Margolin v LaQuaglia

2025 NY Slip Op 32929(U)

July 24, 2025

Supreme Court, New York County

Docket Number: Index No. 805091/2021

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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ETHEL MARGOLIN,

Plaintiff,

- v -

MICHAEL LAQUAGLIA, M.D., and MEMORIAL HOSPITAL FOR CANCER AND ALLIED DISEASES, INC.,

Defendants.

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INDEX NO. 805091/2021

MOTION DATE 07/23/2025

MOTION SEQ. NO. 001

DECISION + ORDER ON MOTION

The following e-filed documents, listed by NYSCEF document number (Motion 001) 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61

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

In this action to recover damages for medical malpractice based on alleged departures from good and accepted practice and lack of informed consent,[1] the defendants move pursuant to CPLR 3212 for summary judgment dismissing the complaint.[2] The plaintiff opposes the motion. The motion is granted to the extent that the defendants are awarded summary judgment dismissing so much of the medical malpractice cause of action as was premised upon allegations that the defendant surgeon Michael LaQuaglia, M.D., failed to perform the surgical procedure that actually had been described in his operative report, failed accurately to inform the plaintiff of intraoperative events that occurred during the subject March 11, 2020 open

[1] Although the complaint did not expressly assert a cause of action to recover for the alleged negligent hiring, training, supervision, and retention of health-care personnel by the defendant Memorial Hospital for Cancer and Allied Diseases, the plaintiff, in her bill of particulars, essentially made such allegations. Hence, the court will treat the defendants' motion as addressed to those allegations as well as the malpractice and lack of informed consent causes of action.

[2] In a stipulation dated October 22, 2022, and so-ordered November 10, 2022, the plaintiff discontinued the action against the defendants Andrea Volpe, M.D., and Kristen Calabro, M.D. In a stipulation dated January 5, 2024 and so-ordered July 23, 2025, the plaintiff discontinued the action against the defendant Patrick Hanford Larkin, P.A. In both of those so-ordered stipulations, the court directed that the caption be amended accordingly.

bilateral ovarian cystectomy procedure, and failed timely to re-examine her after she became febrile at home late in the evening of March 14, 2020 or early in the morning of March 15, 2020, as well as the claim, set forth in her bill of particulars, that the defendant Memorial Hospital for Cancer and Allied Diseases (Memorial) negligently hired, trained, supervised, and retained health-care personnel. The motion is otherwise denied.

The crux of the plaintiff's claim is that, on March 11, 2020, LaQuaglia, a Memorial employee, negligently performed an open bilateral ovarian cystectomy, causing a iatrogenic injury to her sigmoid colon by perforating it in the course of the surgery. In her complaint, she alleged that, as a consequence of that perforation, which was not discovered until several days after she was discharged from Memorial on March 14, 2020, she sustained a peritoneal abscess, and was compelled to undergo a drainage procedure on March 20, 2020 to treat the abscess, along with an exploratory laparotomy and celiotomy, with the creation of a colostomy, the latter of which was not surgically reversed until July 10, 2020.

In her complaint, the plaintiff specifically alleged that, not only did LaQuaglia cause an iatrogenic injury by failing to protect adjacent structures not involved in the subject gynecological surgery, but that he failed timely to discover and repair the injury after he caused it, thus allowing fecal and other intestinal contents to leak from the injured sigmoid colon. She further alleged that he failed to ensure that the integrity of the colon and rectum was maintained before completing the March 11, 2020 procedure. In this respect, the plaintiff asserted that LaQuaglia failed properly to monitor her post-operative condition and, thus, discharged her from Memorial to her home when it was not safe to do so. She further alleged that LaQuaglia delayed her re-evaluation, despite the need for urgent and immediate medical and/or surgical intervention, and failed timely to re-examine her after she became febrile on March 14, 2020. The plaintiff further faulted LaQuaglia for failing to obtain sufficient imaging studies both intraoperatively and postoperatively, and ultimately failed to perform the surgical procedure that had actually been

described the operative report. In addition, the plaintiff alleged that LaQuaglia failed accurately to inform her of intraoperative events that occurred during the March 11, 2020 procedure.

Moreover, the plaintiff alleged that LaQuaglia failed to discuss with her the effect of prior surgeries before performing the March 11, 2020 procedure, and that the defendants failed to maintain complete and proper records of the care that they rendered to her. She further contended that Memorial failed to have sufficiently trained and experienced personnel monitor her, and that the defendants failed to perform necessary postoperative examinations, while improperly performing the examinations that they did conduct.

In her bills of particulars, the plaintiff essentially reiterated the allegations set forth in her complaint, adding that LaQuaglia failed timely and properly to prescribe antibiotics during the postoperative recovery period, and specified that LaQuaglia's failure to order and/or obtain sufficient imaging studies both intraoperatively and postoperatively led to his failure to discover "unintended injury to organs not directly involved in the surgery." She asserted that, as a consequence of the defendants' departures from good practice and failure to obtain her fully informed consent to the procedure, she not only sustained injuries to her rectum and sigmoid colon, but suffered from postoperative wound contamination and infection, and required multiple drainage procedures, surgical procedures on March 20, 2020 and July 10, 2020, and ostomy, which created anxiety with respect to the stigma that frequently accompanies use of a colostomy bag arising from leaks, spills and odors. The plaintiff further asserted that she had to experience the prolonged use of a wound-vacuum and prolonged need for wound care, including ostomy care from March 20, 2020 until July 10, 2020. She averred that the injuries that she sustained left her with scarring about her abdomen, pain in and about her lower abdomen, and the loss of a fallopian tube, which possibly will interfere with her ability to become pregnant and carry a pregnancy to term, thus requiring the need to employ artificial means to become pregnant. The plaintiff also alleged that she suffered from anxiety when she discovered that a surgical sponge had been left in her body at the March 20, 2020 procedure. Finally, she

alleged that all of these physical and emotional injuries interfered with her education, vocational activities, and recreational activities.

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 Flanders v Goodfellow,* _____NY3d_____, 2025 NY Slip Op 02261, *1 [Apr. 17, 2025]; *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]; *see Haymon v Pettit*, 9 NY3d 324, 327 n [2007]). Once the movant meets that 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 the burden of affirmatively establishing entitlement to judgment as a matter of law merely by pointing to gaps in the plaintiff's case, but 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]). Such a cause of action may be premised upon a claim that those departures allowed a patient's condition to worsen, and thus deprived him or her of an opportunity for a cure or a better outcome (*see Mortensen v Memorial Hosp.*, 105 AD2d 151, 156, 159 [1st Dept 1984]; *Kallenberg v Beth Israel Hosp.*, 45 AD2d 177, 178 [1st Dept 1974], *affd no op.* 37 NY2d 719 [1975]). Moreover, 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]).

The court also notes that 8 NYCRR 29.2(a), among other things, requires physicians and hospitals to maintain accurate records, and that a violation of that state regulation may, under certain circumstances, constitute a departure or deviation from accepted practice (*see generally Collado v New York and Presbyterian Hosp.,* 2022 NY Misc LEXIS 43557, *61-62

[Sup Ct, N.Y. County, Aug. 3, 2022] [Kelley, J.]; *Khosrova v Westermann*, 2011 NY Slip Op 32628[U], *5, 2011 NY Misc LEXIS 4768, *13 [Sup Ct, Suffolk County, Oct. 4, 2011]).

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 [emphasis added]; *see also Pancila v Romanzi,* 140 AD3d 516, 516 [1st Dept 2016]; *Callistro ex rel. Rivera v Bebbington*, 94 AD3d 408, 410 [1st Dept 2012], *affd sub nom. Callistro v Bebbington*, 20 NY3d 945 [2012]; *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).

In support of their motion, the defendants submitted the pleadings, the plaintiffs' bills of particulars, transcripts of the parties' deposition testimony, relevant medical and hospital records, the note of issue, a statement of allegedly undisputed material facts, an attorney's affirmation, and the expert affirmation of board-certified surgeon and surgical critical care specialist John McNelis, M.D.

Dr. McNelis opined that neither of the defendants departed from good and accepted medical practice in treating the plaintiff or caring for her postoperatively, and that nothing that they did or did not do caused or contributed to the plaintiff's injuries.

As Dr. McNelis summarized the plaintiff's medical history, the plaintiff first had been diagnosed with bilateral ovarian cysts when she was only 11 years old. He noted that, on April 8, 2011, the plaintiff underwent a laparoscopic ovarian cystectomy performed by LaQuaglia at Memorial, after which surgical pathology revealed mature cystic teratomas of the bilateral

ovaries, as well as a left perimetrial cyst. Dr. McNelis further explained that, on November 18, 2015, when the plaintiff was 16 years old, she underwent a second laparoscopic ovarian cystectomy performed by LaQuaglia, after which surgical pathology revealed that a mature cystic teratoma of the left ovary, a hemorrhagic corpus luteal cyst of the left ovary, and a benign parametrial cyst had been removed. On February 16, 2016, the plaintiff underwent a third laparoscopic procedure with LaQuaglia, consisting of the unroofing of a right ovarian corpus luteum cyst. According to Dr. McNelis, these first three surgeries that LaQuaglia performed upon the plaintiff were "rather uneventful with no complications."

Dr. McNelis asserted that, on February 20, 2020, when the plaintiff was 20 years old, she underwent a computed tomography (CT) scan that depicted bilateral ovarian teratomas, and thus returned to LaQuaglia on March 4, 2020, at which time he recommended that she undergo surgery to remove the teratomas. With respect to the March 11, 2020 surgery that is the subject of this action, he asserted that injury to the sigmoid colon is a known, inherent risk of pelvic surgery, especially surgery to remove ovarian growths, and can occur absent any negligent surgical technique. Dr. McNelis averred that the risk of an injury to the colon increases with each successive pelvic surgery and, inasmuch as the subject procedure performed upon the plaintiff was "at least her fourth surgery in the same pelvic area," there was an increased risk for a bowel injury "given the presence of scarring and adhesions that developed and furthered as a result of each prior surgery." He opined that the plaintiff's prior ovarian teratomas caused inflammatory material that contributed to the extent of scarring and adhesions, explaining that, because of their presence, structures in the pelvis that typically are separate adhered to each other, such that the risk of injury to the colon was a known risk that could occur during a subsequent surgery, even absent any negligent surgical technique.

Upon his review of the operative report and LaQuaglia's deposition testimony, Dr. McNelis asserted that LaQuaglia began the March 11, 2020 procedure laparoscopically, "which was well within the standard of care given plaintiff's young age, expectation for a faster

recovery, and given the fact that plaintiff had no prior history of bowel obstruction or surgical complications." Dr. McNelis expressly opined that LaQuaglia took the proper steps to protect the colon during the laparoscopic portion of the procedure. He averred that, after the laparoscopic ports were placed under direct visualization, LaQuaglia placed plaintiff in the Trendelenburg position, that is, supine with her feet raised higher than her head, and employed high magnification to visualize the pelvis. According to Dr. McNelis, LaQuaglia observed that the sigmoid colon was very adherent to the left ovary, and thus employed a "very fine sharp dissection with scissors to mobilize the bladder from the ovary." Dr. McNelis averred that, during the dissection, LaQuaglia visualized areas of the serosa of the sigmoid colon as being involved in the resection.

Dr. McNelis conceded that LaQuaglia identified "superficial serosal tears to the sigmoid colon [that] had been incurred," and properly decided to convert from a laparoscopic to an open procedure, also known as a laparotomy. As Dr. McNelis interpreted the operative report, once open, LaQuaglia employed gentle bowel forceps to mobilize the colon from the ovary, and cold scissor dissection to peel the ovary off the rectum and colon. He stated that LaQuaglia then properly proceeded with resecting the bilateral ovarian teratomas and an additional paratubal cyst that he had identified intraoperatively. As Dr. McNelis recounted it, LaQuaglia then irrigated the surgical field and observed the serosal cuts---that is, cuts in the outermost lining of the colon---in the rectosigmoid colon, which he explained was the site where the ovary had "scarred/adhered to the colon." Dr. McNelis reiterated LaQuaglia's contention that he did not observe any cuts deeper than the serosal layer and that, consequently, there was no violation of the mucosal layer of the colon that would have indicated a perforation.

As Dr. McNelis explained it, serosal layer injuries to the colon are very common in pelvic surgeries and that they are not necessarily an indication of negligent surgical technique. He opined that, since there were only between two and five serosal cuts in the plaintiff's case, there was no indication of negligent technique, inasmuch as the colon wraps around the ovary, while

the process of mobilizing the ovary away from the colon can result in serosal injury at different locations of the colon. He thus concluded that the serosal cuts in the plaintiff's sigmoid colon during the March 11, 2020 surgery occurred due to the adhesions that formed after plaintiff's three prior surgeries, which adhered the colon to the ovary, and that these cuts did not occur due to any negligent surgical technique by LaQuaglia.

Dr. McNelis rejected that plaintiff's claim that LaQuaglia failed to protect adjacent structures that were not involved in the surgery from iatrogenic injury. He characterized this claim as "baseless" because the structure adjacent to the ovary was the colon, which was anatomically wrapped around the ovary and had adhered to it. Hence, he concluded that the colon was directly involved in the surgical field and that, in order to perform the surgery and remove the ovarian teratomas, LaQuaglia had to mobilize the colon off the ovary. Dr. McNelis described LaQuaglia's surgical technique as "well within the standard of care in an effort to protect the bowel when dissecting the ovary off the bowel," but that "inadvertent and unavoidable injury to the colon occurred despite proper care." He also rejected the plaintiff's contention that LaQuaglia should have discovered the iatrogenic injury to the sigmoid colon with intraoperative imaging, and thereupon repaired the area. Specifically, he opined that LaQuaglia promptly recognized the serosal cuts to the sigmoid colon, and repaired them intraoperatively by placing serial seromuscular sutures in the interior wall of the recto sigmoid, the posterior wall of the rectum, and the distal sigmoid. As he explained it, by applying sutures to these areas, LaQuaglia properly reinforced the colon in an effort to prevent leakage. Dr. McNelis also asserted that, contrary to the plaintiff's contention, there were no imaging studies that could have identified a colon injury intraoperatively. Hence, he concluded that there was no merit to the plaintiff's claim that LaQuaglia should have prevented fecal and intestinal contents from leaking from the injured sigmoid colon and that, in any event, there were no signs of leakage from the colon to have warranted additional intraoperative treatment

In addition, Dr. McNelis rejected the plaintiff's claim that LaQuaglia should have assured that the integrity of the colon/rectum was maintained before completing the procedure, asserting that LaQuaglia did, in fact, verify the integrity of those structures prior to closing. He asserted that, after repairing the serosal tears of the sigmoid colon, LaQuaglia "thoroughly inspected the rectum and colon for any evidence of a leak/bowel perforation," then "irrigated the pelvis with saline and warm bacitracin, and then distended the bowel under the fluid and pressed on it while looking for bubbles that would have indicated a leak in the colon." Since LaQuaglia did not observe any leakage of air or fecal material from the colon while pressing on it underneath the fluid, Dr. McNelis concluded that he appropriately determined there was no evidence of a perforation, inadvertent opening of the colon, burn, or other injury that would have necessitated further intraoperative care. He explained that not all colon perforations that occur during surgery are detectible intraoperatively, and that the evidence here established that the cuts to the plaintiff's colon were of that nature, "despite the proper measures employed by Dr. LaQuaglia to identify a perforation." Hence, Dr. McNelis opined that "it was entirely within the standard of care for Dr. LaQuaglia to have proceeded to closure and completion of the surgery as he did." He also suggested that the subject perforation "may not have been present at the time of surgery and may have occurred later," possibly because of an undetected thermal injury or an unidentified serosal tear that proceeded to full thickness.

Dr. McNelis asserted that, contrary to the plaintiff's contention, LaQuaglia did, in fact, perform the surgery described in the March 11, 2020 operative report, specifically with respect to ovarian cysts. He explained that the preoperative CT scan taken on February 20, 2020 identified a left ovarian mass measuring 3.7 centimeters (cm) by 2.7 cm, while the March 11, 2020 pathology report confirmed that LaQuaglia removed a left ovarian cyst that was pathologically diagnosed as a mature cystic teratoma of the left ovary, grossly described as a 2.0 cm by 1.3 cm by 0.8 cm fragment of cystic tissue. Hence, he concluded that the evidence is

"indisputable" that LaQuaglia removed a teratoma of the left ovary, "which was the purpose of the surgery." As Dr. McNelis further explained,

> "[g]iven the adhesions and serosal cuts in the area of colon that wrapped around the left ovary, if any portion of the left ovary teratoma remained after the surgery, this was not a departure from the standard of care because further cystic tissue may not have been visible given the adhesions in the area of the colon that wrapped around the left ovary and is indicative of the required cautious and prudent surgical technique by Dr. LaQuaglia so as to not cause any further insult to plaintiff. Plaintiff having to undergo another, fifth surgery to remove a further cystic teratoma of the left ovary on July 10, 2020 (that measured 3.8 x 3.5 x 3.0 cm on gross pathologic description) is consistent with her medical history of recurrent cystic teratomas, which have the potential to recur quickly and require further surgery, and not indicative of any negligent performance of the March 11, 2020 surgery."

With respect to the plaintiff's contention that LaQuaglia failed accurately to inform her of the intraoperative events on March 11, 2020, Dr. McNelis averred that, in the immediate postoperative period through March 14, 2020, there was no indication that she had sustained a colon perforation, and that, hence, LaQuaglia had no knowledge of that condition that would have enabled him to inform her thereof. Rather, according to Dr. McNelis, the colon perforation was not identified until the March 20, 2020 surgery and that, in any event, the plaintiff conceded at her deposition that she had been told by one of LaQuaglia's fellows that the March 11, 2020 surgery had been converted from laparoscopic to open because there was "hard access."

Dr. McNelis asserted that the defendants properly monitored the plaintiff postoperatively and that there was no reason for them to have performed postoperative imaging studies to discover injury to organs since, between March 11, 2020 and her discharge from Memorial on March 14, 2020, she "followed an uneventful and expected post-operative course," with no findings concerning for a colon perforation that would have warranted imaging studies prior to her discharge. As Dr. McNelis interpreted the plaintiff's chart, on March 12, 2020, she was hemodynamically stable, had a normal temperature of 36.9 C (98.4 F), had been weaned to be able to breathe room air, and had her Foley catheter removed. Although he conceded that she complained of pain at the surgical site, he asserted that pain is to be expected after an open

abdominal surgery, and that she was evaluated by Memorial's pain service department, whose personnel changed her pain medication from Fentanyl to acetaminophen and ibuprofen. Dr. McNelis further admitted that the plaintiff also complained of gas pain, which he nonetheless described as "entirely normal" after abdominal surgery with insufflation of the abdomen, and averred that she was properly encouraged to ambulate and had her diet "advanced" to a "regular" diet. He asserted that, on March 13, 2020, the plaintiff remained hemodynamically stable and that, although she had been febrile overnight, with a body temperature of 38.2 C (100.8 F), she began to defervesce, and that her fever was "not concerning" for a colon perforation because it is common for patients to develop a fever within the first three days subsequent to surgery. He further noted that the plaintiff's fever abated without targeted intervention, which he characterized as a "reassuring finding." In addition, Dr. McNelis asserted that, on March 13, 2020, the plaintiff continued to tolerate a regular diet, was ambulating, and was passing gas, while her "expected" pain was moderately controlled with acetaminophen and ibuprofen. Despite the plaintiff's continued complaints of lower abdominal pain, Dr. McNelis asserted that LaQuaglia reasonably believed that such pain was related to gaseous distention, as she was passing a large quantity of gas at the time. As relevant here, Dr. McNelis concluded that, from March 12, 2020 to March 14, 2020, there were no findings to suggest a colon perforation, peritonitis, or sepsis, inasmuch as the plaintiff made no complaints of abdominal guarding or rigidity, nausea, vomiting or chills, and had no severe abdominal pain.

Dr. McNelis concluded that it was within the applicable standard of care for the defendants to have discharged the plaintiff from Memorial on March 14, 2020, that it was safe to do so, and that there was no clinical indication to suggest that plaintiff needed to be kept under further observation while remaining in the hospital. In this respect, Dr. McNelis noted that, on March 14, 2020, plaintiff reported that she had a pain level of 1 on a scale of 10, with acceptable pain relief, that she experienced no nausea, vomiting, mental status changes, numbness, fever, chills, severe abdominal pain, swelling, or pain or tenderness upon palpation of the abdomen,

and that she continued to tolerate a regular diet, was passing gas, and ambulating well. Hence, Dr. McNelis opined that there were no signs at the time of plaintiff's discharge on March 14, 2020 that she had a colon injury that would have warranted further care and treatment. In light of the plaintiff's condition, which Dr. McNelis characterized as "stable," he concluded that no imaging studies were indicated, and that the plaintiff was properly and safely discharged to her home on March 14, 2020. He expressly rejected the plaintiff's contention that the defendants failed to correlate the administration of acetaminophen and ibuprofen with her body temperature prior to discharge, since a colon injury could not be masked by those medications, and would have manifested with severe abdominal pain and tenderness to palpation, while the plaintiff was, in fact, afebrile at the time of her discharge. Dr. McNelis also explicitly concluded that LaQuaglia properly determined to forego the prescription of antibiotics at the time of the plaintiff's discharge because intraoperative findings revealed "serosal cuts to the colon that were repaired by sutures with no evidence of the bowel having been perforated," while the plaintiff was "hemodynamically stable with no peritoneal signs (e.g., guarding or rigidity of the abdomen) or signs of sepsis through March 14, 2020 to have suspected a bowel perforation."

Dr. McNelis further concluded that there was no indication for readmitting the plaintiff to Memorial on March 14, 2020, because she did not spike a fever until the early morning hours of March 15, 2020, when her mother called Memorial and spoke with surgical fellow Andrea Volpe, M.D., who advised the plaintiff to return to Memorial, after which the plaintiff in fact returned to Memorial later that day and was readmitted. He further opined that, during the plaintiff's readmission, she was properly reexamined at sufficient intervals, and was properly reevaluated. As Dr. McNelis explained it,

> "[f]irst, when plaintiff was re-admitted the COVID-19 pandemic was in its infancy in New York and likely the reason why a CT scan was not performed until the morning of March 16, 2020. Any delay in performing the CT scan upon readmission is not fairly attributable to Memorial, was not a departure from the standard of care, and nevertheless the timing of the scan on March 16, 2020 resulted in no harm to plaintiff. The CT scan performed on March 16, 2020 showed a loculated collection in the left lower quadrant that was inseparable from

> the adjacent bowel and described as a possible evolving abscess, which was concerning for a defect in the bowel wall. Given that plaintiff still had no peritoneal signs (e.g., guarding/tenderness in the abdomen), it was entirely within the standard of care to first attempt to treat the abscess non-surgically."

Moreover, he asserted that, on March 16, 2020, the plaintiff properly was administered the intravenous broad-spectrum antibiotics piperacillin and tazobactam, and that interventional radiology personnel inserted a catheter to drain a fluid collection and abscess. As Dr. McNelis summarized the chart, after the drain was placed and the antibiotic regimen had commenced, the plaintiff was clinically stable, her fever had improved, and she continued to evince no peritoneal signs. He thus concluded that "it was entirely reasonable to continue to observe plaintiff and wait to see if the area healed on its own without needing surgical intervention."

Dr. McNelis averred that, on March 19, 2020, Memorial was aware of the change in the output from the plaintiff's drain, which turned from serosanguinous to "cloudy and foul-smelling, and started to grow Bacteroides (native to the colon and rectum) on culture." He noted that a contrast study performed on that date revealed a small, narrow fistula between the sigmoid colon and the fluid collection, which he characterized as consistent with the drain output and positive culture. Dr. McNelis nonetheless concluded that no change in the treatment plan was necessary at that time because the plaintiff continued to have no peritoneal signs or sepsis. He asserted that it remained reasonable to continue observation while she was being treated with a drain and antibiotics, as it was possible the fistulous tract might close without surgical intervention. Dr. McNelis asserted, however, that the plaintiff experienced a significant change in her clinical status on March 20, 2020 that warranted surgical intervention. As he described it, this change occurred during the morning hours of March 20, 2020, between the time that the plaintiff was examined by a colorectal surgery fellow in the morning, and the time that the attending colorectal surgeon, Jesse J. Smith, M.D., conducted an examination a few hours later. Dr. McNelis explained that, when the surgical fellow examined plaintiff that morning, the plaintiff complained of mild abdominal pain, but no peritoneal signs, while only a few hours later, when

Dr. Smith examined plaintiff, she had diffuse abdominal tenderness, with peritoneal signs on her left side. He averred that, at that time, the plaintiff "was promptly and properly taken back to the operating room with Dr. Smith," and that during the operation that Dr. Smith performed, he identified a perforation at the distal sigmoid/upper rectum. Dr. McNelis opined that there was no merit to the plaintiff's contention that earlier intervention via colorectal surgery was required to avoid a colostomy, since a colostomy would have been required regardless of when the surgical repair of the colon perforation was performed.

Upon reviewing the operative and postoperative charts, Dr. McNelis concluded that there was no factual basis for the plaintiff's contention that a surgical sponge was left inside her during and after her fifth surgery to remove a cystic teratoma from her ovaries, which was performed on July 10, 2020. According to Dr. McNelis, the July 10, 2020 operating room record documented that "log counts" of the sponges, needles, instruments, and accessories that were employed during that procedure were verified by the circulating nurse, and that the nurse's count was correct. Accordingly, he concluded that there was no evidence of a retained surgical sponge, and that Dr. Smith, who performed that procedure, properly proceeded to final closing. As he explained it,

> "[a]t the end of the procedure a wound vac was in place on the abdomen. When plaintiff was discharged home on July 16, 2020, her wound vac had been discontinued and the wound was replaced with packing. Plaintiff required wound care for the ostomy closure site as an outpatient. When plaintiff returned to Dr. Smith for a post-operative visit on July 22, 2020, one area of seroma of the midline wound was noted and dressed. Dr. Smith noted that plaintiff was recovering well with expected wound care issues. On July 28, 2020, plaintiff reported to Dr. Smith's office that she was irrigating and packing the wound, but it was not getting smaller. On July 31, 2020, plaintiff documented through photographs and a short video the removal of material, which she believes was a surgical sponge left behind during the July 10, 2020 surgery, *but actually shows absorbable packing material* that was used as part of the post-operative wound care"

(emphasis added).

Dr. McNelis concluded that the defendants properly maintained all medical and surgical records, and that there was no basis upon which the plaintiff could claim that she was harmed

by the quality of the medical records. In addition, he averred that there was no evidence that insufficiently trained staff rendered care and treatment to the plaintiff at Memorial, or that sufficiently trained staff were not provided to her. He asserted that LaQuaglia and J. Ted Gerstle, M.D., were in charge of her case, that both those two physicians, as well as the follows, assistants, and nurses who examined and treated her, were all properly trained and supervised, and that none of Memorial's health-care personnel who assisted Drs. LaQuaglia and Smith committed any acts or omissions that would constitute malpractice.

In opposition to the defendants' motion, the plaintiff relied on many of the same documents that the defendants had submitted. She also submitted an attorney's affirmation, her own affidavit, a counterstatement of material facts, and the expert affidavit of a board-certified general surgeon.

The plaintiff's expert surgeon opined that LaQuaglia departed from good and accepted medical practice in failing to discover, confirm, and repair the number and location of inadvertent injuries to the colon that were caused intraoperatively at or near the recto-sigmoid junction and rectum. The surgeon further faulted LaQuaglia in failing to perform a proper leak test to confirm that all such injuries---which were estimated, but not confirmed to be, up to five in number since they were neither delineated in the operative report nor confirmed by testing---had not only been discovered, but repaired in an airtight fashion, prior to completing of the surgery. In addition, the surgeon averred that LaQuaglia negligently failed to investigate the cause of a fever that had persisted into March 14, 2020 prior to the plaintiff's discharge, particularly in light of his knowledge than an uncertain number of colon-wall injuries had occurred. The expert further opined that, had the March 11, 2020 procedure been properly performed, and had the intraoperative injuries to the colon been avoided or properly repaired on March 11, 2020, the surgery performed by Dr. Smith on March 20, 2020, as well as the colostomy reversal of July 10, 2020, would have been unnecessary, as would have been the need for prolonged gauze packing of the wound. The plaintiff's expert surgeon further opined that, based upon a review of

the plaintiff's chart, there was indeed gauze left in the plaintiff's body after the July 10, 2020 surgery that had not been removed until the end of July 2020, that "there is no question that the piece of gauze-like material left in the wound was interfering with wound healing," and that it was "axiomatic, that had there been no need for the surgery of July 10, 2020 to close the ostomy site to restore the integrity and continuity of Ms. Margolin's colon, whatever its source, there would have been no need for material to be in the wound and this discussion would be moot." In this respect, the expert asserted that a text chain between the plaintiff and Dr. Smith subsequent to the July 10, 2020 procedure, and imaging that the expert reviewed, established that gauze had been left in the wound during that procedure, and needed to be removed. The expert thus concluded that it was irrelevant as to whether the material left in the wound was gauze or a surgical sponge, as the plaintiff initially had alleged.

The plaintiff's expert recounted the plaintiff's medical history, explaining that there had been no difficulty reported in connection with the three laparoscopic resections that the plaintiff underwent in the years prior to the March 11, 2020 surgery, but that LaQuaglia himself, who performed the third surgery in 2016, reported the presence of adhesions in the operative field during that procedure. The expert asserted that adhesions can develop after any surgery, and generally appear as a normal healing response to surgical trauma, in the form of either fibrous bands or sheets. The expert averred that adhesions cause organs to "stick" to other tissues or organs, and are commonly encountered by surgeons in areas of the body where prior surgical procedures had been performed. The plaintiff's expert surgeon opined that presence of adhesions during the third surgery made it likely that adhesions would be encountered during the fourth surgery, which was performed March 11, 2020, since each successive surgery causes trauma to the tissues in and about the surgical field, which, in turn, increases the likelihood that adhesions will be encountered at the time of the next surgery.

According to the plaintiffs' expert, LaQuaglia knew or should have known that he would encounter adhesions during his dissections on March 11, 2020, based upon the observations

made during the 2016 surgery, as well as the fact that he had utilized the pfannensteil incision method during surgery the plaintiff's first surgery, which he performed in 2011. Specifically, the expert noted that the February 19, 2016 operative report recited that LaQuaglia found a "moderate amount of adhesions in the area that were easily (sic) to deal with." The expert further noted that LaQuaglia testified at his deposition that he had been "uncomfortable" proceeding laparoscopically during the March 11, 2020 surgery "because of the adherence (sic)" of the various tissues and organs that he had observed and, that, because of the "adherence of the various structures," he made the decision to convert to an open surgery. The expert referred to LaQuaglia's testimony to the effect that, although he observed no "injuries" to the colon itself, he decided to place sutures "in those areas" out of an "abundance of caution." Nonetheless, the expert surgeon asserted that LaQuaglia did, in fact, report the presence of an injury during dissection to the colon wall's serosal surface area at the rectosigmoid and upper rectum, while LaQuaglia further reported that the plaintiff's left ovary was adhered to the sigmoid colon. that he was experiencing difficulty with that dissection, and that "[s]ome serosal cuts" were made to the anterior wall of the recto-sigmoid junction area and upper rectum.

As the plaintiff's expert described it, no enumeration of the number of serosal cuts was made in the March 11, 2020 operative report, nor could LaQuaglia remember the specific number that he observed, nor the number that he attempted to repair. Nonetheless, the expert averred that, inasmuch as that report stated that seromuscular sutures were placed to repair the damage to the colon wall, the sutures likely were placed into the serosa and into the muscular layer below. The expert explained that there would be no reason to place any sutures whatsoever in the colon wall if no area of colon-wall injury had been observed. In this respect, the plaintiff's expert surgeon characterized LaQuaglia's deposition testimony as "misleading," since the relevant operative report clearly stated that "[s]ome serosal cuts in the anterior wall of the rectosigmoid made during the initial dissection were now closed . . . for security." The expert opined that LaQuaglia repaired these areas out of concern that the damage might have

been more extensive than just serosal, since his placement of the sutures for "security" indicated a concern that the plaintiff had experienced a more extensive injury.

The plaintiff's expert opined that, if there is a concern for an injury to the colon, which the plaintiff in fact sustained, "then it is the surgeon's obligation to use every methodology available to ascertain and diagnose any bowel injury." The expert continued, asserting that, in the plaintiff's case, where there were multiple injuries to the colon that LaQuaglia believed had required repairs for "security," a definitive air/leak test had to be performed in order to identify any missed or inadequately repaired injury. According to the expert surgeon, this is performed by insufflating the rectum with air while obstructing the colon above the suspected area of injury, with saline filling the pelvis and area of potential injury. Hence, the expert opined that proper surgical practice requires a thorough investigation to avoid leaving behind unrecognized injured areas or areas where repairs lack sufficient integrity, and that LaQuaglia's failure to so constituted a deviation from accepted practice.

The plaintiff's expert surgeon noted that even Dr. McNelis conceded that there could have been unidentified serosal cuts, and that it would be a reasonable extrapolation that, if there could have been unidentified serosal cuts, there could be even greater damage that was unrecognized, including a full thickness injury that caused or led to a full perforation. Since the expert averred that it is the surgeon's obligation to identify and repair those injuries to prevent the complications that the plaintiff experienced in this case, it was a deviation from accepted surgical practice for LaQuaglia to have failed to identify and repair all injured areas. The expert stated that, absent a definitive leakage test under pressure, there can be no certainty that there were no inadvertent enterotomies, that is, holes in the colon wall. In this respect, the expert asserted that, by distending the bowel with air, a surgeon will have a better opportunity to visualize the colon walls to assure that all serosal cuts could be noted and properly addressed.

With respect to LaQuaglia's testimony that he placed sutures "for security," and not necessarily because there were iatrogenic injuries, the plaintiff's expert asserted that a

> "surgeon does not randomly place sutures unless some defect is observed or suspected. There was no excessive bleeding or other event that prevented Dr. LaQuaglia from thoroughly investigating. Despite Dr. LaQuaglia's testimony to the contrary, the operative report for March 11 . . . clearly states that some unspecified number of serosal cuts had been identified at the anterior wall of the recto-sigmoid area for repair, despite the apparent denial at his deposition."

After explaining the structure of the colon, the plaintiff's expert concluded that an injury to the serosa should be immediately evident to a surgeon, that a surgeon must know what tissues his or her surgical instruments contact, and that careful and continuous inspection is required.

The plaintiff's expert opined that it a deviation from accepted practice to cause an injury to an organ within the operative field, and to fail to discover and address the injury before completing the surgery, explaining that visual observation, such as that relied upon by LaQuaglia, "is insufficient when dealing with the colon because the organ has been mobilized as part of the surgery to access the ovary and injury may not be visible due to positioning or other factors." The expert went on to explain that,

> "[g]enerally, the serosal surface of the large intestine is a smooth tissue surface. When the serosa is injured, there can be bleeding from the injury site. In addition, there is a change to the characteristic appearance of the area. Careful inspection during the surgery and before closing will usually reveal the presence of the injury.
>
> "Once serosal injuries have been identified, the standard of care in 2020, as is the case today, is to perform the needed repairs and to perform a leak test with the bowel adequately distended. Without rigorous investigation to determine tissue integrity, especially as here, when extensive dissection of the area has been undertaken, with apparent injury requiring repair is already noted."

The plaintiff's expert faulted LaQuaglia for merely filling the plaintiff's stomach with saline water and pressing downward from the rectum for the purpose of ascertaining the presence of leaks. The expert opined that this method was not a standard way of performing an air leak test, rejecting LaQuaglia's testimony that such a maneuver would distend the bowel underwater and allow him to look for bubbles, and explaining that there was "no guaranty that he was pressing in an area of potential injury." The surgeon averred that simply pressing on the colon is an insufficient method because it is not likely to generate sufficient internal pressure within the

colon and/or rectum to express bubbles. In any event, the expert asserted that the fact that LaQuaglia felt it necessary to do such a test indicated that, at the very least, the test should have been performed in the generally accepted manner. The expert concluded that the method that LaQuaglia employed not only failed to comport with the standard of care, but placed the plaintiff at risk of an overlooked colon injury or inadequate repair, which actually occurred here, and opined that a formal leak test was required because there were an unknown number of serosal injuries in at least two places in the colon, which the expert explicitly concluded had been caused during the dissection. The plaintiff's expert also expressly opined that the suturing and repairs that LaQuaglia did undertake were inadequate.

According to the plaintiff's expert, LaQuaglia admitted that he was unsure when he injured the plaintiff's colon, instead relying upon his recollection that the injuries likely occurred during the dissection phase of the procedure. Inasmuch as LaQuaglia conceded at his deposition that that the plaintiff had sustained injury to her colon because he could see muscle fibers, the expert concluded that the serosal wall had been fully breached, with LaQuaglia estimating that there were between two and five defects, a difference in quantity that the expert characterized as "great." In other words, since LaQuaglia recalled observing muscle fibers, the expert explained that, by definition, the injuries to the plaintiff's colon wall were significant, and accepted surgical practice required more than visual inspections to determine the number and location of defects requiring repair. In this regard, the expert stated that the location and repair of each defect should have been reflected in LaQuaglia's operative report, and that his failure to memorialize them constituted a departure from accepted standards of record keeping that delayed the treatment that should have been rendered to the plaintiff.

Furthermore, despite Dr. McNelis's statement that LaQuaglia repaired serosal tears of the sigmoid colon, the plaintiff's expert alleged that Dr. McNelis omitted from his affirmation that repair also was made to the posterior wall of the rectum at the recto-sigmoid junction, which the expert characterized as a significant omission because those structures were not anatomically

synonymous with the sigmoid colon. In this respect, the expert surgeon averred that the perforation that was identified during the plaintiff's readmission to Memorial on March 15, 2020 was located at the distal sigmoid/upper rectum area, which the expert described as the areas identified as LaQuaglia at his deposition as the areas that he attempted to repair on March 11, 2020. The plaintiff's expert surgeon reiterated that, by failing to perform appropriate leak tests, it was impossible LaQuaglia, or any surgeon, for that matter, to state with any certainty that all defects in the colon/rectum walls were located and adequately repaired. Consequently, the expert opined that LaQuaglia's failure to locate and repair all defects in the plaintiff's colon/ rectum walls was another clear deviation from accepted practice and was a substantial factor that led to the complications that ensued.

According to the plaintiff's expert, although the plaintiff was afebrile when she was discharged from Memorial on March 14, 2020, because she had experienced "significant unexplained fevers" over the previous two days despite receiving substantial doses of oral and intravenous acetaminophen, and in light of the "known multiple intra-operative colon injuries, the integrity of the colon and the repairs made should have been confirmed before discharging her." In addition, the expert opined that Memorial personnel should have performed a CT scan prior to the plaintiff's discharge and, had it been performed, it was "highly likely that the lack of integrity of the colon wall near the rectum and sigmoid colon (e.g. abnormal fluid collection) would have been revealed, permitting repair before the tissue became friable, allowing primary repair, likely avoiding the need for colostomy." The expert further concluded that it was likely that the same conditions would have been shown at that time as were present 24 to 36 hours after the plaintiff was discharged. The expert noted, as had Dr. McNelis, that the CT scan taken on March 16, 2020 revealed that a large abscess had formed adjacent to and inseparable from the sigmoid colon, in the area where the March 11, 2020 repair of the colon injuries had previously been undertken. According to the expert, it takes four to seven days for an abscess to form, which supported the conclusion that there was an inadvertent, undiagnosed injury

occurring at the time of the March 11, 2020 surgery that caused the abscess. The expert noted that LaQuaglia himself testified at his deposition that he was of the opinion that the cause of the abscess, or at least his "concern," was that "it was a defect in the wall of the rectum or colon."

As the plaintiff's expert interpreted the plaintiff's chart, when Dr. Smith performed repair surgery on March 20, 2020, the latter indicated that he believed that an upper rectal perforation was present, but did not describe any sutures in the area of the perforation that he found, which according to the expert, suggested that LaQuaglia, more likely than not, failed to recognize the perforation at the time of the initial surgery.

In reply, the defendants submitted an attorney's affirmation, in which counsel argued that the plaintiff essentially abandoned all of her substantive claims of departures from good practice because her expert did not address them. She further contended that the opinions of the plaintiff's expert were "contradicted by the evidence and have no probative value." Counsel further characterized that expert's opinion as to the proper method for undertaking leakage test as not supported by the evidence in the medical records.

The court concludes that the defendants made a prima facie showing of their entitlement to judgment as a matter of law in connection with the medical malpractice cause of action. The plaintiff, however, through her submissions, including her expert's affirmation, raised triable issues of fact as to whether LaQuaglia departed from good and accepted practice by negligently performing an open bilateral ovarian cystectomy, failing to protect adjacent structures not involved in the subject gynecological surgery, improperly cutting the colon, failing timely to discover and repair the injury after he caused it, failing to ensure that the integrity of the colon and rectum was maintained before completing the March 11, 2020 procedure, failing properly to monitor the plaintiff's postoperative condition, improperly discharging her from Memorial to her home on March 14, 2020, delaying her reevaluation, and failing to obtain sufficient imaging studies both intraoperatively and postoperatively, and whether Dr. Smith departed from good and accepted care in permitting gauze to remain in her wound after the her July 10, 2020

surgery. The expert's affirmation also raised a triable issue of fact as to whether these departures proximately caused or contributed to her injuries. She further raised a triable issue of fact as to whether adequate operative records were generated and maintained, and whether the failure to fully report or account for the cuts in her colon delayed or negatively affected the course of her treatment and outcome. The court rejects the defendants' contention that the plaintiff abandoned any of these claims, or that her expert's opinion with respect to these claims was unsupported or contradicted by the relevant medical records, charts, and imaging scans. The plaintiff's expert, however, did not address the showing made by the defendants in connection with her claims that LaQuaglia failed to perform the surgical procedure that had actually been described in his operative report, failed accurately to inform her of intraoperative events that occurred during the March 11, 2020 procedure, and failed timely to reexamine her after she became febrile at home on March 14, 2020 or March 15, 2020. Hence, summary judgment is awarded to the defendants dismissing those claims.

"'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 Drs. LaQuaglia and Smith were employees of Memorial when they allegedly committed the acts complained of here. Hence, to the extent that there are triable issues of fact with respect to whether either of those physicians committed malpractice, there are triable issues of fact as to Memorial's vicarious liability with respect to those claims.

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 at 260, 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]). Hence, where a defendant establishes his or her prima facie entitlement to judgment as a matter of law in connection with a lack of informed consent cause of action by submitting an expert affirmation from a physician, a plaintiff can only raise a triable issue of fact by submitting "an expert affirmation stating with certainty that the information defendant[ ] allegedly provided to plaintiff before the [medical] procedures at issue departed from what a reasonable practitioner would have disclosed" (*Leighton v Lowenberg*, 103 AD3d 530, 530 [1st Dept 2013]). Nonetheless, expert testimony is not necessary with respect to the issue of whether a reasonably prudent person, fully informed, would not have consented to the treatment (*see Gray v Williams*, 108 AD3d 1085, 1086-1087 [4th Dept 2013]; *Hugh v Ofodile*, 87 AD3d 508, 509 [1st Dept 2011]; *Andersen v Delaney*, 269 AD2d 193, 193 [1st Dept 2000]; *Hardt v LaTrenta*, 251 AD2d 174, 174 [1st Dept 1998]; *Osorio v Brauner*, 242 AD2d 511, 511-512 [1st Dept 1997]).

"'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]). Nevertheless, 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]).

The defendants established their prima facie entitlement to judgment as a matter of law in connection with the lack of informed consent cause of action with Dr. McNelis's affirmation, in which he asserted that the plaintiff met with LaQuaglia prior to the subject surgery on March 4, 2020, at which time LaQuaglia recommended a fourth procedure to remove an ovarian cyst, and a third procedure to remove ovarian teratomas. He asserted that, having undergone the same type of surgery previously, the plaintiff already was aware of the nature of the procedure and the benefit of having the ovarian teratomas removed. According to Dr. McNelis, LaQuaglia's note for that date indicated that "[t]he risks, benefits, complications, sequelae, and possible alternatives of repeat laparoscopy and resection of ovarian teratomas was explained to the patient and her mother. They asked questions, understand, and wished to proceed." He also noted that the plaintiff had testified at her deposition that she understood that surgery was the only option to remove her ovarian teratomas, while LaQuaglia testified at his deposition that he discussed with plaintiff the possibility of surgical complications, including injury to the colon, the possible need to convert to an open procedure, and the risk of complications in light of her prior surgeries. LaQuaglia further testified that he also discussed with the plaintiff the risk of infection and multiple cysts scarring the fallopian tube, which can cause suboptimal tube function.

Dr. McNelis stated that, on March 4, 2020, the plaintiff signed a consent form for LaQuaglia to perform a laparoscopy and bilateral ovarian cystectomy, as well as a possible laparotomy, that is, an open procedure. Accordingly, he concluded that the consent was qualitatively sufficient. He conceded that the plaintiff testified, at her deposition, that she had not been informed of the risk of perforation, injury to the colon, or the loss of the fallopian tube, and that had she been told, she would have declined a laparoscopic approach, but only consented to a laparotomy, which LaQuaglia ultimately performed. Dr. McNelis rejected the basis for this testimony, explaining that performing the surgery only as an open procedure, rather than shifting intraoperatively from a laparoscopy to a laparotomy, would not have eliminated the risks of perforation, injury to the colon, or loss of the fallopian tube, describing these risks as inherent to ovarian cyst surgery, regardless of the approach. He further adverted to the fact that the plaintiff had had undergone three prior surgeries with LaQuaglia, and that, inasmuch as she needed to have the ovarian teratomas removed, she necessarily agreed to proceed with the surgery, whatever the surgical approach. As Dr. McNelis framed the issue, "no treatment at all was not a proper or realistic alternative because a teratoma might be malignant, and even if benign, a teratoma can grow, twist, and injure or kill the ovary." He concluded that "any reasonable patient in plaintiff's position would have consented to proceed with the March 11, 2020 surgery, despite the risks, given that surgery was the only treatment option."

In response to Dr. McNelis's affirmation, the plaintiff relied both on the affirmation of her expert surgeon, and also submitted her own affidavit. Her expert asserted that the written and signed consent form was dated March 3, 2020, rather than March 4, 2020, but agreed with Dr. McNelis that the form identified a laparoscopy as the proposed method for performing the "bilateral ovarian cystectomy," with, however, a "possible laparotomy." The surgeon further noted that the consent form referable to the February 2016 procedure indicated only a proposed "laparoscopy and excision of right hemorrhagic cyst (6cm)," but not a possible laparotomy, leading the surgeon conclude that LaQuaglia correctly viewed the procedure proposed for

March 11, 2020 to be a potentially a more complicated procedure than the prior one. The surgeon further noted that, in 2016, the plaintiff was still a minor and, hence, the consent form for the February 2016 procedure was signed by her parents, but, by the time she was about to undergo the March 11, 2020 procedure, she had reached her majority and, thus, was the signatory on the relevant consent form. The expert thus implicitly challenged Dr. McNelis's contention that the prior consent that LaQuaglia had obtained from the plaintiff's parents relieved him of the obligation to provide the plaintiff with sufficient information in 2020.

As the plaintiff's expert interpreted LaQuaglia's deposition testimony, LaQuaglia informed both the plaintiff and her parents that he considered the procedure set for March 11, 2020 to be more complicated than any of the prior procedures. The expert referred to the plaintiff's own deposition testimony, which was to the effect that her understanding of the purpose of the surgery was to remove an abnormal cyst from her ovaries, with an expected recovery time of two to three days, and that she further testified that she agreed to proceed on March 11, 2020 because she trusted LaQuaglia and his determination that the cyst had to be removed. The expert, however, noted that, although LaQuaglia wrote in his operative report that he had advised the plaintiff that he might have to convert from a laparoscopy to a laparotomy during the course of the surgery due to the presence of adhesions, the plaintiff expressly testified that he never informed her of that possibility, or of the risks of commencing the surgery as a laparoscopic procedure. The plaintiff's expert surgeon opined that

> "[a] surgeon has an obligation to explain to a patient in language understandable to the patient what the risks benefits and alternatives to the surgery prosed might be. It is clear in this case that Dr. LaQuaglia considered the surgery of March 11 to be more complicated than the three preceding it. Thus, accepted standards of acceptable surgical practice in this regard for this surgery required a discussion of the hazards or complications anticipated due to the adhesions expected to be encountered.

The expert asserted that LaQuaglia was aware that adhesions were likely to be encountered in 2020, as the latter had observed the presence of adhesions during the 2016 surgery. The expert averred that any discussion by surgeon with a reasonably prudent patient under these

circumstances was required to include a discussion of the risks of first proceeding laparoscopically, as opposed to proceeding directly with a laparotomy. The plaintiff's expert asserted that a reasonably prudent surgeon would be expected to inform the patient of the risks and complications likely to be encountered by initiating the procedure as a laparoscopy and why, if applicable, such a procedure would likely carry a higher risk than the prior procedures. The expert opined that LaQuaglia deviated from accepted standards of care by failing to do so.

With respect to the issue of whether a reasonably prudent patient would have agreed to commence the procure laparoscopically, the expert quoted from the plaintiff's deposition testimony, in which she asserted that her understanding about proceeding laparoscopically in 2020 was that "[e]verything [would be] the same as what I had from before. That I had done before," and that she was informed only that "LaQuaglia is going go through the same scars laparoscopically. That's it."

The plaintiff's expert agreed with Dr. McNelis that surgical treatment was the only course to follow to address the plaintiff's bilateral ovarian teratomas, but that where, "as here, there was a choice as to how to proceed, informed consent required the patient be included in such discussion," and that LaQuaglia's failure expressly and explicitly to inform the plaintiff of the risks of commencing the procedure laparoscopically, and the benefits of commencing it as an open procedure, that is, as a laparotomy, constituted a failure properly to obtain her fully informed consent. In this respect, the plaintiff's expert implicitly disagreed that the risk of serosal cuts was the same regardless of the surgical approach that LaQuaglia elected to use.

In her own affidavit, the plaintiff asserted that LaQuaglia did not advise her that he thought that the surgery would be more difficult than her prior surgeries, nor did he discuss with her anything about adhesions. Rather, she explained her understanding that the expected risks included bleeding and infection. Moreover, although she admitted that the word "laparotomy" appeared on the consent form referable to the March 11, 2020 surgery, and that she had a "light hearted conversation about the surgery" with LaQuaglia, she was led to believe that that the

2020 procedure would be "just like the prior three." As she explained it, had LaQuaglia advised her that the prior surgeries were a complicating factor, she "would have had a discussion with him about whether or not it would be more prudent to proceed" initially "with the open procedure (laparotomy) that he later explained was performed." She averred that, had he explained to her "that there were adhesions or other reasons that made the proposed laparoscopic surgery more complicated or risky than the prior three," she "would have asked more questions and would have requested that he perform the procedure with the highest probability of a successful, uncomplicated outcome," particularly because she already had a scar below her bikini line from the first surgical procedure that LaQuaglia performed on her when she was 11 years old.

The court concludes that, although the defendants established their prima facie entitlement to judgment as a matter of law in connection with the lack of informed consent cause of action, the plaintiff raised triable issues of fact with her expert's affirmation as to whether the consent was qualitatively insufficient, and with both that affirmation and her own affidavit as to whether reasonably prudent patient would not have consented to proceed laparoscopically had the patient fully been apprised of the risks of a laparoscopic procedure where adhesions were present, and the benefits of a laparotomy. Consequently, and in light of Memorial's vicarious liability for LaQuaglia's allegedly tortious conduct, that branch of the defendants' motion seeking summary judgment dismissing the lack of informed consent cause of action must be denied.

To establish a cause of action to recover for negligent hiring, supervision, training, and retention of health-care personnel, a plaintiff must demonstrate that the defendants either "knew, 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]). In opposition to the defendants' prima facie showing in this regard, the plaintiff adduced no facts with respect to whether the defendants knew or should have known of the propensity of their

physicians to commit acts of malpractice. Hence, that branch of the defendants' motion seeking summary judgment dismissing that claim must be granted.

Accordingly, it is,

ORDERED that the defendants' motion is granted to the extent that they are awarded summary judgment dismissing so much of the medical malpractice cause of action as was premised upon allegations that the defendant Michael LaQuaglia, M.D., failed to perform the surgical procedure that had actually been described in his operative report, failed accurately to inform the plaintiff of intraoperative events that occurred during the subject March 11, 2020 open bilateral ovarian cystectomy procedure, and failed timely to reexamine her after she became febrile at home late in the evening of March 14, 2020 or early in the morning of March 15, 2020, and the claim, set forth in her bill of particulars, that the defendant Memorial Hospital for Cancer and Allied Diseases negligently hired, trained, supervised, and retained health-care personnel, those claims are dismissed, and the motion is otherwise denied; and it is further,

ORDERED that that, on the court's own motion, the attorneys for all of 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 August 14, 2025, at 3:15 p.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.

7/24/2025
DATE

JOHN J. KELLEY, J.S.C.

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