SUPREME COURT OF THE STATE OF NEW YORK
NEW YORK COUNTY

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

Justice

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SALAMIA G. LASANO, Individually, and as Executor of the Estate of JOS S. LASANO, deceased,

Plaintiff,

- v -

PETER M. KAYE, M.D., NIRMALA NANJAPPA, M.D., JOSEPH MING LEE, M.D., GOOD SAMARITAN HOSPITAL, PRASAHNT SINHA, M.D., GRETA LYNN PIPER, M.D., NYU HOSPITALS CENTER, also known as NEW YORK UNIVERSITY LANGONE MEDICAL CENTER, JOHN DOE, M.D., 1-5; JANE DOE, M.D., 1-5; JOHN ROE, RN 1-5, JANE ROE, RN 1-5, and ABC COMPANIES 1-5,

Defendants.

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INDEX NO.	450987/2019
MOTION DATE	07/23/2025 07/23/2025 07/23/2025 07/23/2025
MOTION SEQ. NO.	006, 007, 008, 009

DECISION + ORDER ON MOTION

The following e-filed documents, listed by NYSCEF document number (Motion 006) 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 345, 349, 350, 357, 361, 362, 363, 364, 365, 369, 373, 377, 381

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

The following e-filed documents, listed by NYSCEF document number (Motion 007) 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 346, 351, 352, 358, 366, 370, 374, 378, 382

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

The following e-filed documents, listed by NYSCEF document number (Motion 008) 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 347, 353, 354, 359, 367, 368, 371, 375, 379, 383

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

The following e-filed documents, listed by NYSCEF document number (Motion 009) 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 348, 355, 356, 360, 372, 376, 380, 384

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

This is an action to recover damages for medical malpractice based on alleged departures from good and accepted practice, lack of informed consent, wrongful death, and loss of spousal consortium. The defendants Peter M. Kaye, M.D., and Good Samaritan Hospital (together the GSH defendants) move pursuant to CPLR 3212 for summary judgment dismissing

the complaint insofar as asserted against them (MOT SEQ 006). The plaintiff opposes that motion. That motion is granted to the extent that the GSH defendants are awarded summary judgment dismissing, insofar as asserted against them, the lack of informed consent cause of action, and so much of the medical malpractice as was premised on upon the plaintiff's allegations that (a) they failed to take a proper medical history of her decedent, (b) failed to perform an exploratory laparotomy upon her decedent, (c) improperly determined that a hemicolectomy was an indicated procedure for her decedent, (d) improperly performed the hemicolectomy, (e) did not initially achieve anastomosis during that procedure, (f) did not appropriately resuscitate the decedent intraoperatively or postoperatively, (g) did not properly treat the decedent for hyperkalemia, diverticulosis, diverticulitis, or anemia, (h) were liable for conduct of health-care personnel other than Kaye, and (i) for negligent hiring, training, supervision, and retention of any health-care personnel, including Kaye.[1] That motion is otherwise denied, provided that, on or before September 23, 2025, the plaintiff serves and files an affirmation or affirmations setting forth a valid explanation as to why she served her opposition papers almost one month after a deadline that had been fixed by the court, and an amended affirmation of her retained expert that includes the language set forth in the second paragraph of the recently amended version of CPLR 2106. The court concludes that there are triable issues of fact as to whether Kaye departed from good and accepted medical practice by failing timely and properly to appreciate, monitor, test for, diagnose the decedent with, and treat the decedent for a postoperative leakage from the colonic anastomosis established during the surgery and by failing timely and properly to appreciate, monitor, test for, diagnose the decedent

[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 plaintiff 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]).

with, and treat the decedent for a serious gastrointestinal infection, and whether those injuries, as well as the decedent's death, were proximately caused by those departures.

The defendant Joseph Ming Lee, M.D., separately moves for summary judgment dismissing the complaint insofar as asserted against him (MOT SEQ 007). The plaintiff did not oppose that motion. That motion is granted, and summary judgment is awarded to Lee dismissing the complaint insofar as asserted against him. The defendants Prashant Sinha, M.D., Greta Lynn Piper, M.D., and NYU Hospitals Center (NYU), also known as New York University Langone Medical Center (collectively the NYU defendants), move for the same relief as to them (MOT SEQ 008). The plaintiff did not oppose that motion. That motion is granted, and summary judgment is awarded to the NYU defendants dismissing the complaint insofar as asserted against them. The defendant Nirmala Nanjappa, M.D., separately moves for the same relief as to her (MOT SEQ 009). The plaintiff did not oppose that motion. That motion is granted, and summary judgment is awarded to Nanjappa dismissing the complaint insofar as asserted against her.

The crux of the plaintiff's claim is that, on July 25, 2014, the defendant colorectal surgeon Kaye, while working for the defendant Good Samaritan Hospital (GSH) in Suffern, New York, improperly performed an emergent, open right hemicolectomy on her decedent, Jos S. Lasano, who had been complaining or rectal bleeding, in order to remove a portion of his colon, and thereupon perforated the remainder of the colon. She also asserted that, during her decedent's stay at GSH, Kaye failed to provide proper postoperative care by failing to repair the perforated colon, permitting her decedent to develop an anastomotic leak, and causing an infection so that, even before her decedent was transferred to the defendant NYU on August 3, 2014, his condition had deteriorated to such an extent that he died on August 10, 2014.

In her complaint, the plaintiff asserted general allegations of medical malpractice and lack of informed consent against all of the defendants. In her bill of particulars as to GSH, she alleged that GSH staff failed to appreciate and ignored the complaints, signs, and symptoms

referable to her decedent's gastrointestinal issues, delayed the ordering and performance of appropriate diagnostic testing, and failed to take an adequate and sufficient history of the decedent. She further alleged that GSH personnel failed to advise her decedent of the true nature of his medical condition, and misdiagnosed him. In addition, she alleged that GSH personnel failed properly to perform the hemicolectomy, specifically, that they failed to ensure that anastomosis was achieved and maintained. The plaintiff further faulted GSH staff for failing properly to monitor her decedent postoperatively, and by failing properly to treat diverticulitis, anemia, hypovolemia, and a postoperative anastomotic leak. Moreover, she alleged that GSH personnel failed to provide adequate resuscitation measures preoperatively, intraoperatively, and postoperatively, failed to develop an appropriate treatment plan, and failed timely and properly to treat her decedent for hypoperfusion, hyperkalemia, and sepsis by, among other things, failing to prescribe and administer the proper prophylactic antibiotics, based upon his exhibited signs and symptoms. The plaintiff asserted that GSH personnel further departed from good and accepted practice by failing timely to perform an exploratory laparotomy upon her decedent. She averred that these departures caused her decedent, among other things, to develop aspirational pneumonia, which the GSH defendants purportedly failed to treat in a timely and proper manner, and that their failures to provide appropriate postoperative care led to cardiopulmonary arrest. The plaintiff also alleged that GSH failed to provide her decedent with medical professionals who possessed and exercised that degree of knowledge, training, expertise, and skill commonly and ordinarily possessed by general hospitals practicing in the community, and that it failed properly to hire and train staff and employees to treat the decedent.

In her bill of particulars as to Kaye---the GSH colorectal surgeon who performed the subject procedure---she reiterated many of the departures that she alleged that GSH had committed with respect to preoperative testing, screening, and treatment, intraoperative surgical intervention, and postoperative monitoring, diagnoses, treatment, and care, adding that Kaye also failed to heed or take note of the risk factors applicable to hemicolectomy surgeries and

failed timely and properly to treat her decedent's anastomotic colonic leak. She further alleged that the departures from accepted care that she had identified caused her decedent's health quickly to deteriorate, ultimately causing his death from cardiopulmonary failure only 16 days after the procedure that Kaye had performed.

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]). Even where an adverse outcome is a known risk of a surgical procedure, a plaintiff may raise a triable issue of fact as to whether a physician committed malpractice by showing that the outcome was caused by improper surgical or medical technique, rather than by an unexplained or incidental event (*see Matney v Boyle,*

237 AD3d 1382, 1384-1385 [3d Dept 2025]; *Bengston v Wang*, 41 AD3d 625, 626 [2d Dept 2007]; *see also Hoffman v Taubel*, 2021 NY Slip Op 31523[U], *4-5, 2021 NY Misc LEXIS 2379, *8-9 [Sup Ct, N.Y. County, Apr. 30, 2021] [Kelley, J.], *affd* 208 AD3d 1099 [1st Dept 2022] [merely because the transection of a ureter is a known risk of a hysterectomy, it does not follow that a surgeon or a surgeon's assistant is excused from properly performing the procedure]; *Mathias v Capuano*, 2015 NY Slip Op 32160[U], *5-6, 2015 NY Misc LEXIS 4141, *12-14 [Sup Ct, Suffolk County, Nov. 5, 2015]; *cf. Henry v Duncan*, 169 AD3d 421, 421 [1st Dept 2019] [plaintiff failed to raise triable issue of fact in opposition to physician's showing that injury was a "known risk that may occur despite competent surgical care having been provided"]).

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, 1044 [2d Dept 2010]; *Grant v Hudson Val. Hosp. Ctr.*, 55 AD3d 874, 874 [2d Dept 2008])

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 GSH defendants submitted the pleadings, the note of issue, relevant medical and hospital records, transcripts of the parties' deposition testimony, an attorney's affirmation, a memorandum of law, and two expert affirmations from board-certified surgeon and colorectal surgeon Jeffrey Aronoff, M.D., who opined that the GSH defendants did

not depart from good and accepted medical practice, and that nothing that they did or did not do caused or contributed to the decedent's injuries or death.

Dr. Aronoff first opined that Kaye did not delay the ordering or performance of proper diagnostic testing of the decedent, or fail to take an adequate medical history. He noted that the defendant Nanjappa took and recorded the relevant history, and that she described the decedent as a 66-year-old male who presented to the GSH emergency room on July 25, 2014 with a gastrointestinal hemorrhage and who had, while at home, passed a large amount of clotted blood over the course of six or seven bowel movements, felt lightheaded, and had fainted. Nanjappa recorded that the decedent did not complain of chest pain, and that, when he was brought to the emergency room, he continued to bleed while his blood pressure dropped. According to Nanjappa's note, the decedent was resuscitated with intravenous fluids, and he denied any abdominal pain or any signs and symptoms of diverticulitis. As set forth in the GSH chart, GSH surgeons examined him, and ordered a nuclear bleeding scan to ascertain whether he was still bleeding, which came back positive for an active cecal/ascending colon bleed, which Dr. Aronoff described as consistent with acute, active gastrointestinal bleeding in the cecum, progressing toward the transverse colon. He asserted that the degree of peristaltic activity that the GSH personnel observed was unusually slow for a patient presenting with such bleeding.

According to Dr. Aronoff, Kaye was called for a consultation, discussed the findings with other GSH physicians, took his own history of the decedent's medical conditions, and performed a physical examination. The history that Kaye memorialized was almost identical to that reported by Nanjappa, although Kaye also included the results of the nuclear bleeding scan, the fact that the decedent had previously undergone a colonoscopy, and that the decedent reported a prior episode of diverticulitis a few years earlier that had been treated without surgery.

In support of his opinion as to whether proper tests were ordered in a timely fashion, Dr. Aronoff asserted that Kaye's physical examination documented that the decedent did not appear to be in distress. He further alleged that, although the examination revealed that the

decedent appeared pale, the decedent nonetheless was alert, was oriented with appropriate thought content, evinced a normal cephalic condition with no obvious abnormalities, and was atraumatic, while his eyes and hearing "seemed" to be normal. Dr. Aronoff averred that, at that time, Kaye's examination reflected that the decedent evinced regular heart rate and rhythm upon auscultation, as well as normal air entry, with a flat, nontender abdomen, and pale and dry skin. He stated that, neurologically, the decedent was moving all extremities with no focal or neurological deficits. Upon an anorectal exam, Kaye found that there was no mass present, although there was blood present in the rectal vault. Dr. Aronoff asserted that Kaye's assessment of gastrointestinal hemorrhage "was within good and acceptable medical standards based upon the physical examination, clinical presentation, history and the results of the nuclear bleeding scan." He further opined that the nuclear bleeding scan was the appropriate test to determine the etiology of the bleed, and that no further tests were required prior to surgery.

Dr. Aronoff concluded that Kaye appropriately determined to perform a hemicolectomy, properly performed that procedure within the standard of care, and took all appropriate steps to ensure that anastomosis was achieved and maintained intraoperatively and postoperatively. He explained that Kaye performed an open hemicolectomy, which provided "excellent" accessibility to the surgical site and appropriate control, since that technique provided immediate access to the bleeding site. More specifically, based on the relevant operative report, Dr. Aronoff asserted that Kaye appropriately explored the abdominal cavity while looking for any obvious pathology, and that there was nothing obvious other than blood within the colon. He further opined that Kaye ensured that anastomosis, that is, the surgical connection between two tubular structures, was achieved and maintained by careful dissection and preservation of the blood vessels supplying the colon. According to Dr. Aronoff, Kaye also ensured that the ends of the colon that were being joined to the small intestine were adequately mobilized to create a tension-free anastomosis. He asserted that Kaye appropriately checked the anastomosis intraoperatively, and confirmed it to be "tension-free, untwisted, and well perfused."

Additionally, Dr. Aronoff asserted that Kaye adequately resuscitated the decedent and timely and properly treated him for hypoperfusion. As he explained it, inasmuch as the decedent had come to the GSH emergency room with an active bleed, it would have been very difficult for Kaye to know exactly how much blood loss occurred, and how much resuscitation was needed. He further averred that, during the procedure itself, Kaye would not have been actively resuscitating the decedent because resuscitation is the role of the anesthesiologist. Dr. Aronoff noted that the decedent was administered two units of blood during the surgery, which he characterized as appropriate in light of the decedent's preoperative hemoglobin level of 11.8 grams per deciliter of blood (g/dL) and hematocrit level indicating that 36.6% of the decedent's total volume of blood consisted of red blood cells, and his postoperative hemoglobin level of 12.5 g/dL and hematocrit level of 37.6%. As Dr. Aronoff described it, these results were consistent with appropriate fluid replacement and resuscitation, while postoperative time intervals and trending of these blood counts were appropriate. Dr. Aronoff asserted that a patient without any signs of active bleeding, or signs of instability or under-resuscitation, would not require a blood transfusion if he had a hemoglobin level of 9.4 g/dL or higher. He noted that, as soon as the decedent's hemoglobin reached a critical level of under 8.0 g/dL on July 26, 2014, Kaye ordered that the decedent be transfused with an additional four units of blood, and concluded that Kaye appropriately administered both the blood, intravenous fluids, and electrolytes to the decedent in the course of the resuscitation process. Dr. Aronoff opined that this treatment for hypoperfusion was proper and within the standard of care. In this respect, he also stated that Kaye formulated an appropriate differential diagnosis, obtained the appropriate cardiology consultation, and ordered this aggressive transfusion to reverse the condition. Moreover, Dr. Aronoff stated that hypoperfusion and under-resuscitation are known risks of an active gastrointestinal bleed, and that nothing that Kaye did or did not do caused the decedent to experience this condition, which were inherent in the condition presented by the decedent.

Dr. Aronoff further opined that Kaye timely and properly treated the decedent's hyperkalemia, which he described as a medical condition characterized by elevated levels of potassium in the bloodstream that could be caused by kidney dysfunction and metabolic acidosis. He explained that proper treatment of hyperkalemia includes dietary modifications, discontinuation or adjustment of medications, and the administration of medications to enhance potassium excretion, such as loop diuretics and potassium-binding substances. Dr. Aronoff approved of Kaye's treatment of this condition with the loop diuretic Lasix, and his consultation with a renal specialist for fluid management and the treatment of any kidney disease. As Dr. Aronoff recounted it, on July 27, 2014, Kaye documented that the decedent's "condition dramatically improved. Renal function improving. Blood pressure normalized."

Dr. Aronoff expressly rejected the plaintiff's contention that Kaye did not timely or properly treat the decedent's diverticulitis or diverticulosis. As he explained it, Kaye had never treated the decedent prior to the latter's presentation GSH on July 25, 2014, and Kaye knew only that the decedent had a prior history of diverticulosis. In connection with this history, Dr. Aronoff opined that Kaye properly explored the decedent's abdominal cavity intraoperatively to look for any obvious pathology, and that, following the surgery, he examined the specimen on a side table to see if there was anything obvious that caused the bleed. He asserted that Kaye observed one diverticulum that appeared as if it had been bleeding, and thus appropriately sent the resected portion of the decedent's colon for pathological examination to confirm the diagnosis of diverticulosis and assess the severity of the condition, while also properly prescribing a regimen of antibiotics postoperatively to prevent or treat infection. He asserted that Kaye then "closely monitored" the decedent by examining him daily for any signs or symptoms of complications related to the surgery.

With respect to the propriety of the antibiotics that Kaye prescribed to the decedent postoperatively, Dr. Aronoff concluded that the administration of one preoperative and two postoperative doses of Cefepime, a broad-spectrum cephalosporin antibiotic, was appropriate

and within the standard of care in connection with a colon resection performed to treat a gastrointestinal bleed. As he explained it, as with any antibiotic, Cefepime should be used judiciously to minimize the risk of antimicrobial resistance and adverse effects, and that it was within the standard of care to discontinue antibiotics within 24 hours after surgery to minimize the risk of antibiotic-related complications and antimicrobial resistance. Since, according to Dr. Aronoff, the decedent was not exhibiting any signs of infection, and had been improving after he received the blood transfusion, Kaye provided the appropriate preoperative and postoperative antibiotics to the decedent, and appropriately discontinued them on July 27, 2014, as there was then no evidence of sepsis or infection.

Additionally, Dr. Aronoff concluded that Kaye timely and properly treated the decedent for anemia. He explained that the primary cause of anemia in a patient such as the decedent is acute blood loss from the gastrointestinal tract, and that anemia would be expected to occur due to colon bleed itself. Dr. Aronoff asserted that Kaye was properly treating the decedent's blood loss, monitoring the results of laboratory studies, and documenting them within every progress note. He reiterated that Kaye promptly and timely ordered a blood transfusion on July 26, 2014, and memorialized that the decedent "[r]esponded well to transfusion of 4 units pRBC. BP is up as well as the UO. Creatinine is down and Lactate pending. He has better color and abdomen is soft with appropriate peri-incisional tenderness. Will continue to monitor." Dr. Aronoff also reiterated his opinion that Kaye properly monitored the decedent postoperatively, and properly ordered and/or performed all appropriate testing, examinations, and investigations. He referred to Kaye's deposition testimony, in which the latter averred that it was his common practice to see an especially sick patient like the decedent more than once a day, and that Kaye was in constant communication with the nursing team and other consultants, conduct that also was reflected in Kaye's progress notes.

Dr. Aronoff quoted at length from GSH's chart, in which Kaye reported on the various blood, urine, blood pressure, and heart-monitoring tests that Kaye had ordered or performed

each day between July 26, 2014 and August 3, 2014, as well as Kaye's assessments of the decedent's condition with respect to cardiac, circulatory, pulmonary, gastrointestinal, renal, and nutritional issues, along with possible anastomotic leakage and infections, and came to the conclusion that Kaye properly monitored, examined, and treated the decedent postoperatively. He also concluded that Kaye's postoperative diagnoses and follow-up plans for the treatment of the decedent were within the applicable standards of care, and that all of the additional imaging scans and laboratory testing that were performed were appropriately ordered and appreciated.

Dr. Aronoff noted that the hemicolectomy that Kaye performed upon the decedent was an emergent surgery necessary to save his life, and explained that an anastomotic leak is a medical complication that is a known risk associated with intestinal surgeries, and can occur due to a combination of factors "related to the patient's condition, the inherent complexity of the surgery, and the body's unpredictable healing response," thus suggesting that any leakage involved in the decedent's case arose from those causes and not from anything that Kaye did or did not do. Hence, he concluded that Kaye's conduct was not the proximate cause of the decedent's injuries or death.

In connection with the claims asserted against GSH, Dr. Aronoff asserted that the decedent was expeditiously placed in a room within 12 minutes of arriving at that facility, and was seen by an attending physician within 16 minutes of his arrival. He referred to the GSH chart, in which it was reported that the decedent presented with an active bleed, that GSH personnel inserted two intravenous lines, including one to administer normal saline solution, and that GSH staff requested a consultation with Kaye, who reported to the emergency room to evaluate the decedent's condition. Dr. Aronoff stated that the decedent then was appropriately referred for a nuclear bleeding scan, properly admitted to GSH as an inpatient, and correctly transferred to GSH's surgery department under Kaye's care. He concluded that the decedent was properly and timely evaluated while in the emergency department, that the appropriate consultations and diagnostic studies were ordered and performed, and that all care and

treatment provided to the decedent, up to and including the time of his admission, satisfied good and acceptable hospital standards of care. Dr. Aronoff further averred that GSH staff complied with all appropriate physician's orders. Dr. Aronoff opined that none of the care that GSH rendered to the decedent, including that rendered by GSH nurses and technicians, caused or contributed to the decedent's injuries, losses, or death, as "[a]ll decisions with respect to testing, consultations, diagnosis, treatment and follow-up care lie within the purview of the private attending physicians and not within the purview of hospital employees (i.e., nurses and technicians of a private voluntary hospital)." He nonetheless did not assert that Kaye was the decedent's "private attending physician," since neither the decedent nor the plaintiff expressly retained Kaye, but, rather, GSH assigned him as the decedent's physician because Kaye was the surgeon on call when the decedent presented to the GSH emergency room.

In opposition to the GSH defendants' motion, the plaintiff relied on many of the documents that they had submitted, and also submitted an attorney's affirmation and the expert affirmation of board-certified internist and gastroenterologist William Bisordi, M.D., who opined that Kaye did, in fact, depart from several applicable standards of care in the treatment that he rendered to the decedent, and that those departures caused or contributed to his declining physical condition and, ultimately, to his death.

Specifically, after recapitulating some of the decedent's medical history that Dr. Aronoff had described, Dr. Bisordi noted that Kaye had continued to manage the decedent's case from July 26, 2014 until July 31, 2014, when, on August 1, 2014, the decedent was worked up for a possible anastomotic leak and bowel perforation. He asserted that the August 1, 2014 CT scan of the decedent's abdomen and pelvis revealed a moderate amount of free fluid in the right upper quadrant, and that GSH physicians noted the presence of bilateral pleural effusions, as well as mild-to-moderate third spacing of fluid within the subcutaneous soft tissues of the lower abdomen and pelvis. He explained that, on August 3, 2014, the decedent's family decided to transfer him to NYU for further management, after which a CT scan revealed both dehiscense,

that is, the opening of a closed incision, and a large leak at the anastomotic site. He stated that the defendant surgeon Sinha thereupon admitted the decedent to NYU, and performed a colon resection and ileostomy/colostomy. According to Dr. Bisordi, by August 8, 2014, the decedent's condition had deteriorated significantly, he had developed difficulty breathing, and by that evening he had experienced an episode of emesis, had aspirated, and was in severe respiratory distress, requiring intubation. Dr. Bisordi stated that the decedent continued to decompensate until he was pronounced dead at NYU on August 10, 2014.

Dr. Bisordi opined that Kaye departed from good and accepted medical care in failing adequately and sufficiently to transfuse blood into the decedent, both preoperatively and intraoperatively, resulting in hypotension, global ischemia, pre-renal azotemia, and organ failure. Although he noted that GSH personnel had administered two units of "packed cells," after the nuclear bleeding scan showed active bleeding in the right colon and Kaye had prepared the decedent for right hemicolectomy, he concluded that, in light of the potential for severe hypotension and extremely low hemoglobin levels, the administration of only two units of packed cells at that juncture did not constitute a necessary or sufficient transfusion of blood. Dr. Bisordi averred that Kaye's failure to transfuse the patient preoperatively and intraoperatively was a proximate cause of the decedent's postoperative hypotension, ischemia, azotemia and organ failure. He also implicitly suggested, by his opinion, that the transfusion of four units of blood one day after the surgery was effectuated too late to make a difference.

Dr. Bisordi also faulted Kaye for failing timely to diagnose a leaking anastomosis postoperatively, which he concluded was a proximate cause of the decedent's postoperative peritonitis, sepsis, and ultimate demise. In this respect, Dr. Bisordi asserted that the decedent presented with "multiple tell-tale signs of an anastomotic leak, postoperatively," specifically, that, on July 26, 2014, only one day after the subject procedure, the decedent was in metabolic acidosis, was hypotensive, and had a high white blood cell count, with fluctuating hemoglobin levels. He asserted that, by July 27, 2014, the decedent had spiked a fever and had worsening

kidney function, while a consultation with an infectious disease specialist documented distention and moderate tenderness of abdomen in the lower left quadrant. Dr. Bisordi further pointed out that, on July 28, 2014, Nanjappa documented that the decedent had experienced episodes of respiratory distress, had no bowel movements, and had a body temperature of 101 degrees Fahrenheit. While he additionally noted that, by July 29, 2014, the decedent's body temperature had normalized, the decedent remained constipated. As Dr. Bisordi explained it, after a few days of seeming improvements, on July 31, 2014, GSH staff documented the decedent with abdominal distention, vomiting, and continued constipation. He thus concluded that, by August 1, 2014, the decedent was in acute renal failure.

Dr. Bisordi asserted that, although Kaye had ordered the CT scan that depicted a fluid collection, the image did not reveal the presence of free air, and that, while the administration of antibiotics was restarted, the decedent nonetheless experienced two bloody bowel movements. Dr. Bisordi thus concluded that Kaye failed to ensure that the anastomosis was maintained, despite almost immediate signs that it was not maintained postoperatively. He opined that Kaye should have been suspicious for an anastomotic leak immediately after the procedure, when the decedent's blood count was elevated, and should have ordered CT scan imaging no later than July 29, 2014, since, by that time, the decedent evinced an elevated temperature and lack of bowel movements. He asserted that Kaye failed to perform proper physical examinations and was not sufficiently proactive in his care and treatment of the decedent, as Kaye never sought to identify the source of the free fluid collection and never addressed or explained the etiology of the decedent's reappearing bloody stools. He thus concluded that the decedent had developed an intra-abdominal infection, "likely developing immediately after the procedure," and that, by the time that the decedent presented to NYU, he already was suffering from "irreversible multi system failure and organ damage as evidence[d] by his coagulopathy, elevated lactate [levels], and kidney injury upon admission at NYU."

Dr. Bisordi expressly disagreed with Dr. Aronoff's opinion that the lack of observable free air on the August 1, 2014 CT scan warranted the conclusion that there was no anastomotic leak. As he explained it, the multiple symptoms that were observable in the days leading up August 1, 2014, the unexplained free fluid seen on the scan, and the decedent's bloody bowel movements later that day, "should have led Dr. Kaye to conclude that there was an anastomotic leak." Dr. Bisordi additionally opined that, had the leak timely been identified, a surgical repair could have been performed, the immediate administration of proper antibiotics could have been ordered, and any infection could have been drained. He thus concluded that Kaye departed from good practice in failing to test for and identify the anastomotic leak on or before July 29, 2014, failed to test for, diagnose, and treat the decedent's otherwise treatable infection, including via drainage of the infection and the timely administration of antibiotics, and that, had Kaye done so, the infection would not have spread, and the decedent would not have died.

In reply, the GSH defendant submitted an attorney's affirmation, in which counsel argued that the court should reject the plaintiff's opposition papers as untimely, since they were served, without excuse, more than one month after the date for the service of opposition papers had been agreed to and so-ordered by the court. She further argued that, although Dr. Bisordi prefaced his affirmation with the phrase "being duly sworn deposes and says the following under the penalty of perjury," the document was not actually "sworn to" because the document was not notarized and, if he elected to employ an affirmation, he was required to recite, either verbatim or in substantially similar form, the language set forth in the second paragraph of CPLR 2106 (L 2023, ch 559, eff. Jan. 1, 2024), which provides that the statement included in an affirmation by an affirmant must be in "substantially the following form:

> I affirm this ___ day of _____, ____, under the penalties of perjury under the laws of New York, which may include a fine or imprisonment, that the foregoing is true, and I understand that this document may be filed in an action or proceeding in a court of law."

In addition, she argued that Dr. Bisordi was not qualified by education, training, or experience to render an opinion as to proper postoperative monitoring of a hemicolectomy because he is not a surgeon, but only an internist and gastroenterologist. Finally, she contended that Dr. Bisordi's opinion was conclusory, speculative, and unsupported by the facts in the medical records.

Initially, the court concludes that, although the GSH defendants correctly argue that the court is not obligated to consider the plaintiff's late opposition papers, "[t]he court retains the discretion to accept late opposition papers upon a showing of a valid excuse" (*Wilson v Tully Rinckey, PLLC*, 200 AD3d 1466, 1466 [3d Dept 2021]; *see Mo v Zhou,* 235 AD3d 556, 557 [1st Dept 2025]; *Wilcox v Newark Val. Cent. Sch. Dist.*, 107 AD3d 1127, 1130 [3d Dept 2013]; *see generally* CPLR 2004). Crucially, the GSH defendants did not request an extension of time within which to prepare and serve reply papers, they nonetheless were able to submit reply papers in a timely fashion, and the court sua sponte adjourned the return date of the motion several times, during which the GSH defendants could have requested permission to supplement their reply papers. Hence, there would be no prejudice were the court to consider the plaintiff's late opposition papers (*see Wilson v Tully Rinckey, PLLC*, 200 AD3d at 1466; *Heath v Normile*, 131 AD3d 754, 756 [3d Dept 2015]). Nonetheless, despite the "strong public policy of this State that, in the absence of prejudice, a matter should be disposed of on its merits" (*Noriega v Presbyterian Hosp.*, 305 AD2d 220, 221 [1st Dept 2003]), inasmuch as the plaintiff has yet to articulate a valid explanation for the late service and filing of her opposition papers, the court will excuse such tardiness only on condition that, on or before September 23, 2025, her attorneys serve and file an affirmation explaining the reasons for their significant delay in the service and filing of those papers. If the court finds the explanation to be valid, it will excuse the delay; if the excuse is not valid, it reserves the right to modify this order sua sponte by deeming the GSH defendants' motion to have been unopposed. In connection with the limited prefatory language employed by Dr. Bisordi in connection with his affirmation, the court also agrees with the GSH defendants that, although there is no appellate precedent addressing

the issue, the "fine or imprisonment" and "may be filed in an action" language articulated in paragraph two of the recently enacted amendment to CPLR 2106, which is required to be set forth immediately before an affirmant's signature, is mandatory (*see Alternative Funding Group Corp. v Dancie Enters., Inc.,* 2025 NY Slip Op 51363[U], *2-3, 2025 NY Misc LEXIS 7034, *6 [Sup Ct, Kings County, Aug. 19, 2025]). Nonetheless, as with the failure of an affiant or affirmant to include a certificate of conformity with an affidavit or affirmation executed outside of the State of New York, or the failure of a physician not licensed to practice medicine in New York to submit an affidavit instead of an affirmation, as previously required by CPLR former 2106(a), the court concludes that it possesses discretion to permit Dr. Bisordi's affirmation to be corrected nunc pro tunc (*see generally Khurdayan v Kassir,* 223 AD3d 590, 591 [1st Dept 2024]). The court exercises its discretion, and will consider Dr. Bisordi's affirmation on condition that, on or before September 23, 2025, the plaintiff submit an amended affirmation that includes that language substantially in the form and format set forth in the second paragraph of the current version of CPLR 2106.

The court rejects the NYPH defendants' contention that the plaintiffs' expert was not qualified to render an opinion as to the propriety Kaye's postoperative care, and, in the exercise of its discretion (*see Guzman v 4030 Bronx Blvd. Assoc., LLC*, 54 AD3d 42, 49 [1st Dept 2008]), concludes that Dr. Bisordi was, in fact, qualified by training, education, and experience to render all of the opinions set forth in his affirmation (*see Fuller v Preis*, 35 NY2d 425, 431 [1974]; *Bartolacci-Meir v Sassoon*, 149 AD3d 567, 572 [1st Dept 2017]; *Bickom v Bierwagen*, 48 AD3d 1247,1248 [4th Dept 2008]; *Julien v Physician's Hosp*., 231 AD2d 678, 680 [2d Dept 1996]; *Matter of Enu v Sobol*, 171 AD2d 302, 304 [3d Dept 1991]; *Joswick v Lenox Hill Hosp*., 161 AD2d 352, 355 [1st Dept 1990]). "Contrary to [the GSH] defendants' assertion, this doctor did not opine on the surgery, which would have exceeded his expertise" (*Khurdayan v Kassir*, 223 AD3d at 591). Rather, he opined only as to Kaye's alleged failure timely and properly to appreciate, monitor, test for, diagnose the decedent with, and treat the decedent for a

postoperative leakage from the colonic anastomosis and the development of a serious gastrointestinal infection as a consequence thereof. These are departures with respect to which Dr. Bisordi is indeed qualified to render an opinion.

With respect to the merits of the motion, although the court agrees with the GSH defendants that they have established their prima facie entitlement to judgment as a matter of law in connection with the medical malpractice cause of action, it disagrees with them that Dr. Bisordi's affirmation was insufficient to raise a triable issue of fact with respect to the plaintiff's claims that Kaye departed from good and accepted practice by failing timely and properly to appreciate, monitor, test for, diagnose the decedent with, and treat the decedent for a postoperative leakage from the colonic anastomosis and by failing timely and properly to appreciate, monitor, test for, diagnose the decedent with, and treat the decedent for a serious gastrointestinal infection that arose as a consequence of the failure to address the leakage. He also raised triable issues of fact as to whether those departures caused or contributed to the decedent's sepsis, respiratory failure, and death. Hence, the court must deny that branch of the GSH defendants' motion seeking summary judgment dismissing, insofar as asserted against them, so much of the medical malpractice cause of action as was premised upon those claims.

The GSH defendants, however, must be awarded summary judgment dismissing, insofar as asserted against them, so much of the medical malpractice cause of action as was premised upon the plaintiff's allegations that they failed to take a proper medical history of the decedent, failed to perform an exploratory laparotomy upon her decedent, improperly determined that a hemicolectomy was an indicated procedure for her decedent, improperly performed the hemicolectomy, did not initially achieve anastomosis during that procedure, did not appropriately resuscitate the decedent intraoperatively or postoperatively, and did not properly treat the decedent for hyperkalemia, diverticulosis, diverticulitis, or anemia, since they made the necessary prima facie showing with respect to those claims, and the plaintiff failed to raise

triable issues of fact in connection with these claims because Dr. Bisordi did not address those claims or refute Dr. Aronoff's opinions with respect thereto.

"'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]). As there is no dispute that Kaye was employed by GSH during the time that he rendered care to the decedent, to the extent that the court has determined that there are triable issues of fact as to whether Kaye committed malpractice, there are triable issues of fact as to whether GSH may be held vicariously liable therefor. Nonetheless, since the GSH defendants established that no other GSH employee committed any act of malpractice, and the plaintiff did not address Dr. Aronoff's opinion in this respect, summary judgment must be awarded to GSH dismissing, insofar as asserted against it, so much of the medical malpractice cause of action as was premised upon the plaintiff's allegations that GSH health-care personnel other than Kaye departed from the applicable standard of care.

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]). "'[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]). Expert testimony, however, 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]). Nonetheless, a defendant may satisfy the burden of demonstrating a 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 is also evidence that the necessity of the procedure, along with known risks and dangers, were discussed prior to the surgery (*see Bamberg-Taylor v Strauch*, 192 AD3d 401, 401-402 [1st Dept 2021]).

Dr. Aronoff asserted in his affirmation that Kaye did not fail to obtain the decedent's fully informed consent to the hemicolectomy. In the first instance, he referred to Kaye's consultation note, in which the latter wrote that he

> "[s]poke to the patient about laparoscopic right hemicolectomy, possible open. Alternatives were discussed. Explained aspects of surgical intervention, methods, and the risks which include but are not limited to infection, bleeding, anastomotic leak (which would require urgent surgery), damage to intra-abdominal organs, wound infections, prolonged wound healing and venous thromboembolic phenomenon, as well as the risks of general anesthesia including respiratory failure, myocardial infarction, stroke, and death. Outlined the preoperative preparation, the hospital course, and the postoperative course with the patient. All questions were answered to the patient's satisfaction. I do not think observation is an option in the setting of a large bleed with a positive bleeding scan and an episode of hypotension. The patient and his wife understand that despite the positive scan, there is always the small chance that he continues to bleed post-op which would warrant a completion colectomy. The patient does wish to proceed with surgery."

Dr. Aronoff further adverted to Kaye's deposition testimony, which was to the effect that he advised decedent and his wife of the risks. With respect to the lack of informed consent cause of action insofar as asserted against GSH, Dr. Aronoff averred that the plaintiff raised only "generic and undefined allegations of inadequate informed consent," and reiterated that Kaye wrote a detailed progress note as to how informed consent was obtained. In opposition to the motion, Dr. Bisordi did not render an opinion as to the lack of informed consent cause of action. On that ground alone, summary judgment must be awarded to the GSH defendants dismissing the lack of informed consent cause of action as asserted against them.

In any event, to the extent that the lack of informed consent cause of action was premised upon the hemicolectomy procedure itself, the GSH defendants established that the procedure that Kaye performed upon the plaintiff's decedent was an emergency procedure, and that, consequently, the lack of informed consent cause of action was not viable even if the plaintiff addressed that issue in her opposition papers (*see Ortiz v Vernenkar*, 101 AD3d 637, 637-638 [1st Dept 2012]). Moreover, "[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. Furthermore, a claim

to recover for lack of informed consent cannot be maintained where the alleged injuries resulted either from the failure to undertake a procedure or the postponement of that procedure (*see Akel v Gerardi*, 200 AD3d 445 [lack of informed consent cannot be based on failure to perform procedure or administer drug]; *Ellis v Eng*, 70 AD3d 887, 892 [2d Dept 2010]; *Jaycox v Reid*, 5 AD3d 994, 995 [4th Dept 1994]). To the extent that the lack of informed consent cause of action was premised upon Kaye's alleged failure to diagnose her decedent with any condition, either preoperatively or postoperatively, or upon the postponement of any procedure or treatment, it must be summarily dismissed, notwithstanding the sufficiency of the opposition papers.

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 GSH defendants demonstrated that Kaye and all other health-care personnel working for both Kaye and GSH were properly trained. Since the plaintiff, in her opposition papers, adduced no facts with respect to whether the GSH 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 against them must be granted.

"'In a wrongful death action, an award of damages is limited to the fair and just compensation for the pecuniary injuries resulting from the decedent's death to the persons for whose benefit the action is brought'" (*Leger v Chasky*, 55 AD3d 564, 565 [2d Dept 2008], quoting *Plotkin v New York City Health & Hosps. Corp.*, 221 AD2d 425, 426 [2d Dept 1995]; *see* EPTL 5-4.3 [a]). In addition, a surviving spouse may prosecute a derivative cause of action for loss of consortium, albeit one that is limited to the period of time during which the decedent was alive, and suffering from injuries caused by a defendant (*see Liff v Schildkrout*, 49 NY2d 622, 632 [1980]). In connection with the wrongful death cause of action,

> "[t]here are four elements of compensable loss encompassed by the general term pecuniary loss: (1) decedent's loss of earnings; (2) loss of services each survivor may have received from decedent; (3) loss of parental guidance from decedent; and (4) the possibility of inheritance from decedent"

(*Huthmacher v Dunlop Tire Corp*., 309 AD2d 1175, 1176 [4th Dept 2003] [citations omitted]). The court concludes that, based on the plaintiff's deposition testimony, there are triable issues of fact as to whether her decedent's death caused pecuniary loss to the beneficiaries of his estate. Hence, to the extent that the court has concluded that there are triable issues of fact in connection with the medical malpractice cause of action, there are triable issues of fact as to both the plaintiff's loss of spousal consortium and wrongful death causes of action, and those branches of the GSH defendants' motion seeking summary judgment dismissing those causes of action insofar as asserted against them must be denied.

The court notes that EPTL 11-3.2(b) provides that, in addition to a wrongful death cause of action,

> "[n]o cause of action for injury to person or property is lost because of the death of the person in whose favor the cause of action existed. For any injury an action may be brought or continued by the personal representative of the decedent,"

thus permitting the representative of the estate to prosecute a so-called "survival action" to recover for the conscious pain and suffering caused by the defendants and sustained by the decedent while the decedent remained alive. This item of recovery, however, is subsumed in the medical malpractice cause of action, and is not properly asserted as part of the wrongful death cause of action.[2]

The defendant Lee established his prima facie entitlement to judgment as a matter of law with his submissions, which included the expert affirmations of board-certified internist, clinical cardiac electrophysiologist, and cardiovascular disease specialist Hugh Calkins, M.D.,

[2] The court further notes that a survival claim for conscious pain and suffering that is prosecuted pursuant to EPTL 11-3.2(b) "belongs" to the estate, and not to the distributees of the estate, while wrongful death claims to recover pecuniary loss "belong" to the distributees (*Cragg v Allstate Indem. Corp*., 17 NY3d 118, 121 [2011]; *see Heslin v County of Greene*, 14 NY3d 67, 76-77 [2010]).

and board-certified general surgeon and colorectal surgeon Randolph Steinhagen, M.D., both of whom provided detailed opinions that Lee did not depart from good and accepted practice, and that nothing that he did or did not do caused or contributed to the decedent's deterioration or death. Since the plaintiff did not oppose Lee's motion, she failed to raise triable issues of fact in response to that showing, and summary judgment must be awarded to Lee dismissing the complaint insofar as asserted against him. Similarly, the NYU defendants established their prima facie entitlement to judgment as a matter of law with their submissions, which included the expert affirmation of surgeon and critical care surgery specialist Peter Rhee, M.D., who concluded, in his detailed affirmation, that none of the NYU defendants departed from good and accepted medical practice, and that nothing that they did or did not do caused or contributed to the decedent's injuries or death. Since the plaintiff did not oppose that motion, she failed to raise triable issues of fact in response to that showing, and summary judgment must be awarded to the NYU defendants dismissing the complaint insofar as asserted against them. Likewise, the defendant Nanjappa established her prima facie entitlement to judgment as a matter of law with her submissions, which included the expert affirmation of board-certified internist Peter M. Pasley, who opined in detail that Nanjappa did not depart from good and accepted practice, and that nothing that she did or did not do caused or contributed to the decedent's injuries. Since the plaintiff did not oppose Nanjappa's motion, she failed to raise triable issues of fact in response to that showing, and summary judgment must be awarded to Nanjappa dismissing the complaint insofar as asserted against her.

With respect to the defendants denominated as John Doe, M.D., 1-5, Jane Doe, M.D., 1-5, John Roe, RN 1-5, Jane Roe, RN 1-5, and ABC Companies 1-5, the plaintiff made no showing of any efforts that she made to identify these fictitious defendants, and never sought to amend the caption to substitute any entity or person in their places as a party defendant. Consequently, the plaintiff is precluded from relying on CPLR 1024 to maintain this action

against those fictitious parties (*see generally Fountain v Ocean View II Assocs., L.P.*, 266 AD2d 339 [2d Dept 1999]), and the complaint must be dismissed insofar as asserted against them.

In light of the foregoing, it is,

ORDERED that the motion of the defendants Peter M. Kaye, M.D., and Good Samaritan Hospital for summary judgment dismissing the complaint insofar as asserted against them (MOT SEQ 006) is granted to the extent that they are awarded summary judgment dismissing, insofar as asserted against them, the lack of informed consent cause of action, and so much of the medical malpractice as was premised on upon the plaintiff's allegations that they:

(a) failed to take a proper medical history of her decedent;

(b) failed to perform an exploratory laparotomy upon her decedent,

(c) improperly determined that a hemicolectomy was an indicated procedure for her decedent,

(d) improperly performed the hemicolectomy,

(e) did not initially achieve anastomosis during that procedure,

(f) did not appropriately resuscitate her decedent intraoperatively or postoperatively,

(g) did not properly treat her decedent for hyperkalemia, diverticulosis, diverticulitis, or anemia,

(h) were liable for the conduct of health-care personnel other than Kaye, and

(i) were liable for the negligent hiring, training, supervision, and retention of health-care personnel, including Kaye,

that cause of action and those claims are dismissed, and that motion is otherwise denied, upon the condition that, on or before September 23, 2025, the plaintiff serve and file an affirmation or affirmations setting forth a valid excuse for the late service and filing of her opposition papers, and that she serve and file an amended affirmation of her retained expert that includes the language set forth in the second paragraph of the recently amended version of CPLR 2106 in the form required by that statute, or language that is in a form that is substantially similar to the text and format of that paragraph; and it is further,

ORDERED that the motion of the defendant Joseph Ming Lee, M.D., for summary judgment dismissing the complaint insofar as asserted against him (MOT SEQ 007) is granted, without opposition, and the complaint is dismissed insofar as asserted against the defendant Joseph Ming Lee, M.D.; and it is further,

ORDERED that, on the court's own motion, the action is severed against the defendant Joseph Ming Lee, M.D.; and it is further,

ORDERED that the Clerk of the court is directed to enter judgment dismissing the complaint insofar as asserted against the defendant Joseph Ming Lee, M.D.; and it is further,

ORDERED that the motion of the defendants Prashant Sinha, M.D., Greta Lynn Piper, M.D., and NYU Hospitals Center, also known as New York University Langone Medical Center, for summary judgment dismissing the complaint insofar as asserted against them (MOT SEQ 008) is granted, without opposition, and the complaint is dismissed insofar as asserted against the defendants Prashant Sinha, M.D., Greta Lynn Piper, M.D., and NYU Hospitals Center, also known as New York University Langone Medical Center; and it is further,

ORDERED that, on the court's own motion, the action is severed against the defendants Prashant Sinha, M.D., Greta Lynn Piper, M.D., and NYU Hospitals Center, also known as New York University Langone Medical Center; and it is further,

ORDERED that the Clerk of the court is directed to enter judgment dismissing the complaint insofar as asserted against the defendants Prashant Sinha, M.D., Greta Lynn Piper, M.D., and NYU Hospitals Center, also known as New York University Langone Medical Center; and it is further,

ORDERED that the motion of the defendant Nirmala Nanjappa, M.D., for summary judgment dismissing the complaint insofar as asserted against her (MOT SEQ 009) is granted, without opposition, and the complaint is dismissed insofar asserted against the defendant Nirmala Nanjappa, M.D.; and it is further,

ORDERED that, on the court's own motion, the action is severed against the defendant Nirmala Nanjappa, M.D.; and it is further,

ORDERED that the Clerk of the court is directed to enter judgment dismissing the complaint insofar as asserted against the defendant Nirmala Nanjappa, M.D.; and it is further,

ORDERED that, on the court's own motion, the complaint is dismissed insofar as asserted against the fictitious defendants denominated as John Doe, M.D., 1-5, Jane Doe, M.D., 1-5, John Roe, RN 1-5, Jane Roe, RN 1-5, and ABC Companies 1-5; 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 October 7, 2025, at 10:30 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.

9/9/2025
DATE

JOHN J. KELLEY, J.S.C.

MOTION 006:		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
MOTION 007:		CASE DISPOSED			X	NON-FINAL DISPOSITION		
	X	GRANTED		DENIED		GRANTED IN PART		OTHER
APPLICATION:		SETTLE ORDER				SUBMIT ORDER		
CHECK IF APPROPRIATE:		INCLUDES TRANSFER/REASSIGN				FIDUCIARY APPOINTMENT		REFERENCE
MOTION 008:		CASE DISPOSED			X	NON-FINAL DISPOSITION		
	X	GRANTED		DENIED		GRANTED IN PART		OTHER
APPLICATION:		SETTLE ORDER				SUBMIT ORDER		
CHECK IF APPROPRIATE:		INCLUDES TRANSFER/REASSIGN				FIDUCIARY APPOINTMENT		REFERENCE
MOTION 009:		CASE DISPOSED			X	NON-FINAL DISPOSITION		
	X	GRANTED		DENIED		GRANTED IN PART		OTHER
APPLICATION:		SETTLE ORDER				SUBMIT ORDER		
CHECK IF APPROPRIATE:		INCLUDES TRANSFER/REASSIGN				FIDUCIARY APPOINTMENT		REFERENCE