of abdominal surgery, the failure to detect a palpably visible 1 cm perforation in this location is a deviation from the acceptable standard of medical care, not a recognized risk.

According to Dr. Mayer, Dr. Edward and Dr. Taub's failure to detect and repair the perforation during the January 29<sup>th</sup> surgery led to a severe septic infection and peritonitis within 50 hours. This delay permitted extensive abdominal contamination, necessitating open surgical wounds, therapeutic coma, paralysis, and a wound vacuum pump. Consequently, the infection severely compromised Ms. Donnelly-Friedmann's abdominal tissues, impairing their ability to heal, and substantially reduced her chance of a satisfactory surgical outcome, even considering her prior wound healing issues. Dr. Mayer explains that the gradual onset of symptoms and the amount of abdominal fluid are typical of a missed small bowel enterotomy, which would not cause the

immediate, severe symptoms of a large bowel perforation. Dr. Mayer opines that even if the injury was initially partial thickness, the standard of care required the Defendants to identify and repair it during the initial surgery rather than allowing it to progress to a full perforation. He further states that their failure to detect and repair this condition was a deviation from acceptable medical care, noting the absence of any mention of such a partial thickness injury in the operative report. Consequently, Dr. Mayer opines that the failure by Dr. Edwards and Dr. Taub to detect and repair the bowel perforation, thereby preventing infection, caused injuries far exceeding Plaintiff's initial presentation and was exacerbated by the hospital permitting Dr. Taub to participate in bowel surgery beyond the scope of his consent for abdominal wall repair, as he also failed in his duty to inspect the bowel.

The Court finds that the Plaintiffs' expert raises issues of fact regarding alleged deviations and whether such deviations proximately caused Plaintiffs' injuries, thus, rebutting the Defendants' prima facie entitlement to summary judgment based on the showing that the mere presence of an injury is insufficient to support a claim of medical malpractice (*see Johnson v St. Barnabas Hosp.*, 52 AD3d 286 [1st Dept 2008], appeal denied 11 NY3d 705 [2008]; *Landau v Rappaport*, 306 AD2d 446 [2d Dept 2003]; *Nabozny v Cappelletti*, 267 AD2d 623 [3d Dept 1999]; *Johnson v Jacobowitz*, 65 AD3d 610 [2d Dept 2009]).

“Summary judgment is not appropriate . . . [when] the parties [submit] conflicting medical expert opinions because [s]uch conflicting expert opinions will raise credibility issues which can only be resolved by a jury” (*Cummings v Brooklyn Hosp. Ctr.*, 147 AD3d 902, 904 [2d Dept 2017], quoting *DiGeronimo v Fuchs*, 101 AD3d 933 [2d Dept 2012] [internal quotation marks omitted]; see *Elmes v Yelon*, 140 AD3d 1009 [2d Dept 2016]; *Leto v Feld*, 131 AD3d 590 [2d Dept 2015]). Similarly, since Plaintiffs' cause of action for loss of consortium are derivative of the

injured spouse's right to recover damages for any injuries sustained as a result of the Defendants' alleged malpractice, dismissal is precluded (*see Liff v Schildkrout*, 49 NY2d 622 [1980]).

Given that triable issues of fact exist as to the care and treatment by Drs. Edward and Taub, employees of the Mount Sinai Defendants, and whether such treatment proximately caused Plaintiffs' alleged injuries, dismissal is not warranted against the Mount Sinai Defendants, under the doctrine of respondeat superior (*see Sessa v Peconic Bay Medical Center*, 200 AD3d 1085 [2d Dept 2021]; *Klippel v Rubinstein*, 300 AD2d 448 [2d Dept 2002]; *Rivera v County of Suffolk*, 290 AD2d 430 [2d Dept 2002]; *Mduba v Benedictine Hosp.*, 52 AD2d 450 [3d Dept 1976]).

As to Plaintiffs' cause of action for loss of consortium, dismissal is precluded since it is derivative of the injured spouse's right to recover damages for any injuries sustained as a result of the Defendants' alleged malpractice (*see Liff v Schildkrout*, 49 NY2d 622 [1980]).

### **CONCLUSION**

Accordingly, it is hereby

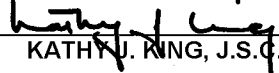
**ORDERED** that Defendants' motion for summary judgment dismissing the amended complaint is denied; and it is further

**ORDERED** that within twenty (20) days of entry of this order, counsel for Plaintiffs shall serve a copy of this order with notice of entry upon all parties; and it is further

**ORDERED** that the parties are directed to appear for a settlement conference on September 16<sup>th</sup>, 2025, at 2:30 pm, at 60 Centre Street, Room #351, New York, NY.

This constitutes the Decision and Order of the Court.

This constitutes the decision and order of the Court.

<u>4/9/2025</u> DATE					 KATHY J. KING, J.S.C.
CHECK ONE:	<input type="checkbox"/>	CASE DISPOSED	<input checked="" type="checkbox"/>	DENIED	<input checked="" type="checkbox"/> NON-FINAL DISPOSITION
APPLICATION:	<input type="checkbox"/>	GRANTED	<input checked="" type="checkbox"/>	DENIED	<input type="checkbox"/> GRANTED IN PART
CHECK IF APPROPRIATE:	<input type="checkbox"/>	SETTLE ORDER	<input type="checkbox"/>		<input type="checkbox"/> OTHER
	<input type="checkbox"/>	INCLUDES TRANSFER/REASSIGN	<input type="checkbox"/>		<input type="checkbox"/> FIDUCIARY APPOINTMENT
	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> REFERENCE