Piazza v Dobri

2025 NY Slip Op 33188(U)

August 25, 2025

Supreme Court, New York County

Docket Number: Index No. 805158/2021

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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LYNNE PIAZZA and AUGUST PIAZZA,

Plaintiffs,

- v -

GEORGIANA A. DOBRI, M.D., WEILL CORNELL NEUROLOGICAL SURGERY, NEW YORK-PRESBYTERIAN/WEILL CORNELL MEDICAL CENTER, and THE NEW YORK AND PRESBYTERIAN HOSPITAL,

Defendants.

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INDEX NO. 805158/2021

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) 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 49, 50

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, lack of informed consent, and loss of spousal consortium, the defendants move pursuant to CPLR 3212 for summary judgment dismissing the complaint. The plaintiffs oppose the motion. The motion is granted only to the extent that the defendants are awarded summary judgment dismissing the lack of informed consent cause of action, and so much of the medical malpractice cause of action as was premised upon the doctrine of res ipsa loquitur, negligent hiring and training of health-care personnel, and the failure to biopsy a suspected adenoma. The motion is otherwise denied.

The crux of the plaintiffs' claims is that, between June 6, 2016 and September 1, 2017, the defendant neuroendocrinologist Georgiana A. Dobri, M.D., while employed by the defendants Weill Cornell Neurological Surgery, New York-Presbyterian/Weill Cornell Medical Center, and The New York and Presbyterian Hospital (collectively the institutional defendants) departed from good and accepted medical practice by failing to diagnose the plaintiff Lynne Piazza (the patient) with cyclical Cushing Syndrome, a condition in which an excess of the

hormone cortisol builds up in a person's body. They further alleged that the institutional defendants, under whose care she remained between December 9, 2016 and November 30, 2018, were vicariously liable for Dobri's malpractice, either because Dobri was their employee, or by virtue of the doctrine of implied or ostensible agency.

In their complaint, the plaintiffs alleged that the defendants committed malpractice in failing timely and properly to order, perform, and interpret the necessary and proper workup to determine the patient's true medical condition, including diagnostic, surgical, pathological, and radiological tests and procedures. They specifically referred to Dobri's failure properly to interpret the magnetic resonance imaging (MRI) scans of the patient's pituitary gland that Dobri had ordered on June 6, 2016 and September 1, 2017, which they alleged revealed the presence of a pituitary microadenoma. The plaintiffs further asserted that, as a consequence, the defendants failed to obtain a tissue sample for a biopsy of the microadenoma, to recommend further testing or exploration of the microadenoma, and to order and perform petrosal venous sampling which, in turn, led to the defendants' misdiagnosis of "severe metabolic syndrome," their concomitant failure to diagnose not only the presence of an adrenocorticotropic hormone (ACTH)-secreting adenoma causing a condition known as Crooke's hyaline adenoma, but to diagnose Cushing Syndrome as well, and their consequent failure to treat the patient for those conditions. In this respect, they averred that the defendants failed to recognize, heed, or monitor the patient's signs and symptoms via repeated imaging studies for a condition that they characterized as "life threatening," since the patient evinced obesity, weight gain, a buildup of bodily fluids, "moon face," menstrual changes, hirsutism, hypertension, ecchymoses, lethargy, depression, an inability properly to heal bone fractures, dorsal fat pad, striae, edema, proximal muscle weakness, osteopenia or fracture, headache, backache, recurrent infections, abdominal pain, nausea, diarrhea, and the loss of hair on her head. More specifically, they asserted that the patient's adenoma continued to grow in size during the relevant period of time.

The plaintiffs also alleged in their complaint that the defendants' failure to properly treat the patient for the conditions from which she was, in fact, suffering, included their failure timely to refer her for surgical resection of the microadenoma, thus depriving her of a statistically significant chance of a better medical outcome, and ultimately requiring the removal of her pituitary gland. They further faulted the defendants for negligently advising her that she did not have Cushing Syndrome. The plaintiffs additionally asserted that the defendants ignored the recommendations of other qualified medical professionals, who told the defendants that the patient's presentation, laboratory testing, and other diagnostic studies were consistent with Cushing Syndrome. They claimed that the defendants departed from good practice in failing to timely to refer the patient or further evaluation and consultation, including additional MRIs, computed tomography (CT) scans, positron emission tomography (PET) scans, ultrasound scans, and biopsies, and in failing to prescribe appropriate medications. The plaintiffs averred that, as result of the defendants' malpractice, the patient not only lost her pituitary gland, but was caused to suffer from panhypopituitarism, diabetes insipidus, adrenal insufficiency, fatty liver disease, hypogonadism, infertility, early onset menopause, lack of growth hormone, and hypothyroidism, and now is at higher risk of cardiac complications and sudden death.

In addition to these specific departures from good and accepted practice, the plaintiffs alleged, in their medical malpractice cause of action, that the defendants failed to hire and adequately train competent personnel,[1] and that the plaintiffs would also be relying on the doctrine of res ipsa loquitur.

[1] The court notes that, while allegations of negligent hiring, training, supervision, and retention constitute a cause of action independent of a medical malpractice cause of action, and the plaintiffs did not separately plead a such cause of action, the court will address that claim as if it had been separately pleaded (*see Estate of Gebert v Huntington Hills Ctr. for Health*, 2024 NY Misc LEXIS 51911, *16 [Sup Ct, Suffolk County, Sep. 5, 2024]; *see also Taylor v Methodist Hosp.*, 6 Misc 3d 1008[A], 2004 NY Slip Op 51750[U], *4, 2004 NY Misc LEXIS 2898, *9 [Sup Ct, Kings County, Nov. 1, 2004] [deeming claim alleging "negligent credentialing" to constitute an independent cause of action]).

In their bill of particulars, the plaintiffs essentially reiterated the detailed allegations set forth in their complaint, adding that the laboratory results that should have been performed, or, if they were performed, should have alerted the defendants to the patient's actual condition, included further testing for urine free cortisol, late night salivary cortisol, dexamethasone suppression testing, ACTH, and hemoglobin A1C levels. They further asserted that, as part of their differential diagnosis, the defendants not only should have included consideration of Cushing Syndrome, but also should have formulated a differential diagnosis that excluded type II diabetes mellitus, obesity, metabolic syndrome, and adrenal gland irregularities. In addition, the plaintiffs asserted that the defendants prescribed improper medications, such as Metformin, Victoza, and Saxenda. With respect to the injuries that the patient identified in the complaint, the plaintiffs additionally alleged, in their bill of particulars, that, as a consequence of the defendants' wrongdoing, the patient also was deprived of substantial chance for a meaningful medical or surgical intervention, is faced with a worsened prognosis that adversely impacted her overall outcome, and that she experienced physical and emotional pain and suffering, as well as extreme fear, anxiety, distress, and the fear of a premature death.

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]).

Although a plaintiff asserting a medical malpractice claim usually must demonstrate that the defendant physician or hospital deviated from acceptable medical practice, and that such deviation was a proximate cause of the plaintiff's injury (*see Rivera v Kleinman*, 16 NY3d 757, 759, [2011]; *Frye v Montefiore Med. Ctr*., 70 AD3d at 24; *Terranova v Finklea*, 45 AD3d at 572; *Zellar v Tompkins Community Hosp.*, 124 AD2d 287, 288-289 [3d Dept 1986]), the theory of res ipsa loquitur may be applied to occurrences "[w]here the actual or specific cause of an accident is unknown" (*Kambat v St. Francis Hosp*., 89 NY2d 489, 494 [1997]). Under such circumstances, "a jury may . . . infer negligence merely from the happening of an event and the defendant's relation to it" (*id*.; *see States v Lourdes Hosp*., 100 NY2d 208, 211-212 [2003]; Restatement [Second] of Torts § 328D). To establish a prima facie case of negligence in support of a res ipsa loquitur charge, plaintiff must establish three elements:

> "[1.] the event must be of a kind that ordinarily does not occur in the absence of someone's negligence;
>
> "[2.] it must be caused by an agency or instrumentality within the exclusive control of the defendant; and
>
> "[3.] it must not have been due to any voluntary action or contribution on the part of the plaintiff"

(*Kambat v St. Francis Hosp.,* 89 NY2d at 494; *see James v Wormuth*, 21 NY3d 540, 545-546 [2013]; *Ebanks v New York City Tr. Auth*., 70 NY2d 621, 623 [1987]; Prosser and Keeton, Torts § 39 at 244 [5th ed]). Res ipsa loquitur, a doctrine of ancient origin (*see Byrne v Boadle*, 2 H & C 722, 159 Eng Rep 299 [1863]), derives from the understanding that some events ordinarily do not occur in the absence of negligence (*see id.; see also Dermatossian v New York City Tr. Auth*., 67 NY2d 219, 226 [1986]). Once a plaintiff satisfies the burden of proof on these three elements, the res ipsa loquitur doctrine permits the jury to infer negligence from the mere fact of the occurrence (*see States v Lourdes Hosp.*, 100 NY2d at 211-212; *Kambat v St. Francis Hosp.,* 89 NY2d at 495). Thus, for example, where "a foreign object is left in the body of the patient, or the patient, while anesthetized, experiences an unexplained injury in an area which is remote from the treatment site" (*McCarthy v Northern Westchester Hosp*., 139 AD3d 825, 827 [2d Dept 2016] [citation omitted]), the invocation of the doctrine of res ipsa loquitur may be warranted (*see id.; see also Mattison v OrthopedicsNY, LLP*, 189 AD3d 2025, 2027 [3d Dept 2020]*; Swoboda v Fontanetta*, 131 AD3d 1042, 1045 [2d Dept 2015]; *DiGiacomo v Cabrini Med. Ctr*., 21 AD3d 1052, 1054 [2d Dept 2005]; *Escobar v Allen*, 5 AD3d 242, 243 [1st Dept 2004]; *Leone v United Health Servs*., 282 AD2d 860, 860-861 [3d Dept 2001]; *Hill v Highland Hospital*, 142 AD2d 955, 956 [4th Dept 1988]).

To make a prima facie showing of entitlement to judgment as a matter of law, a defendant physician moving for summary judgment must establish the absence of a triable issue of fact as to his or her alleged departure from accepted standards of medical practice (*Alvarez v Prospect Hosp*., 68 NY2d 320, 324 [1986]; *Barry v Lee*, 180 AD3d 103, 107 [1st Dept 2019]; *Frye v Montefiore Med. Ctr*., 70 AD3d at 24) or establish that the plaintiff was not injured by such treatment (*see Pullman v Silverman,* 28 NY3d 1060, 1063 [2016]; *McGuigan v Centereach Mgt. Group, Inc*., 94 AD3d 955 [2d Dept 2012]; *Sharp v Weber*, 77 AD3d 812 [2d Dept 2010]; *see generally Stukas v Streiter*, 83 AD3d 18 [2d Dept 2011]). To satisfy this burden, a defendant must present expert opinion testimony that is supported by the facts in the

record, addresses the essential allegations in the complaint or the bill of particulars, and is detailed, specific, and factual in nature (*see Roques v Noble*, 73 AD3d at 206; *Joyner-Pack v Sykes*, 54 AD3d 727, 729 [2d Dept 2008]; *Koi Hou Chan v Yeung*, 66 AD3d 642 [2d Dept 2009]; *Jones v Ricciardelli*, 40 AD3d 935 [2d Dept 2007]). If the expert's opinion is not based on facts in the record, the facts must be personally known to the expert and, in any event, the opinion of a defendant's expert should specify "in what way" the patient's treatment was proper and "elucidate the standard of care" (*Ocasio-Gary v Lawrence Hospital,* 69 AD3d 403, 404 [1st Dept 2010]). Stated another way, the defendant's expert's opinion must "explain 'what defendant did and why'" (*id*., quoting *Wasserman v Carella*, 307 AD2d 225, 226 [1st Dept 2003]). Moreover, as noted, to satisfy his or her burden on a motion for summary judgment, a defendant must address and rebut specific allegations of malpractice set forth in the plaintiff's bill of particulars (*see Wall v Flushing Hosp. Med. Ctr*., 78 AD3d 1043 [2d Dept 2010]; *Grant v Hudson Val. Hosp. Ctr.*, 55 AD3d 874 [2d Dept 2008]; *Terranova v Finklea*, 45 AD3d 572 [2d Dept 2007]).

Once satisfied by the defendant, the burden shifts to the plaintiff to demonstrate the existence of a triable issue of fact by submitting an expert's affidavit or affirmation attesting to a departure from accepted medical practice and/or opining that the defendant's acts or omissions were a competent producing cause of the plaintiff's injuries (*see Roques v Noble*, 73 AD3d at 207; *Landry v Jakubowitz*, 68 AD3d 728 [2d Dept 2009]; *Luu v Paskowski*, 57 AD3d 856 [2d Dept 2008]). Thus, to defeat a defendant's prima facie showing of entitlement to judgment as a matter of law, a plaintiff must produce expert testimony regarding specific acts of malpractice, and not just testimony that contains "[g]eneral allegations of medical malpractice, merely conclusory and unsupported by competent evidence tending to establish the essential elements of medical malpractice" (*Alvarez v Prospect Hosp.,* 68 NY2d at 325; *see 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' bill of particulars, transcripts of the parties' deposition testimony, relevant medical and hospital records, email correspondence between the patient and the defendants, the note of issue, an attorney's affirmation, and the expert affidavit of board-certified endocrinologist Lewis S. Blevins, M.D., who opined that the defendants did not depart from good and accepted medical practice in examining, testing, and treating the patient, and that nothing that the defendants did or did not do caused or contributed to any of the patient's claimed injuries.

Dr. Blevins first explicitly opined that Dobri appropriately assessed and worked up the patient for Cushing Syndrome, timely ordered all appropriate diagnostic tests to determine whether she suffered from Cushing Syndrome, timely and appropriately interpreted the results of the various diagnostic tests, appropriately declined to order additional diagnostic testing or surgery, and appropriately ruled out Cushing Syndrome as the cause of the patient's signs and symptoms, since there never was conclusive proof or evidence suggesting that the patient suffered from that condition.

As Dr. Blevins described the patient's history, on both March 10, 2016 and May 13, 2016, the patient presented to endocrinologist Stuart Morduchowitz, M.D., for a workup to ascertain whether she had Cushing Syndrome. According to Dr. Blevins, after this workup, Dr. Morduchowitz concluded that he doubted that the patient had Cushing Syndrome, but noted there was a "small possibility" that she may have been suffering from cyclical Cushing's, and never diagnosed her with Cushing Syndrome or cyclical Cushing's. Dr. Blevins asserted that Dr. Morduchowitz then referred the patient to endocrinologist Stuart Weinerman, M.D., and that she never returned to see the former. He stated that, on June 6, 2016, the patient underwent an MRI of her brain, which identified a 3 millimeter (mm)-to-4 mm focus of delayed contrast

enhancement in her pituitary gland, consistent with a microadenoma, and that, on July 7, 2016, she presented to Dr. Weinerman for a second opinion, who, according to Dr. Blevins, did not believe that she had Cushing Syndrome, but that her symptoms were caused by polycystic ovarian syndrome (PCOS), after which she never returned see to Dr. Weinerman. As Dr. Blevins explained it, on December 9, 2016, the patient presented to neurosurgeon Theodore Schwartz, M.D., for yet another opinion as to whether she suffered from Cushing Syndrome, after which Dr. Schwartz reported in her chart that she previously had been worked up for Cushing Syndrome. As set forth in Dr. Schwartz's chart, the patient's salivary cortisol levels had been normal when evaluated in a hospital setting by cardiologist James Klepper, M.D., during an October 12, 2016 test, but a 24-hour urine test was positive for free cortisol, she failed a dexamethasone suppression test, and a microadenoma had been found on an overall magnetic resonance lymphangiography image. Dr. Schwartz did, in fact, note that that the patient possibly had Cushing Syndrome and a possible small adenoma.

According to Dr. Blevins, Dobri thereafter was slated to evaluate the patient's laboratory test results and determine if she needed inferior petrosal sinus sampling (IPSS) to test for the presence of ACTH, and further wrote that the patient might be a candidate for surgery if it could firmly be established that her pituitary gland was the source of that hormone. Dr. Blevins asserted that, on December 9, 2016, the patient also presented to Dobri for evaluation of possible Cushing Syndrome, and reported to Dobri that an endocrinologist previously had diagnosed her with cyclical Cushing's. As Dr. Blevins framed it, although the patient's symptoms initially fluctuated, she reported that they had been constant over the previous year, and that the symptoms included hair loss on her scalp, hirsutism presenting as facial hair, and weight gain, while she experienced amenorrhea when she was a college student, and had then been diagnosed with PCOS. Dobri's chart also reflected that the patient reported having experienced hypertension since 2014, along with primarily central abdominal weight gain, proximal muscle weakness, and multiple infections. At Dobri's December 9, 2016 examination,

the patient weighed 215 pounds, and appeared "Cushingoid," that is, she presented with signs and symptoms typical of Cushing Syndrome, in light of her central abdominal obesity, with thin arms and legs. Dr. Blevins asserted, however, that her legs were still muscular with normal strength and muscle mass present, with no muscle wasting, albeit with the presence of pink stretch marks. She had a pink mark measuring approximately 1 centimeter (cm) wide, dark velvety coloring of her skin, known as acanthosis nigricans, and facial hair. Dobri documented the prior diagnostic test results, including the "questionable" microadenoma seen on the MRI scan, the elevated urine cortisol level of 97.2 nanograms (ng) of free cortisol per deciliter (dL) of urine, normal ACTH levels, an elevated salivary cortisol level, and a "borderline dexamethasone test." At that time, the patient was on maintenance doses of the diuretic chlorthalidone, the diuretic and antihypertension drug furosemide, the anti-nausea medication ondansetron, and the antidepressant Sertaline.

As Dr. Blevins interpreted the patient's chart, Dobri wrote that the patient presented as someone with partial lipodystrophy. He stated, however, that Dobri's differential diagnosis did, in fact, include Cushing Syndrome, along with severe metabolic syndrome with partial lipodystrophy, that is, a condition known as pseudo-Cushing's. Dr. Blevins explained that metabolic syndrome is a combination of pathophysiologic findings that include increased abdominal girth, obesity, high blood pressure and high glucose levels despite fasting, and may also include low levels of high-density cholesterol, or a high level of triglycerides in the blood.

Dobri's plan was to repeat the workup for Cushing Syndrome, which included, but was not limited to, a salivary cortisol test, a 24-hour urine free cortisol test, and a dexamethasone suppression test. Dobri wrote in the chart that, in light of patient's past workup, which had reflected a low-to-normal level of ACTH, the patient's symptoms more likely suggested an adrenal, rather than a pituitary, etiology. Dobri advised the patient to restart the drug Metformin in connection with her pre-diabetic and metabolic syndromes, and instructed the patient as to how to collect saliva and urine samples for cortisol testing. As of the date of this appointment,

the patient had a normal ACTH of 10 picograms (pg) per milliliter (mL) of blood, with respect to which Dr. Blevins explained that the reference range was 6 pg/mL to 58 pg/mL, and a normal serum cortisol level of 11.5 micrograms (µg) per dL of blood, with respect to which Dr. Blevins explained that the reference range was 6.7 µg/dL to 22.6 µg/dL.

According to Dr. Blevins, on December 14, 2016, the patient's midnight salivary cortisol samples were all normal at 0.068 µg/dL, 0.012 µg/dL, and 0.017 µg/dL of saliva, with respect to which he explained that the reference range was 0.010 µg/dL to 0.090 µg/dL, her 24-hour urine cortisol level was normal at 23 ng/dL, with respect to which he explained that the reference range was 0 ng/dL to 50 ng/dL, her ACTH test was again low to normal at 2.3 pg/mL, and her dexamethasone suppression test was negative, with a morning serum cortisol level of 0.8 µg/dL after dexamethasone had been administered to her. He further stated that, on December 25, 2016, the patient's 24-hour urine cortisol test, her salivary cortisol test, and her dexamethasone suppression test revealed no signs of excess cortisol, that is, she evinced no laboratory testing indicia of Cushing Syndrome. Dr. Blevins concluded that, at that time, the patient had a case of severe insulin resistance, with partial lipodystrophy, and that she generally needed to lose weight. Dobri again advised the patient to restart Metformin to treat the insulin resistance, and to continue to check her morning fasting insulin level, leptin levels, and hemoglobin A1C levels.

Dr. Blevins recapitulated the results of the patient's testing between January 2017 and July 2017, noting that several salivary cortisol tests were slightly elevated, while urine cortisol tests were normal, albeit at the very high end of the reference range, with a high creatinine-to-urine ratio, and normal ACTH levels. He described her weight as "stable" at 217 pounds. In February 2017, Dobri prescribed the patient the glucagon-like-peptide-1 (GLP) drug Saxenda for weight loss and insulin resistance, and planned to test the patient's post-dexamethasone administration serum cortisol levels. On April 26, 2017, a nurse practitioner in Dobri's office called the patient to discuss the test results, and informed her that there was "no evidence of excessive cortisol," despite the fact that a 24-hour urine collection study was positive for that

condition. According to Dr. Blevins, "it appeared that the urine collection had an over sampling result because the creatinine was also elevated." In any event, he concluded that there was no evidence to support a diagnosis of Cushing Syndrome at that time, and that Dobri would repeat the studies a few weeks hence. Dr. Blevins noted that, on May 2, 2017, the patient requested a repeat of her workup because she believed that she was experiencing irregular cortisol levels, but Dobri did not have her in for testing until June 21, 2017, when the patient's 24-hour urine free cortisol level was borderline elevated at 51 ng/dL, but her 24-hour urine creatinine level again was high, at 2.4 grams. On July 3, 2017, the patient's serum cortisol level, after the administration of dexamethasone, was low, at 0.7 µg/dL,

Dr. Blevins explained that, on September 1, 2017, the patient returned to see Dobri, and that the patient's weight remained stable. Dobri wrote in the patient's chart that she spoke to the patient about lipodystrophy (pseudo-Cushing's), and that she would order an abdominal CT scan to check for liver enlargement and to assess the adrenal glands. On that date, the patient did not undergo a CT scan, but, rather, a repeat MRI scan of the brain, which depicted a heterogeneous enhancement in the right aspect of her pituitary gland, albeit without a discrete lesion. On September 9, 2017, the patient's 24-hour urine cortisol test revealed an elevated level of free cortisol at 68 ng/dL, and on October 4, 2017, that same test revealed an elevated free cortisol level of 77 ng/dL. Dr. Blevins asserted, however, that "[t]he validity of these result[s] is in question given that the creatine was not included by the lab." The patient finally underwent an abdominal and pelvic CT scan on October 5, 2017, which identified a right adnexal cystic structure, measuring 5.5 cm by 4.6 cm, and fatty liver, but Dr. Blevins asserted that the scan depicted normal adrenal glands, lung, pancreas, and spleen. He asserted that, on November 13, 2017, Dobri wrote in the patient's chart that the latter had normal pituitary and adrenal imaging, but also reported that the patient's 24-hour urine cortisol remained "mildly elevated." Dobri further memorialized that a desmopressin (DDAVP) test, in which DDAVP is injected to measure a patient's ACTH response, was needed to investigate the etiology of the

elevated urine cortisol levels. Dr. Blevins maintained that this "slight" elevation in urine cortisol levels did not support a diagnosis of Cushing Syndrome. Hence, on December 1, 2017, Dobri recommended that the patient undergo a DDAVP test, which, according to Dr. Blevins, would be sensitive to the presence of cyclical Cushing's as well as Cushing Syndrome.

According to Dr. Blevins, on January 8, 2018, the patient's 24-hour urine cortisol level was elevated at 50 ng/dL, but he explained that her 24-hour urine test for creatinine again was an elevated 2.5 grams. On January 10, 2018, the patient underwent DDAVP stimulation testing. On January 29, 2018, Dobri informed the patient at an office visit that the results of the DDAVP test were "inconsistent" with Cushing Syndrome since, as Dr. Blevins explained it, there were no significant increases in ACTH levels and, consequently, "no real suspicion for a tumor secreting ACTH/cortisol." Dr. Blevins asserted that, at that time, Dobri suggested that the patient contact endocrinologist Lynette K. Nieman, M.D., at the National Institutes of Health (NIH) Clinical Center in Bethesda, Maryland, since Dr. Nieman specialized in Cushing Syndrome, and that Dobri also referred the patient to endocrinologist Ira Goldberg, M.D., at NYU Langone Hospital, who specialized in lipids and lipodystrophy. Dr. Blevins further averred that Dobri also continued to manage the patient's pre-diabetes and obesity, recommending that the patient institute a low-carbohydrate diet and restart the drugs Metformin and Saxenda. On February 6, 2018, Dobri emailed Dr. Nieman, seeking the latter's opinion as to a proper diagnosis. After Dr. Nieman responded with some additional questions, and recommended certain additional testing, Dobri replied and ordered those tests.

As Dr. Blevins read the patient's chart, on both February 12, 2018 and February 22, 2018, the patient's saliva cortisol level was normal, while on May 10, 2018, her 24-hour urine cortisol level was slightly elevated, her 24-hour urine creatinine level was high, and her ACTH and salivary cortisol levels were normal. On May 24, 2018, her 24-hour urine cortisol again was "slightly" elevated and her 24-hour urine creatinine level was high, while, on May 25, 2018, her serum cortisol level and her midnight saliva cortisol level were normal, and ACTH was not

detectable. Dr. Blevins asserted that testing between May 31, 2018 and August 8, 2018 was normal for 24-hour urine cortisol, low or normal for morning serum cortisol, and normal for ACTH, although the results for two midnight salivary cortisol tests were high, one of which Dr. Blevins attributed to "blood contaminant." He further averred that, on November 1, 2018, the 24-hour urine cortisol test was normal.

Dr. Blevins stated that, on February 11, 2019, Dr. Nieman emailed the patient and Dobri, informing them that, based upon her review of the patient's test results, she agreed with Dobri that they were not suggestive of Cushing Syndrome. On February 25, 2019, the patient presented to endocrinologist Alice Levine, M.D., who ordered her own laboratory studies to determine whether the patient had Cushing Syndrome. Dr. Blevins stated that, on March 6, 2019, Dr. Levine reported that the results of all of the laboratory tests that she had ordered, including those for cortisol, ACTH, androstenedione, dehydroepiandrosterone sulfate (DHEAS), and prolactin levels, were normal. On March 11, 2019, Dr. Levine informed the patient of these results, and recommended that the patient be treated only for diabetes and hypertension, with a reassessment in several months. She nonetheless thereafter discussed the patient's case at a multidisciplinary conference concerning pituitary disorders, and concluded that it was reasonable to consider surgical resection of that gland. Although she referred the patient to neurosurgeon Joshua B. Bederson, M.D., at Mount Sinai Hospital, she wrote in the patient's chart that IPSS would not be a helpful test in light of the patient's normal laboratory results. According to Dr. Blevins, Dr. Levine never diagnosed the patient with Cushing Syndrome.

On March 18, 2019, the patient presented to Dr. Bederson for an evaluation of a pituitary microadenoma and possible Cushing Syndrome, upon which Dr. Bederson ordered another MRI study, which was performed on April 16, 2019, and revealed a slightly heterogeneous enhancement of the pituitary, but, according to Dr. Blevins, no definite hypo-enhancing or well-circumscribed pituitary lesion. On April 22, 2019, Dr. Bederson reported that, based on the MRI scan, he determined to proceed with a resection of what he considered to be

an ACTH-secreting tumor. On May 13, 2019, Mount Sinai neurosurgeon Reade De Leacy, M.D., performed an IPSS to evaluate the patient for Cushing Syndrome and, on June 3, 2019, the patient underwent another brain MRI scan, which revealed heterogenous enhancement of the pituitary gland, with three possible hypo-enhancing foci that Dr. Blevins admitted could have reflected the presence of microadenomas. On June 6, 2019, the patient presented to Mount Sinai Hospital to undergo surgical exploration and a resection of her pituitary gland. Dr. Bederson's operative report stated that the indication for surgery included the fact that the patient was a 40-year-old female with Cushing Syndrome, an equivocal MRI, and a positive IPSS present for exploration. As Dr. Blevins interpreted the report, a small area of abnormality that appeared consistent with a tumor was resected from the pituitary gland and sent to the pathology laboratory. The patient was discharged home with a prescription for hydrocortisone.

On June 17, 2019, a Mount Sinai surgical pathologist reported that there was no evidence of a pituitary adenoma either at the initial or deeper levels, while the entire sample reflected the presence of mixed multi-hormonal staining, and that pathologists identified no doughnut-shaped patterns in the pituitary basophil cells, known as Crooke's hyaline change, which is indicative of excessive glucocorticoids. On September 3, 2019, the patient followed up with Dr. Bederson, who ordered a postoperative MRI scan of the pituitary gland, which revealed the presence of a lesion in the *right* side of the gland that was slightly enlarged, as compared to a preoperative and an immediately postoperative MRI scan. Dr. Bederson reported in the patient's chart that Cushing symptoms appeared to be returning, and wrote that the increased size of the lesion could be consistent with an ACTH-secreting lesion, although he noted that, during the procedure, the lesion was not explored as extensively as the lesion on the left side of the patient's pituitary gland. He thus recommended additional surgery. On October 3, 2019, Dr. Bederson re-explored the patient's pituitary gland, and reported the presence of a small area of abnormality that appeared consistent with a tumor in the pituitary gland. Dr. Bederson again resected the gland, and sent a sample to the Mount Sinai pathology department for analysis.

The pathology report indicated that there was no evidence of a pituitary adenoma, and tissue samples showed mixed multi-hormonal staining, although, this time, the report noted the presence of focal Crooke's hyaline change in benign adenohypophysis.

Dr. Blevins explained that Cushing Syndrome is a condition resulting in an excess of cortisol in the body that is related either to a tumor in the adrenal glands or to an ACTH-secreting pituitary tumor, the latter of which stimulates the adrenal glands to produce an excess amount of cortisol. He described cortisol as an essential hormone that affects almost every organ by regulating the body's stress response and controlling the use of fats. He asserted that cortisol levels spike when one is stressed, upset, in pain, or sick. As Dr. Blevins explained it, approximately 95% of Cushing's patients either suffer from an adrenal, cortisol-secreting tumor or a pituitary, ACTH-secreting tumor, with the remaining 5% evincing the presence of tumors in the other areas of the body that secrete ACTH. He further contended that 80% of ACTH-secreting tumors in women are situated within the pituitary gland. Dr. Blevins further explained that patients with Cushing Syndrome can suffer weight gain, central obesity in the abdomen, the growth of facial hair, the loss of hair on the scalp, hypertension, high glucose, mood changes, decreased immunity, purple stretch marks, muscle wasting in the extremities, and susceptibility to bone fractures. He asserted that all of these symptoms nonetheless overlap with other endocrine conditions, such as a metabolic syndrome, which he characterized as "pseudo-Cushing's," since it mimics the symptoms of Cushing Syndrome, as do PCOS, diabetes, central obesity, and depression. According to Dr. Blevins, the patient was diagnosed with all of these other conditions, none of which is related to a tumor, but all of which cause a spike in cortisol.

Dr. Blevins opined that Cushing Syndrome is very difficult to diagnose and that, to diagnose a patient with that condition, a physician must be "close to certain" that the excess cortisol is related to a tumor, since the treatment for Cushing Syndrome is the surgical removal of the tumor. He asserted that the implications for misdiagnosing Cushing Syndrome and performing a resection that is not indicated are serious, such as permanent damage to the

pituitary gland. In this respect, Dr. Blevins's stated that, unless it can be proven that the pituitary tumor is active and functional, thus causing increases in ACTH and cortisol levels, a physician should not diagnose patient with Cushing Syndrome or recommend surgery. Dr. Blevins explicitly concluded that the patient never met the diagnostic criteria for Cushing Syndrome. He rejected any contention that the patient had a pituitary tumor, that is, a microadenoma, that caused her symptoms and test results. As he explained it, while she did have a suspected small pituitary tumor on imaging, its presence was not definitive on various studies, and that the result of the imaging, in of itself, did not establish that she had Cushing Syndrome, and did not warrant its removal. He asserted that, although 5% of persons have pituitary tumors, most of these lesions are totally benign and not active, and the latter patients do not have Cushing Syndrome.

Inasmuch as Dr. Blevins concluded that the lesions identified on the patient's MRI scans were not active, she required only monitoring, which he averred that Dobri accomplished by continual testing and repeated imaging studies over a period of almost two years, with no appreciable changes seen. More particularly, Dr. Blevins explained that the patient's ACTH levels were at all times normal, and within the lower boundary of the reference range, despite being tested 18 times. Thus, he concluded that the absence of Cushing Syndrome was demonstrated by the laboratory test results standing alone. As he framed the issue, "[w]hatever was seen on the MRI, whether it was a tumor or not, is irrelevant as it was clearly not producing an excess in ACTH and thus not sufficient to diagnose Cushing's disease and recommend removing the tumor." Dr. Blevins thus concluded that Dobri properly did not diagnose the patient with Cushing Syndrome, properly did not recommend a biopsy, and properly did not order surgical removal of the suspected pituitary tumor. In this respect, he asserted that a biopsy would not be indicated in light of the small size of the lesion seen on the patient's MRI scan, that is, because it was a microadenoma. Rather, the entire tumor would need to be

removed, “so as not to expose the patient to multiple risky procedures to the pituitary gland,” but that such a procedure was not indicated for the patient in any event.

Nevertheless, Dr. Blevins opined that Dobri conducted an appropriate workup for Cushing Syndrome over the two-year period between 2016 and 2018 in light of the patient’s symptoms, which he again described as “Cushingoid,” that is, similar to those presented by patients who do have Cushing Syndrome. Thus, although he conceded that the patient’s abdomen was disproportionately larger than her limbs, that sign was not enough to make a diagnosis, particularly because the patient did not evince any muscle wasting in her extremities, but had full strength, a finding that he described as inconsistent with Cushing Syndrome. Furthermore, although Dr. Blevins asserted that, although the presence of stretch marks can be consistent with Cushing Syndrome, they have to be over 1 cm in size and purple in color, while the patient’s marks were smaller than that and pink in color and, thus, inconsistent with Cushing Syndrome, but consistent with weight gain. As he phrased it, “nearly all of the patient’s other presenting symptoms[,] including[,] but not limited to[,] weight gain, central obesity in the abdomen, hair loss, facial hair, weakness, stretch marks, infections, prior fractures, high glucose and hypertension all overlap with this patient also having a metabolic syndrome.”

Dr. Blevins opined that, to meet the standard of care in making a diagnosis of Cushing Syndrome, at least two out of three positive screening tests for cortisol that Dobri in fact ordered must be “concordant,” that is, elevated *at the same time*, and that the results for cortisol levels need to be significant and distinctly abnormal, since there are many factors that can cause cortisol levels to increase, but only Cushing Syndrome would make them increase so dramatically. Once this criterion is satisfied, Dr. Blevins explained that the physician next must perform “dynamic testing,” such as daily morning and midnight saliva self-testing, and frequent serum, 24-hour urine collection, and dexamethasone suppression tests, which Dobri did, in fact, direct the patient to perform in an appropriate fashion, that is, when she wasn’t stressed, had just eaten, or had fallen asleep and woken up.

Dr. Blevins opined that, although the patient's March 2016 dexamethasone suppression test revealed elevated cortisol levels, since it was performed in a hospital setting, the "result is not reliable as any test done in that type of stressful setting will always cause cortisol to be elevated." He asserted that Dobri satisfied the standard of care by repeating that test herself. He asserted that the patient's only two elevated saliva tests, in February 2017 and July 2018, were "outliers" and only "borderline high," since they were not two to three times the upper limit of the reference range, and never were concordant with other positive screening tests. With respect to the seven 24-hour urine cortisol tests that were performed during the course of Dobri's treatment, and which revealed elevated cortisol levels, Dr. Blevins characterized them as "slightly borderline elevations," and he noted that the patient also simultaneously evinced elevated creatinine levels, which he described as "evidence that oversampling" of the urine "could have" resulted in the slight elevations, and that the patient also was taking diuretics, which increase urine production and "may account" for the findings. According to Dr. Blevins, the results of all this testing provided Dobri with "more than sufficient alternative explanations as to why these borderline elevations were not related to Cushing's."

Dr. Blevins further rejected the notion that the plaintiff had cyclical Cushing's, a condition that he described as involving a tumor that is sometimes dormant, and only "sometimes active," thus secreting either cortisol or ACTH. He opined, however, that this condition is even more difficult to diagnose than regular Cushing Syndrome, as the standard of care requires three peaks of concordant screening test levels, followed by two valleys, to make a diagnosis. Dr. Blevins explained that, in some patients, the tumors are active on a weekly basis, while others are active only on a monthly basis, and a physician would "have to catch it at just the right time" to make such a diagnosis, which is "very often difficult to do." He thus concluded that Dobri appropriately ordered numerous screening tests over a period of two years in an attempt to rule in or out cyclical Cushing's. Dr. Blevins asserted that the disease never presented itself, since the patient never had elevated ACTH levels, which would rule out a pituitary source of the

cyclical Cushing's, and she never evinced any concordantly elevated screening tests. He further explained that, if the tumor were, in fact, “cycling,” an increase in clinical symptoms would be expected when the tumor was active, with a dramatic improvement in symptoms when the tumor was dormant. Since the patient’s examinations and clinical symptoms remained stable during the two years that Dobri treated her, Dr. Blevins concluded that she did not meet the diagnostic criteria for cyclical Cushing’s, and that Dobri performed “more than enough screening tests to determine that the patient did not meet” those criteria. Nevertheless, he concluded that, out of an abundance of caution, Dobri nonetheless proceeded to perform dynamic testing in January 2018, including DDAVP testing, but that, inasmuch as that testing was negative, Dobri’s conclusions concerning Cushing Syndrome were supported.

As Dr. Blevins further explained, although the results of September 2017 MRI scan were unchanged from the prior results, and there was a “possible adenoma,” the scan was “nowhere close to being definitive,” since the lesion that was depicted therein remained “extremely small in size,” and barely observable. He averred that, since there was no progression in the size of the tumor over 15 months, and pituitary tumors, particularly benign ones, are very slow growing, the patient did not require frequent repeat imaging. Moreover, he asserted that the October 2017 abdominal and pelvic CT scan established that the patient’s adrenal glands were normal, and revealed no evidence of tumor located anywhere else on the imaging, all of which further supported the conclusion the patient did not have Cushing Syndrome, particularly because the adrenal glands would have been enlarged had there been a pituitary tumor. Dr. Blevins also explained that the positive diagnosis for fatty liver was consistent with the “overall metabolic syndrome diagnosis.” Hence, he concluded that the standard of care did not obligate Dobri to perform any additional screening or dynamic testing.

In addition, Dr. Blevins rejected any allegation that Dobri was obligated by the standard of care to perform an invasive IPSS test, since that test is not diagnostic for Cushing Syndrome, but is only performed in connection with a patient who already has been diagnosed with

Cushing Syndrome, and is warranted only upon confirmation that the patient has an ACTH-secreting tumor somewhere in his or her body. He explained that the IPSS test should only be performed to confirm whether the source of the ACTH secretion is the pituitary gland or some other gland or organ. Since he asserted that Cushing Syndrome had never been biochemically confirmed in the patient, he concluded that any IPSS test, including the one performed upon her at Mount Sinai in May 2019, would be "meaningless," and that the results of that test did not support a diagnosis of Cushing Syndrome or the need for surgery. He noted that even Dr. Levine, one of the patient's subsequent treating endocrinologists, agreed with that assessment.

Dr. Blevins further lauded Dobri for referring the patient to Dr. Nieman, essentially concluding that this constituted conduct above and beyond the standard of care, and he noted that Dr. Nieman agreed that there was not enough evidence to support a diagnosis of Cushing Syndrome. He also asserted that Dobri appropriately monitored and managed the patient's actual endocrine conditions, including her diabetes, metabolic syndrome, and obesity, by placing her on Metformin, Victoza and Saxenda, as well as a low-carbohydrate diet. Dr. Blevins rejected the motion that these medications were ineffective, inasmuch as the patient "admitted non-compliance with the medications, stopping them on her own accord." He further approved Dobri's referral of the patient to Dr. Goldberg for a workup for lipodystrophy, explaining that,

> "[i]f the for[e]going was not enough to demonstrate why this patient did not have Cushing's, the subsequent surgical pituitary pathology only further demonstrates that this patient never had Cushing's. While a patient may have many markers consistent with the disease, the only way to know for sure is on pathology. Here, the pathology equivocally and conclusively demonstrates she does not have Cushings."

In this respect, Dr. Blevins explained that neither of the surgical pathology studies from the June 2019 and October 2019 surgeries demonstrated any evidence of a tumor, and that the description of the pathological tissue described "normal pituitary gland tissue." He further asserted that the presence of Crooke's hyaline change is not diagnostic of Cushing Syndrome,

but "its absence does prove that there is no Cushing's disease." Dr. Blevins asserted that no Crooke's hyaline change was seen on the June 2019 pathology report and that

> "[t]he fact that it was seen on the October, 2019 pathology is not diagnostic of Cushing's either as many factors can cause this including diabetes, metabolic syndrome as well as prior steroid use, all of which apply to this patient because she was treated with steroids after the first operation. Still, if this change was related to Cushing's, it would be present on the first pathology specimen, too, and it was not seen."

Additionally, he opined that, if the patient actually had Cushing Syndrome, which, by his definition, required the presence of an ACTH-secreting tumor, "the pathology results would only demonstrate the presence of ACTH," while both pathology reports demonstrated not only the presence of ACTH, but the presence of growth hormone, follicle-stimulating hormone, luteinizing hormone, and thyroid-stimulating hormone as well. Dr. Blevins concluded that the presence of these other hormones indicated that healthy pituitary tissue was removed during both surgeries.

Dr. Blevins asserted that, even though Dobri did not improperly fail to diagnose Cushing Syndrome, nothing that she did or did not do caused the "purported" pituitary microadenoma to grow in size, since the MRI scans taken in 2016, 2017, and 2019 all demonstrated consistent findings, no definitive tumor, and no definitive growth in any purported tumor. He averred that this conclusion is supported by the fact that the surgeons reported no pathological evidence of tumor from the 2019 surgeries.

Dr. Blevins ultimately concluded that, while the patient may have initially appeared "Cushingoid," her clinical symptoms overlapped with general metabolic syndrome. He continued that, "[u]nfortunately, the patient ultimately underwent two surgeries to her pituitary gland at Mount Sinai," and that the surgeries themselves, rather than Dobri's alleged misdiagnosis, "caused her current alleged injuries which are related to panhypopituitarism," which he defined as the loss of function of the pituitary gland that can cause the failure of other glands, such as the thyroid, ovaries, and adrenals, and can also cause the "important" loss of growth hormone. Dr. Blevins asserted that loss of function is a known risk of pituitary gland

surgery, and that Dobri was "wary of" this outcome "during her treatment of the patient." He thus concluded that none of the injuries alleged by the patient was in any way caused by Dobri's care and treatment, and that, "[i]f anything, DR. DOBRI endeavored to prevent these injuries by not giving the patient a diagnosis of Cushing's and/or recommending surgery."

In opposition to the motion, the plaintiffs relied on many of the same documents that the defendants submitted, and also submitted an attorney's affirmation and the expert affirmation of a board-certified internist, endocrinologist, and metabolic disease specialist. The plaintiffs' expert opined that Dobri departed from good and accepted medical practice, and that her departures caused or contributed to the growth of pituitary adenomas and the patient's need for pituitary resection surgery.

After reiterating the patient's history of treatment, the plaintiffs' expert noted that the patient "indisputably had abnormal results from at least two different first line tests," evinced most of the clinical and physical presentations of Cushing Syndrome, and had a "notable pituitary microadenoma." The expert thus concluded that, contrary to Dr. Blevins's opinion, the patient did, in fact, suffer from Cushing Syndrome, that Dobri should have diagnosed her with that condition, and that Dobri departed from the standards of good and accepted medical practice by failing timely and properly to diagnose it. The expert further asserted that Dobri departed from good practice by failing to order subsequent testing that was necessary to determine the root cause of the condition, to order additional and more frequent imaging to monitor the presence of the pituitary adenoma, and to recommend surgical intervention to remove the pituitary adenoma.

As the plaintiffs' expert explained it, the patient presented with physical symptoms of Cushing Syndrome, including centralized obesity, an almost 1-cm stretch mark that was pink and purplish in color, a round face, and thin legs and arms, with complaints of muscle weakness. The expert further adverted to progress notes from the patient's prior treating physicians, indicating that she had difficulty raising her hands above her head, which

demonstrated muscle weakness, contrary to Dobri's report that a visual examination confirmed normal muscle tone. The expert additionally noted that the patient's laboratory testing reflected at least two abnormal biochemical test results, consisting of her frequently high urine free cortisol levels and a failed March 2016 dexamethasone suppression test. Based on these symptoms and test results, the expert concluded that the standard of care required Dobri to have made an appropriate diagnosis of Cushing Syndrome and to continue further testing "to determine the root cause, as well as to manage and treat the patient to either alleviate the symptoms or utilize surgical intervention to remove the cause." In addition to Dobri's failure to diagnose Cushing Syndrome, the plaintiffs' expert opined that Dobri departed from good practice in failing to order subsequent tests, such as a corticotropin-releasing hormone (CRH) test and a measurement of DHEAS levels to detect the cause of the disease, and failed to recommend surgical intervention to remove the pituitary adenoma, or, at the very least, "to more timely order additional and more detailed imaging studies to monitor its growth." The plaintiffs' expert explicitly concluded that Dobri's departures in these respects caused the patient's condition to remain undiagnosed and untreated, which, in turn, caused the microadenomas in her pituitary glands to grow and spread, ultimately necessitating the removal of the entirety of the patient's pituitary gland and associated symptomology.

The plaintiffs' expert expressly disagreed with Dr. Blevins's opinion that Dobri properly assessed and worked the patient up for Cushing Syndrome, since Dobri failed to heed the significance of the patient's clinical presentations and her abnormal test results, which led to Dobri's failure to make the proper diagnosis and her failure to order additional testing to determine the cause of the patient's Cushing Syndrome. The expert faulted Dobri for delaying other testing, including a more than one-year delay in ordering additional MRI imaging of the patient's pituitary glands, and her failure to order or perform additional imaging. As the expert framed the issue,

> "[w]hen viewing Ms. Piazza's presenting symptoms and lack of improvement combined with the two MRI reports that show a microadenoma present in the pituitary, the standard of care would require additional and more detailed MRI imaging within the year and especially since Ms. Piazza's symptoms were not improving. Additionally, . . . DOBRI departed from the standards of good and accepted medical practice in failing to timely and properly order an Inferior petrosal sinus sampling ("IPSS") test for Ms. Piazza given her progressive symptoms, high cortisol levels, and presence of a pituitary microadenoma. . . . [A] timely IPSS test could have led to a sooner diagnosis and prevented the microadenoma from spreading throughout the pituitary gland, thereby requiring the entire gland to be removed. As a result of that departure, . . . additional microadenomas formed in Ms. Piazza's pituitary, resulting in her requiring her entire pituitary gland to be removed instead of a more simple and less invasive resection had it been addressed earlier."

The plaintiffs' expert further disagreed with Dr. Blevins's opinion that Dobri timely and appropriately interpreted the results of the various diagnostic tests that she had, in fact, ordered, as well as prior testing by the patient's previous treating physicians. As the expert explained it, although the patient's results were "not constantly abnormal," she nonetheless displayed abnormal results in connection with her salivary cortisol level testing, which, "when viewed in totality with the other symptoms and biochemical results, would paint a clear diagnosis for Cushing's syndrome." The expert asserted that a diagnosis of Cushing Syndrome, "in any form," is established "when at least two different first-line tests show abnormal results, especially when a patient's presenting clinical symptoms is indicative of Cushing's Syndrome." Although Dr. Blevins opined that there was never any conclusive proof or evidence that the patient suffered from Cushing Syndrome, the plaintiffs' expert "disagree[d] wholeheartedly with his opinion." Rather, the expert concluded that the patient's presenting symptoms, past medical history, and diagnostic test results, including results that "clearly show the presence of Crooke's hyaline change, a hallmark indicator of Cushing's," constituted "conclusive evidence to support a diagnosis of Cushing's diseases/syndrome," and that Dobri's failure to diagnose that condition, and recommend surgery, further compromised the patient's pituitary gland.

The plaintiffs' expert also pointedly disagreed with Dr. Blevins's opinions and general overview of Cushing Syndrome, asserting that the latter "overbroadly and incorrectly

misattributes Cushing's Syndrome to being the result of a tumor," and incorrectly failed to "factor in the many other potential exogenous and endogenous causes of Cushing's." Although Dr. Blevins stated that almost all of the symptoms of Cushing Syndrome can overlap with metabolic syndrome, the plaintiffs' expert opined that Dr. Blevins failed to note that "excess cortisol levels are not as often seen in metabolic syndrome," nor is Crooke's hyaline change seen in patients with metabolic syndrome, while the patient evinced both excess cortisol levels during the time that Dobri was treating her, and presented with Crooke's hyaline change during the second of her two surgeries. Hence, the expert disagreed with Dr. Blevins's opinion that the patient never met the diagnostic criteria for Cushing Syndrome. Moreover, the expert "strongly disagree[d]" with Dr. Blevins's opinion that one "cannot make a diagnosis of Cushing's disease, i.e., an ACTH secreting tumor in the pituitary gland without elevated ACTH levels or inappropriately normal ACTH levels in the setting of absolute cortisol excess or failure to suppress cortisol with dexamethasone." The plaintiffs' expert stated that Dr. Blevins's opinion did not discuss the *diagnostic criteria* for Cushing Syndrome, which the expert reiterated were satisfied when at least two different first-line tests showed abnormal results, especially when a patient's presenting clinical symptoms are indicative of Cushing Syndrome, all of which were present in the patient's case prior to her first meeting with Dobri, with her clinical symptoms getting progressively worse during her course of treatment with Dobri. As the expert framed the issue, the standards of good and accepted medical practice emphasize that, when symptoms associated with Cushing Syndrome are progressively getting worse, that progression, coupled with high cortisol levels in a patient's urine, which were established by at least six positive 24-hour urine collection cortisol tests over a three-year span, are paramount to making a diagnosis.

Moreover, the plaintiffs' expert asserted that the presence of a pituitary adenoma, especially in a person who presents with the classic signs and symptoms of Cushing Syndrome, "can be highly indicative of a Cushing's diagnosis, as it is recognized that more than 50% of patients with Cushing's disease have pituitary adenomas." The expert explained that Dobri, in

her own chart, had reported that, throughout the course of her treatment of the patient, the latter evinced skin stretch marks that were pink and almost 1 cm in width, the patient presented with acanthosis nigricans, she was easily bruised, she had excess hair growth over her face, she had difficulty raising her arms over her head and getting up from a seated position, she presented with central obesity with thin arms and legs, tests had revealed elevated cortisol levels in her urine, she had at least one suppressed ACTH level from the administration of 1 mg of dexamethasone, she had a few midnight salivary cortisol levels that were elevated, she had failed a previous dexamethasone suppression test, and a prior treating physician suspected her of suffering from Cushing Syndrome.

Furthermore, the expert expressly disagreed with Dr. Blevins's opinion that to "meet the standard of care in making a diagnosis of Cushing's syndrome, you first need to have at least two out of three positive screening tests that are concordant, i.e., elevated at the same time." Rather, the expert opined that, although the diagnosis of that condition is dependent on whether the patient presents with a low index of suspicion or a high index of suspicion, the diagnosis "does not necessarily need the tests to be positive *at the same time*," only that "there be at least two abnormal results especially when there are clinical symptoms present as well." In any event, since the expert asserted that the patient did, in fact, have at least two abnormal test results from screening tests, and clearly presented with classic clinical symptoms of Cushing Syndrome, there was "more than enough to make a diagnosis of Cushing's." The expert thus opined that Dobri departed from the standard of care in waiting for abnormal results to appear all at once and at the same time before making the proper diagnosis.

Ultimately, the expert concluded that the deviations from good practice that he or she identified were a substantial factor and proximate cause of the patient's injuries, including, but not limited to, panhypopituitarism, that is, the absence of production of pituitary hormones, increased mortality due to cardiovascular and respiratory diseases, risk of sudden death, cardiac complications, hypothyroidism, lack of growth hormone, adrenal insufficiency, fatty liver

disease, hypogonadism, infertility, early menopause, fatigue, deprivation of a substantial chance for a meaningful medical or surgical intervention, a diminished quality of life, physical and emotional pain and suffering, extreme fear, anxiety, and distress, and the fear of death.

In reply, the defendants submitted an attorney's affirmation, in which counsel argued that the plaintiffs would do "anything" to find an expert who could rebut Dr. Blevins's opinions, and that the affirmation of the plaintiffs' expert did not rebut those opinions in any event, since the expert ignored Dr. Blevins's opinions as to why the first-line screening tests were not consistent with Cushing Syndrome. Counsel further argued that the opinions of the plaintiffs' expert were conclusory, speculative, and unsupported by the medical records.

The court concludes that, although the defendants made a prima facie showing of their entitlement to judgment as a matter of law in connection with so much of the medical malpractice cause of action against Dobri as was based on alleged departures from good and accepted practice, the plaintiffs raised triable issues of fact as to both liability and proximate cause with their expert's affirmation. The court concludes that the plaintiffs' expert's affirmation did, in fact, clearly, pointedly, and expressly rebut several of the key opinions rendered by Dr. Blevins as to the diagnostic criteria for diagnosing Cushing Syndrome, whether the patient satisfied those criteria, whether Dobri should have ordered certain additional diagnostic testing that their expert identified, whether Dobri's delay in ordering that testing or further imaging deprived the patient of the opportunity for a better outcome, whether the resection surgeries were indicated, and whether an earlier surgical intervention would have spared the patient from additional suffering or a worsening condition. Counsel's reply affirmation simply underscores the sharp disagreement between the experts as to what the medical records actually reflected and revealed, and how a physician must properly apply the appropriate diagnostic criteria. Were the court to determine those issues on a motion for summary judgment, it would be usurping the jury's function, and improperly assessing the experts' credibility, which the court may not do (*see Grasso v Nassau County,* 180 AD3d 1008, 1012 [2d Dept 2020] [defendants'

contention that plaintiff's expert "misstated facts from the record" is an issue "as to the expert's credibility that should be resolved by a jury"]; *Torgersen v A&F Black Creek Realty, LLC*, 158 AD3d 1042, 1044 [3d Dept 2018]). Hence, the court must deny that branch of the defendants' motion seeking summary judgment dismissing so much of the medical malpractice cause of action against Dobri as was premised upon her alleged departures from good practice.

Since the plaintiffs did not address whether Dobri departed from good practice in failing to order a biopsy of the patient's suspected adenoma, the court must grant that branch of their motion seeking summary judgment dismissing so much of the medical malpractice cause of action against Dobri as was premised upon this purported departure. Moreover,

> "[c]ases such as this, which allege medical malpractice for failure to diagnose a condition or to render appropriate treatment, pertain to the level or standard of care expected of a physician in the community, and do not encompass matters within the ordinary knowledge and experience of laypersons (*see Mosberg v Elahi,* 176 AD2d 710 [1991], *affd* 80 NY2d 941 [1992]). The doctrine of res ipsa loquitur is therefore not applicable to this case (*see Bin Xin Tan v St. Vincent's Hosp. & Med. Ctr. of N.Y.,* 294 AD2d 122 [2002])"

(*Monzon v Chiaramonte*, 140 AD3d 1126, 1128 [2d Dept 2016]). Hence, that branch of the defendants' motion seeking summary judgment dismissing so much of the medical malpractice cause of action as was premised upon the doctrine of res ipsa loquitur must be granted. 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]). The defendants established, prima facie, that Dobri and all other health-care personnel working for both Dobri and the institutional defendants were properly trained. Since the plaintiffs, in their opposition papers, adduced no facts with respect to whether the defendants knew or should have known of the propensity of any employee to commit acts of malpractice, that branch of their motion seeking summary judgment dismissing that claim must be granted.

"'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]). Since there is no dispute that Dobri was employed by the institutional defendants during the time that she rendered care to the patient, to the extent that the court has determined that there are triable issues of fact in connection with the medical malpractice cause of action against Dobri, there are triable issues of fact as to whether the institutional defendants may be held vicariously liable therefor.

As a derivative claim, the loss of consortium cause of action asserted by August Piazza, as the patient's husband, remains viable to the extent that the patient's medical malpractice cause of action remains viable (*see Robinson v Northwell Health, Inc*., 2021 NY Slip Op 33146[U], *8. 2021 NY Misc LEXIS 8552, *16-17 [Sup Ct, Queens County, Dec. 6, 2021]; *see generally Clarke v City of New York*, 82 AD3d 1143, 1144 [2d Dept 2011]; *Kaisman v Hernandez*, 61 AD3d 565, 566 [1st Dept 2009]).

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]). 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]). "'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]). Nonetheless, a defendant may satisfy his or her burden of demonstrating his or her prima facie entitlement to judgment as a matter of law in connection with such a cause of action where a patient signs a detailed consent form, and there also is evidence that the necessity of the procedure, along with known risks and dangers, was discussed prior to the surgery (*see Bamberg-Taylor v Strauch*, 192 AD3d 401, 401-402 [1st Dept 2021]).

In any event, "[a] failure to diagnose cannot be the basis of a cause of action for lack of informed consent unless associated with a diagnostic procedure that 'involve[s] invasion or disruption of the integrity of the body'" (*Janeczko v Russell*, 46 AD3d 324, 325 [1st Dept 2007], quoting Public Health Law § 2805-d[2][b]; *see Lewis v Rutkovsky*, 153 AD3d at 456), and that invasion or disruption is claimed to have caused the injury. Here, the plaintiffs asserted that Dobri failed properly to diagnose the patient with Cushing Syndrome. That failure to diagnose did not involve an invasion or disruption of the patient's bodily integrity, but only the alleged delay in initiating proper treatment. Hence, that branch of the defendants' motion seeking summary judgment dismissing the lack of informed consent cause of action must be granted.

Accordingly, it is,

ORDERED that the defendants' motion for summary judgment dismissing the complaint is granted only to the extent that they are awarded summary judgment dismissing the lack of informed consent cause of action, and so much of the medical malpractice cause of action as was premised upon the doctrine of res ipsa loquitur, negligent hiring and training of health-care personnel, and the failure of the defendant Georgiana A. Dobri, M.D., to order a biopsy of the patient's suspected pituitary adenoma, that cause of action and those claims are dismissed, and the motion is otherwise denied; and it is further,

ORDERED 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 September 16, 2025, at 11:30 a.m., at which time they shall be prepared to discuss resolution of the action and the scheduling of a firm date for the commencement of jury selection.

This constitutes the Decision and Order of the court.

8/25/2025
DATE

JOHN J. KELLEY, J.S.C.

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