SUPREME COURT OF THE STATE OF NEW YORK
NEW YORK COUNTY

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

Justice

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MOISES RODRIGUEZ and ANA JULIA CRUZ,

Plaintiffs,

- v -

DOREEN CHUNG, M.D., GUARINEX JOEL DECASTRO, M.D., and NEW YORK PRESBYTERIAN/COLUMBIA UNIVERSITY MEDICAL CENTER,

Defendants.

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INDEX NO. 805067/2019

MOTION DATE 10/09/2025

MOTION SEQ. NO. 001

DECISION + ORDER ON MOTION

The following e-filed documents, listed by NYSCEF document number (Motion 001) 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 59, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74

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

In this action to recover damages for medical malpractice based on alleged departures from good and accepted practice and 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, and the complaint is dismissed.

The crux of the plaintiffs' claims against the defendants is that, on October 31, 2017, they committed malpractice in performing a robotic cystectomy on the plaintiff Moises Rodriguez (the patient), and in failing to provide him with adequate postoperative care, thus causing him to sustain injuries. In their bill of particulars addressed to the defendant urologist Doreen Chung, M.D., the plaintiffs alleged that she negligently performed a robotic-assisted laparoscopic cystectomy on the patient, along with a small bowel resection and the placement of an ileal conduit, by failing to use competent and proper surgical technique and by failing intraoperatively and postoperatively to diagnose an ileal anastomotic perforation, thus permitting the patient's condition to deteriorate. They further faulted Chung for failing timely to order an indicated computed tomography (CT) scan of the patient's abdomen and pelvis, with and without contrast,

as well as an abdominal x-ray, and therefore failed timely to intervene surgically in response to the patient's continued postoperative complaints. In their bill of particulars addressed to the defendant urologist Guarinex Joel DeCastro, M.D., the plaintiff reiterated the allegations of malpractice that they had asserted against Chung, and further asserted that DeCastro failed to perform a timely and indicated exploratory ileocecectomy and ileostomy until December 13, 2017. In their bill of particulars addressed to the defendant hospital New York Presbyterian/ Columbia University Medical Center (NYPH), the plaintiffs essentially repeated the allegations that they made against Chung, and claimed that NYPH was vicariously liable for the malpractice allegedly committed by Chung and DeCastro. The plaintiffs averred that, as a consequence of the defendants' alleged malpractice, the patient was caused to sustain an ileal anastomotic perforation, peritonitis, bilateral hydronephrosis, extensive bilateral perinephric stranding, and tachycardia secondary to stress, necessitating a postoperative exploratory laparotomy, Ileocecectomy, and a blood transfusion, the latter of which caused the patient to experience an adverse reaction. They further asserted that the patient sustained injury to, and the need for the repair of, a perforation of the left ureter and cecum during that exploratory laparotomy and ileocecectomy, causing sepsis, pain, discomfort, and fever, all of which required drainage from the midline abdominal incision, and resulting in the deterioration of his health and the necessity of temporarily placing him on a life support protocol.

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 his or her burden of affirmatively establishing entitlement to judgment as a matter of law merely by pointing to gaps in the plaintiff's case, 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]). 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]).

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 the burden on a summary judgment motion, 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, 1045 [2d Dept 2010]; *Grant v Hudson Val. Hosp. Ctr.*, 55 AD3d 874, 874 [2d Dept 2008]; *Terranova v Finklea*, 45 AD3d 572, 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; *Luu v Paskowski*, 57 AD3d 856, 857 [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).

"'Expert testimony is necessary to prove a deviation from accepted standards of medical care and to establish proximate cause'" (*McAlwee v Westchester Health Assoc., PLLC*, 163 AD3d 549, 551 [2d Dept 2018], quoting *Burns v Goyal*, 145 AD3d 952, 954 [2d Dept 2016]). Thus, where a moving defendant in a medical malpractice action makes a prima facie showing that he or she did not depart from good and accepted practice, or that the treatment rendered to the plaintiff did not cause or contribute to the plaintiff's injuries, the plaintiff, to defeat summary

judgment, must submit an expert affirmation or affidavit in opposition; a plaintiff's failure to submit such an expert affirmation or affidavit under such circumstances requires the court to award summary judgment to the moving defendant (*see Benedetto v Tannenbaum*, 186 AD3d 1596, 1598 [2d Dept 2020]; *Bethune v Monhian*, 168 AD3d 902, 903 [2d Dept 2019]; *Koster v Davenport*, 142 AD3d 966, 969 [2d Dept 2016]; *Whitnum v Plastic & Reconstructive Surgery, P.C.*, 142 AD3d 495, 497 [2d Dept 2016]; *Roques v Noble*, 73 AD3d at 207; *Bailey v Owens*, 17 AD3d 222, 223 [1st Dept 2005]; *cf. Williams v Sahay*, 12 AD3d 366, 368 [2d Dept 2004] [unsworn affidavit of unnamed expert that was not affirmed under the penalties for perjury is insufficient to raise triable issue of fact as to defendants' alleged malpractice]).

In support of their motion, the defendants submitted the pleadings, the plaintiffs' bills of particulars, transcripts of the parties' deposition testimony, relevant medical and hospital records, correspondence from the plaintiffs, a memorandum of law, an attorney's affirmation, and the expert affirmation of board-certified urologist David Albala, M.D., who is the director of urologic robotic surgery at Crouse Hospital in Syracuse, New York. Dr. Albala opined that none of the defendants departed from good and accepted practice in the course of examining and treating the patient, and that nothing that they did or did not do caused or contributed to the patient's injuries or any adverse outcome.

After providing a detailed recitation of the then-50-year-old patient's preoperative medical history, which was positive for chronic nephrolithiasis, also known as kidney stones, chronic renal failure, and chronic bilateral hydronephrosis, and his complaints to NYPH healthcare personnel, which included dysuria (pain or discomfort when urinating) and hematuria (blood in the urine), Dr. Albala explained the nature of the initial preoperative examination performed upon the patient at NYPH on January 11, 2017. As Dr. Albala interpreted the NYPH chart, the patient returned to the NYPH emergency department on February 3, 2017, complaining of a fever, dark colored urine, flank pain, and difficulty with straight catheterization. At that time, the patient was admitted to NYPH for 14 days, and Chung, who was assigned as

his attending urologist, diagnosed him with persistent right-sided hydronephrosis, which was observed on imaging, and a urinary tract infection, which was treated with a course of antibiotics. She performed a cystoscopy by inserting a right internal ureteral "double-j" stent. Chung concluded that the patient was experiencing end stage bladder chronic disease, and NYPH personnel monitored him until his discharge on February 17, 2017.

Dr. Albala provided a granular, detailed explanation of the patient's treatment by the defendants and his admissions to NYPH, which occurred between March 8, 2017 and December 2017. Specifically, he explained that the patient next saw Chung on March 8, 2017 at the NYPH urology department clinic, complaining of severe urinary frequency, and that his heart was racing at times, with palpitations. The patient informed Chung that, in November 2016, he had undergone a procedure for the placement of bilateral ureteral stents at Lincoln Hospital in Bronx, New York, although he was unclear as to the reason for that procedure. According to Dr. Albala, the patient was not a candidate for clean intermittent catheterization (CIC) at the time, and, therefore, was advised to retain the Foley catheter that had been placed. Dr. Albala explained that urodynamic testing revealed that the patient had a small capacity bladder, which could retain less than 200 milliliters (mL) of urine, poor compliance, detrusor underactivity, incomplete bladder emptying, impaired sensation, and bilateral vesicoureteral reflux. NYPH healthcare staff thus scheduled him for a bladder Botox injection, and then a CIC procedure after the injection. Chung injected the Botox into the patient's bladder on March 15, 2017, and the patient followed up with Chung on May 24, 2017, informing her that he was catheterizing four times per day and obtained 50 mL of urine during each voiding episode, but that he voided every 15 minutes, with some incontinence. Chung scheduled the patient for another Botox injection for some time in June 2017, and discussed surgical options with him, including the placement of a suprapubic cystotomy tube and augmentation cystoplasty, but advised him that, due to his poor renal function, he would not be a good candidate for augmentation cystoplasty, and an ileal conduit procedure was offered as a better option.

On June 21, 2017, Chung performed another intravesical injection with 300U allergan Botox, and found that the patient evinced a small, poorly compliant bladder that was very friable. On both July 11, 2017 and August 18, 2017, the patient was again admitted to NYPH for recurrent urinary tract infections, was treated with antibiotics, and was discharged. On September 20, 2017, the patient presented to nonparty urologist Gina Badalato, M.D., who reported that the patient had been non-compliant with the CIC protocol, which led to his prior hospital admissions, and that he continued to urinate approximately 10 times each night. Dr. Badalato further noted that a CT scan from his recent hospitalization reflected the presence of a calculi in the lower pole of his left kidney, after which, on October 5, 2017, NYPH personnel performed a ureteroscopy, laser lithotripsy, and stone removal.

On October 11, 2017, Chung met with the patient, and noted that he was scheduled for a robotic assisted laparoscopic cystectomy, that is, the removal of his bladder, on October 31, 2017. As an alternative, Chung suggested that the patient consider a suprapubic cystostomy tube placement, in response to which the patient informed her that he wished to proceed with the cystectomy, and that he would prefer a minimally invasive procedure, such as a laparoscopic procedure, rather than an open procedure.

On October 31, 2027, the plaintiff presented to NYPH for a robotic assisted laparoscopic cystectomy, along with the placement of an ileal conduit. Chung, assisted by DeCastro, performed the procedure, with the latter's assistance consisting of the robotic cystectomy portion of the surgery, while Chung herself performed the urinary diversion, that is, the placement of the ileal conduit. DeCastro wrote in the operative report that he had encountered several sigmoid adhesions that likely were due to the plaintiff's past infections, and that both ureters were quite adhered to the surrounding tissue, which Dr. Albala concluded presented a challenge to the identification of organs and the dissection thereof. Nonetheless, Dr. Albala asserted that DeCastro identified the patient's left ureter, and slowly traced it down to the bladder, after which DeCastro identified the bladder, dissected the ureter distally to the bladder,

and thereupon clipped and transected it. As Dr. Albala interpreted the operative report, DeCastro took down the lateral attachments of the bladder on each side, separated the bladder from the pubic bone, and identified and dissected the bladder neck, until the bladder was liberated and placed into an Endocatch bed. He explained that DeCastro inspected the resected bed and cauterized areas of bleeding, and that, after he brought over the left ureter to the right beneath the sigmoid colon, he tagged the sutures proximal to the cecum, and turned over the procedure to Chung so that she could proceed, along with DeCastro, with the urinary diversion and creation of the ileal conduit.

As Dr. Albala explained it, during the cystectomy portion of the procedure, "one surgeon operates at a time utilizing a console approximately 10 feet away from the patient." He asserted that DeCastro did not perform any work on the bowel. Dr. Albala asserted that, to proceed with the urinary diversion, Chng undocked the robotic device, made a midline incision, and created the ileal conduit with resected small bowel tissue. He further explained that Chung employed a gastrointestinal anastomosis, that is, a tubular connection between gastrointestinal structures and the bladder, and placed silk sutures at the ends of a bowel anastomosis, while the corners were cut off at the end. Dr. Albala stated that this conduit was laid out in position and irrigated with fluid to wash out the contents of the patient's bowel.

According to Dr. Albala, at that juncture, "it was noted that the mesentery had torn." He explained that Chung then decided that the piece of bowel that she had attempted to employ was inadequate for the conduit, since it would have provided only a tenuous blood supply, and she thus discarded that piece if bowel and sent it to the pathology department for analysis. As Dr. Albala described it, Chung then decided to create a new ileal conduit, and repeated the process for creating the anastomosis, after which she inspected the conduit to assure sufficient blood supply and created a mesenteric window. Dr. Albala stated that the bowel ends that were to be anastomosed were brought together with 3-0 stay sutures, after which Chung made sure that the conduit would lie in a good position so that the blood supply would not be "comprised"

close to the previously marked stoma site. Chung noted that the patient manifested a thick, stiff, and non-elastic mesentery. In any event, Chung created the ureteral anastomoses with interrupted biosyn sutures, and placed a "single-J" ureteral stent through the kidney, after which she repeated this process with respect to the patient's right ureter and irrigated the conduit, observing no leak at the ureteral anastomosis. Dr. Albala averred that Chung also checked for further bleeding, and observed none. According to Dr. Albala, the

> "stoma was then created. The conduit was placed through the stoma site, and vicryl sutures were placed through the skin and through the stoma site. The skin was closed with staples. MR. RODRIGUEZ tolerated the procedure well, without any complications. He was transferred to recovery in stable condition."

Dr, Albala referred to Chung's deposition, at which she testified that, during the subject procedure, the patient's tissues were very friable, meaning that they were very delicate, and that they ripped easily. According to Chung, when she examined the mesentery after creating the initial ileal conduit, it appeared as if it had ripped, and she did not think that the blood supply was sufficient anymore, after which she consequently removed that part of the small bowel and created a new conduit. She stated that, typically, the mesenteric window is closed, so that bowel does not go through, but since the mesentery itself and the soft tissue were friable, she decided not to close the mesenteric window because she did not want to risk stretching or ripping the tissue. She testified that she did not find anything suggestive of an ileal anastomotic perforation prior to closing the patient.

According to Dr. Albala, Chung consulted with the patient postoperatively on November 2, 2017, at which time his abdomen was soft, his wounds were closed, and the osteotomy was pink and healthy, although he was tachycardic, which was consonant with his history of tachycardia, and cardiologists were asked to see him. Dr. Albala asserted that, as of November 2, 2017, the patient was comfortable and feeling fine, and his body temperature was normal, while, on November 3, 2017, his abdomen was soft, non-tender, his heart rate was improved, and he was moving around well, with his body temperature within normal limits, and his surgical

wounds dry and intact. Nonetheless, Dr. Albala noted that the patient manifested some abdominal distention. A nasogastric feeding tube thus was placed, after which his abdomen was softer, but still mildly distended. On November 4, 2017, DeCastro met with the patient, and, although the patient's feeding tube had fallen out, DeCastro determined not to reinsert it because the patient was not experiencing nausea, his abdomen was not distended, he was ambulating, and he was passing gas. A team from the NYPH urology department met with the patient on November 5, 2017, and reported that the patient had spiked an overnight body temperature of 38.4 degrees Celsius, which Dr. Albala characterized as a low-grade fever, but that the patient's temperature was a "normal" 37.1 degrees Celsius by the time that the urology team met with him. According to Dr. Albala, the plaintiff did not have any specific complaints at this time, his abdomen was only minimally distended, he was advanced to a regular diet, his previously administered patient-controlled analgesia was discontinued, and he was started on pills for the pain, which, as Dr. Albala characterized it, was an indication that his pain was improving. After his transfer to a "medical" floor at NYPH on November 6, 2017, the patient was discharged to his home on November 7, 2017.

On November 20, 2017, the plaintiff presented to NYPH's emergency department, complaining of purulent drainage from the operative incision, although he evinced normal body temperature, respiratory rate, and blood oxygenation levels. NYPH emergency personnel treated him for a wound dehiscence. Following a urology consultation with Vinson Wang, M.D., he was cleared for discharge, and instructed to follow up with a urologist. Chung then conferred with Dr. Wang, and the residents who examined the patient told Chung that the patient's wound was shallow, which, according to Dr. Albala, meant that the wound was open to the skin but not to any lower level. Two NYPH emergency medicine physicians determined that the patient did not require antibiotics, and could be discharged with homecare for daily dressing changes, upon which they instructed the patient to self-administer home care and follow up with Chung.

On November 25, 2017, the patient returned to the NYPH emergency department, complaining of foul-smelling urine emanating from the ileal conduit, as well as drainage from the inferior portion of the prior mid-line abdominal incision, along with a fever. According to the NYPH chart, he denied any nausea or vomiting. While in the emergency room, the patient's temperature spiked to 39.6 degrees Celsius, and he became hypotensive and tachycardic, with a heart rate of approximately 133 beats per minute. He was admitted and administered broad-spectrum antibiotics, including Zosyn and Vancomycin, as well as an intravenous fluid bolus to treat the hypotension. Emergency room personnel took blood and urine samples for testing and culturing, while an abdominal CT scan revealed an inflammatory process involving the ileal conduit within the right lower quadrant, resulting in bilateral pyelonephritis, severe bilateral hydronephrosis, and focal fluid adjacent to the ileal conduit, measuring 2.4 centimeters (cm) by 2.3 cm, which, according to Dr. Albala, may have reflected the presence of an abscess. The plaintiff was admitted to NYPH's surgical intensive care unit for management of urosepsis. On November 26, 2017, a member of the NYPH urology team examined the patient, and reported that an NYPH interventional radiologist had concluded that the abscess was not amenable to drainage. The patient's antibiotic regimen of Vancomycin and Zosyn was continued, and he again was administered a three-liter intravenous bolus to treat hypotension. On November 27, 2017, an NYPH urology resident examined the patient, and reported that he had been experiencing transient low-grade fevers since 6:00 p.m. on November 26, 2017, as well as a hypotensive event, which had since resolved after the administration of a two-liter lactated ring bolus and a phenylephrine drip. Chung reported that the likely source of the sepsis was a urinary tract infection in the setting of a capacious system with urinary stasis, after which the patient was transferred to the NYPH step-down unit.

On November 28, 2017, Chung again met with and examined the patient, and reported that the blood and urine cultures had grown resistant bacteria, upon which she ordered that the plaintiff's antibiotic be changed to ertapenem. According to Chung, the patient's wound was

granulating well. She ordered the patient to undergo a loopogram that day to investigate a potential leak from the ileal conduit. According to Dr. Albala, the results of that test revealed no evidence of extravasated contrast to suggest a leak, and no evidence of an obstruction. On November 29, 2017, physicians from NYPH's urology department again met with the patient, and reported no acute overnight events, and no fever. Chung again met with the patient, and ordered the placement of a peripherally inserted central catheter (PICC) for the administration of the ertapenem. NYPH discharged the patient on November 30, 2017, providing him with visiting nurse services for wound care and a PICC line for the continued administration of antibiotics.

On December 12, 2017, the patient once more presented to NYPH, complaining of chills and abdominal pain in the right lower quadrant of the abdomen. DeCastro met with the patient for a urology consultation. An abdominal and pelvic CT scan taken that day demonstrated the presence a small amount of free air and free fluid, with inflammatory changes localized around the enteric anastomosis in the right lower quadrant, which DeCastro characterized as suspicious for an anastomotic leak. Upon DeCastro's recommendation, the patient again was admitted to the NYPH urology department to undergo an exploratory laparotomy. On December 13, 2017, DeCastro, assisted by nonparty general surgeon Katherine Fischkoff, M.D., performed an exploratory laparotomy, lysis of adhesions, and an ileectomy, with end ileostomy, to treat an anastomotic leak. As Dr. Albala described it, during this procedure, the patient's ileal conduit was "taken down" and repaired, and an ileal anastomotic leak that had been draining fecal matter was identified. He stated that DeCastro "presumed" this leak to be the source of the infection. Dr. Fischkoff performed the diversion of the ileostomy, after which the patient was transferred to the intensive care unit, with a diagnosis of sepsis. NYPH continued to treat the patient with intravenous antibiotics, until he was discharged on January 1, 2018.

Dr. Albala explained that, inasmuch as DeCastro's participation in October 31, 2017 procedure was limited solely to the removal of the patient's bladder, and DeCastro did not take part in the resection of the small bowel or the creation of the ileal conduit, any allegation

stemming from the propriety of that resection or the creation of the conduit itself on October 31, 2017 could not be applied to DeCastro. In this respect, Dr. Albala opined that DeCastro not only could not be held responsible for any insufficiency of the conduit or the anastomosis, but he would not have had any opportunity to make an intraoperative diagnosis of an ileal anastomotic perforation. Moreover, since DeCastro did not treat the patient during the latter's November 20, 2017 and November 25, 2017 admissions to NYPH, Dr. Albala concluded that DeCastro could not be held liable for any alleged malpractice that occurred on those dates.

Dr. Albala asserted that, inasmuch as the patient presented with a neurogenic bladder, a robotic-assisted laparoscopic cystectomy was an indicated and necessary procedure in the patient's case. After describing the nature of a robotic-assisted laparoscopic cystectomy, and the details of how such a procedure is performed, Dr. Albala concluded that neither Chung nor DeCastro departed from the standards of care applicable to the surgical techniques that a physician must employ during that type of procedure. In this respect, he opined that

> "the urinary diversion, and creation of the ileal anastomosis was also at all times appropriate and performed within good and accepted standards of medical practice. First, after the initial small piece of bowel was resected, DR. CHUNG appropriately inspected the conduit prior to the placement of the anastomosis. DR. CHUNG ensured that the small bowel piece used for the conduit was intact and would provide adequate blood supply for tissue viability. DR. CHUNG's decision to irrigate and inspect the conduit prior to creating the anastomosis evinces careful and adequate surgical technique. When DR. CHUNG discovered that the mesentery was torn, and the bowel was no longer good due to the risk of tenuous blood supply, DR. CHUNG's decision to discard that piece of bowel and create a new conduit evinces careful consideration of this patient's anatomy. Only after creating the new conduit, lying it in the appropriate position, and evaluating the adequacy of the blood supply, DR. CHUNG moved on to creating her anastomosis. Additionally, when DR. CHUNG came across tears in the mesentery, they were appropriately oversewn to prevent leakage. For the reasons stated above, DR. CHUNG's resection of the small bowel and creation of the ileal conduit conformed with good and accepted surgical practice."

Dr. Albala explained in detail why the remainder of the urinary diversion procedure was performed within accepted surgical standards, since Chung employed appropriate surgical techniques, there were no intraoperative complications, and the patient was stable when brought to recovery. He further concluded that Chung did not depart from the standard of care

in then failing to diagnose an ileal anastomotic perforation, inasmuch as, once she had attached the ileal conduit to the patient's two ureters, she had noted that the conduit was irrigated and, upon inspection, no leak was seen at the ureteral anastomoses, and an inspection revealed no bleeding. Moreover, because Chung had discarded a piece of bowel tissue that had been resected, and upon observing that the mesentery was torn, she removed it from the patient's body and sent it for pathology analysis. He concluded that all of these actions established that, both before and after the creation of the ileal conduit, Chung appropriately inspected both the surgical area upon the completion of the anastomosis, and the piece of ileum itself prior to the creation of the anastomosis, and that there were no signs of any perforation at that time.

Dr. Albala further opined that the postoperative care and treatment rendered to the patient by the NYPH urology team, which included both Chung and DeCastro, were in accordance with good and accepted standards of medical practice. He asserted that, at no time from October 31, 2017 through November 7, 2017 did these physicians fail to diagnose an ileal anastomotic leak, since no such leak existed. As Dr. Albala explained it, after laparoscopic surgery, it is normal for a patient to have some residual abdominal distention, specifically where there is an ileus, which he described as a common postoperative event in which there is slow or absent gastrointestinal motility after a surgical procedure. He further asserted that it was not abnormal for patients who had recently undergone laparoscopic surgery to experience some residual distention, since, during a laparoscopic procedure, the abdomen is insufflated with air in a process known as pneumoperitoneum, which is effectuated in order to enable the surgeon to visualize the surgical field. Hence, Dr. Albala concluded that the standard of care did not require the defendants to order abdominal imaging during the patient's October 31, 2017 admission. In any event, he explained that, while the patient evinced mild distention shortly after his discharge from that admission, it was relieved by the insertion of a nasogastric tube.

Moreover, because there was no indication that the patient experienced any abdominal pain that deviated from normal postoperative discomfort, Dr. Albala concluded that there was no

clinical indication that the patient had any underlying abdominal pathology requiring a CT scan. He further asserted that the defendants satisfied the standard of care by placing a nasogastric tube for decompression that permitted them to ascertain whether the patient's symptoms of distention had resolved, which they did in the patient's case. Consequently, Dr. Albala concluded that the patient's postoperative abdominal distention was concerning for an ileal anastomotic perforation, but, instead, was a common postoperative event that resolved in fewer than four days. Nor did he believe that any of the patient's other symptoms, including one isolated, transient instance of a slightly elevated body temperature, and occasional tachycardia, were consistent with an anastomotic perforation during the October 31, 2017 procedure or immediately thereafter. Rather, Dr. Albala concluded that the patient's ostomy site was clear and appeared healthy, without any significant drainage or erythema, any signs or symptoms of an infection, or any serious postoperative complications. Hence, he opined that it was within the standard of care to discharge the patient from NYPH on November 7, 2017.

Dr. Albala further concluded that, in light of the patient's vital signs, the status of his surgical wound, the results of diagnostic tests, and the nature of his complaints, Chung acted within the standard of care on November 20, 2017, and did not commit malpractice by failing to diagnose an anastomotic perforation at that time, particularly in light of the fact that the patient was then hemodynamically stable. Rather, based on the appearance of the surgical site, Dr. Albala described the presence of superficial wound dehiscence, which he explained could lead to some increased drainage at the wound site, but that, in light of all of the patient's presenting conditions, the standard of care required conservative management only, consisting of a daily wound care protocol, but did not require the administration of antibiotics at that time. Moreover, he concluded that the standard of care did not require any abdominal imaging during this visit, since the patient made no significant abdominal complaints, including significant pain, nausea, or vomiting, while the physical examination revealed a soft and non-distended abdomen, with no signs of infection, but only minor leakage at the wound site.

With respect to the patient's treatment at NYPH between November 25, 2017 and November 30, 2017, Dr Albala concluded that it was at all times appropriate and within good and accepted standards of medical practice. Since, during that admission, the patient did, in fact, present with a fever, an elevated white blood cell count, and was hypotensive, Dr. Albala concluded that "the appropriate consideration of sepsis due to a possible urinary tract infection was made and treated." Moreover, he opined that, while NYPH physicians were awaiting the results of blood and urine cultures, they appropriately administered the broad-spectrum antibiotics Vancomycin and Zosyn to the patient to treat "an array of potential organisms," and that, when the results were reported, Chung appropriately switched the antibiotic to ertapenem to target the specific organism causing the infection. In this respect, Dr. Albala concluded that the diagnosis of a urinary tract infection/urosepsis was appropriate, given the results of the cultures and the patient's clinical presentation. He further asserted that NYPH healthcare personnel appropriately administered a loopogram on November 28, 2017 to rule in or out an anastomotic perforation as the cause of the patient's infection, and that, at that juncture, the results were negative for any leakage, specifically, there was no evidence of extravasated contrast to suggest a leak, and no evidence of an obstruction. Consequently, Dr. Albala concluded that the patient was not suffering from a postoperative anastomotic leak or perforation between November 25, 2017 and November 30, 2017, and that the defendants did not commit malpractice by failing to diagnose that condition at that time. As relevant to this opinion, Dr. Albala additionally concluded that the loopogram and CT scan that were performed during that admission were proper and sufficient, and that the standard of care did not obligate the defendants to order additional imaging studies. He explained that the collection of fluid that was observed on the imaging studies was not, in and of itself, an indication of a perforated anastomosis, that the loopogram actually confirmed that there was no leak from that conduit, and that, consequently the standard of care did not require surgery, which he characterized as "not indicated." Rather, Dr. Albala concluded that NYPH urologists acted appropriately by

involving an interventional radiologist to assist in the potential drainage of the fluid collection, and that they reasonably relied on the opinion of the interventional radiologist that the fluid collection was not amenable to drainage. In light the patient's hemodynamic stability after antibiotic administration, coupled with the loopogram findings, Dr. Albala opined that surgical intervention was not warranted during that hospital admission, and that the deferral of exploratory surgery was appropriate under the circumstances then existing, which Dr. Albala characterized as consistent with a resolving infection. Consequently, he concluded that the defendants satisfied the standard of care by continuing the antibiotic regimen at the patient's home upon his discharge to ensure adequate clearance of the infection.

Ultimately, Dr. Albala concluded that, when the patient again was admitted to NYPH December 12, 2017, new findings that were not observable or ascertainable from the diagnostic testing performed during the November 25, 2017 to November 30, 2017 admission did indeed warrant the diagnosis of sepsis due to an anastomotic leak, and that DeCastro and other NYPH physicians then made the proper diagnosis and appropriately treated the patient with surgery.

The defendants made the instant motion (MOT SEQ 001) on October 27, 2023 (*see* CPLR 2211), and fixed the initial return date of the motion for December 22, 2023. The return date of the motion was first adjourned at the plaintiffs' request until February 22, 2024, and then again until March 25, 2024. On March 19, 2024, and, thus, during the pendency of this motion, the plaintiffs' attorney moved for permission to be relieved as counsel (MOT SEQ 002), on the ground that he was unable to identify an expert physician who could rebut or refute Dr. Albala's opinions. The court scheduled oral argument on that motion for April 10, 2024. On that date, the court, on its own motion, then adjourned the return dates of both of the motions until July 19, 2024 to permit the plaintiffs to obtain new counsel and/or a physician who might be able to address Dr. Albala's opinions. In an order dated October 4, 2024, the court granted the motion of the plaintiffs' attorney, and permitted him to withdraw as their counsel. At the plaintiffs' request, the court adjourned the return date of the instant motion on two additional occasions,

until February 28, 2025. On March 20, 2025, the plaintiffs submitted their own joint affidavit in opposition to this motion, in which they wrote the following:

> "I need to postpone or extend my case for now, because I need Justice on my case.
>
> "I Moises Rodriguez and Ana Julia Cruz would like to ask if you could stop the Motion or Petition; Because the case is still not clear and it needs to be clarified as a patient it is know [sic] that he under went [sic] Medical Malpractice which paralyzed his entire life to the point that sometimes he wishe [sic] to be death [sic]; They really end my life.
>
> "I Ana J. Cruz as his wife and mother of his children, we have 30 year [sic] together.
>
> "In another note I have 15 years as a doctor in my country; my knowledge in the area of medicine I asure [sic] you that they did a Medical Malpractice during the procedure they did to my husband. As a doctor I feel so disappointed but as his wife and mother of his kids they change [sic] our life together due to after th[e] process he is not the same as husband and father."

On March 27, 2025, the defendants submitted an attorney's reply affirmation and memorandum of law, arguing that there was no basis for further adjournments of the motion, and that the plaintiffs simply failed to submit medical testimony in admissible form by a qualified physician to counter Dr. Albala's opinions.

The court, on its own motion, twice further adjourned the return date of the motion, with the final return date fixed for July 31, 2025, and additionally adjourned it administratively until October 13, 2025. During the entire course of motion practice, which entailed the very delay that the plaintiffs sought, they never submitted any additional affirmations from a qualified expert in opposition to the defendants' motion.

Although Cruz asserted that she was doctor in her own country, she did not specify in what area or specialty of medicine she practiced, or in which country she was licensed to practice. She did not state that she had any education, training, or experience in general surgery, urology, robotic laparoscopic procedures, or postoperative diagnoses and treatment. Nor did she specify precisely what the defendants did or did not do that departed from the standard of care applicable to urologists and surgeons in the New York metropolitan area, or

how or why such departures caused the anastomosis to leak, caused sepsis, or required the patient to undergo further surgery and procedures.

The determination of whether a witness is qualified to give expert testimony is entrusted to the sound discretion of the trial court, the provident exercise of which will not be disturbed absent a serious mistake or an error of law (*see Guzman v 4030 Bronx Blvd. Assoc., LLC*, 54 AD3d 42, 49 [1st Dept 2008]). Although courts repeatedly have rejected the concept that only a specialist practicing in a defendant's particular specialty is competent to testify that another specialist departed from accepted practice in the specialty (*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]), a practitioner who is put forward by a party as an expert qualified to support or oppose a summary judgment motion nonetheless must assert that he or she possesses the necessary knowledge and training in the relevant specialty, or explain how he or she came to it, and also must articulate the standard of care that allegedly was applicable (*see Colwin v Katz*, 122 AD3d 523, 524 [1st Dept 2014]).

> "To qualify as an expert, the witness should be possessed of the requisite skill, training, education, knowledge or experience from which it can be assumed that the opinion rendered is reliable. Thus, if a physician possesses the requisite knowledge and expertise to make a determination on the issue presented, he need not be a specialist in the field. The question of whether a physician may testify regarding the standard of accepted medical practice outside the scope of his specialty can be a troublesome one, but appellate courts have rejected claims of error directed at a physician's qualifications to offer an opinion outside the scope of his specialty when the witness's specialty is closely related to the specialty at issue"

(*Matter of Enu v Sobol*, 171 AD2d at 304 [citations omitted]). Thus,

> *"the affidavit must be by a qualified expert who 'profess[es] personal knowledge of the standard of care in the field of . . . medicine [at issue], whether acquired through his practice or studies or in some other way'* (*Nguyen v Dorce*, 125 AD3d 571, 572 [1st Dept 2015] [pathologist not qualified to render opinion as to whether defendant deviated from the standard of care in the field of emergency medicine]; *see also Atkins v Beth Abraham Health Servs.*, 133 AD3d 491 [1st

> Dept 2015] [osteopath not qualified to render opinion on treatment of a geriatric patient with diabetes and other conditions]; *Udoye v Westchester-Bronx OB/GYN, P.C.,* 126 AD3d 653 [1st Dept 2015] [pathologist not qualified to render an opinion as to the standard of care in obstetrics or cardiology]; *Mustello v Berg,* 44 AD3d 1018 [2d Dept 2007] [general surgeon not qualified to render opinion as to gastroenterological treatment])"

(*Bartolacci-Meir v Sassoon*, 149 AD3d at 572-573 [emphasis added]).

Consequently, since Cruz has not demonstrated her familiarity with, training in, or experience with any aspects of urology, general surgery, urological surgery, robotic-assisted laparoscopic cystectomies, postoperative care, the diagnostic and imaging tests required to monitor a patient such as her husband postoperatively, or the diagnosis of a failed anastomosis, let alone what constitutes the applicable standard of care in New York, she cannot be deemed to have the requisite experience, training, or knowledge necessary to render an opinion as to whether Chung or DeCastro departed from standards of good practice that proximately caused injury to the patient (*see Vargas v Bhalodkar,* 204 AD3d 556, 557 [1st Dept 2022] ["(p)laintiff's expert, an internist and gastroenterologist with no apparent training or knowledge in cardiology, did not set forth sufficient qualifications to opine on whether [defendant] deviated from the relevant standard of care when she gave cardiac clearance for decedent to temporarily cease taking blood thinners and undergo a colonoscopy"]; *Newell v City of New York*., 204 AD3d 574, 574 [1st Dept 2022] ["an internist who demonstrated no familiarity with surgery in general or abdominal surgery in particular, was not qualified to render an opinion that [defendant] departed from accepted standards of medical care in performing plaintiff's appendectomy"]; *Samer v Desai*, 179 AD3d 860, 862-863 [2d Dept 2020] [general and vascular surgeon not qualified to render opinion as to orthopedics or family medicine]; *Bartolacci-Meir v Sassoon*, 149 AD3d at 572 [1st Dept 2017] [general surgeon lacked any experience in gastroenterology sufficient to qualify him as an expert]; *Steinberg v Lenox Hill Hosp*., 148 AD3d 612, 613 [1st Dept 2017] [plaintiffs' expert was "not qualified to offer an opinion as to causation[,as h]e specializes in cardiovascular surgery, not neurology or ophthalmology [and] failed to 'profess the requisite

personal knowledge' necessary to make a determination on the issue of whether [an arterial] perforation was responsible for plaintiff's visual impairment"]).

The court concludes that there is no basis for further adjournments of, or delay in, determining this motion. It further concludes that the defendants established their prima facie entitlement to judgment as a matter of law by submitting the pleadings, the parties' deposition transcripts, and the affirmation of their expert, who explicitly explained how and why the defendants did not depart from the applicable standards of care, and that nothing that they did or did not do caused leakage of the patient's anastomosis and concomitant sepsis. Since the plaintiffs failed to oppose the motion with an affirmation or affidavit from a qualified medical professional, they have failed to raise triable issues of fact in opposition to the defendants' showing. The law does not require a health-care provider to guarantee a good result (*see Saliaris v D'Amelia*, 143 AD2d 996, 996 [2d Dept 1988]), and, although an outcome or result may truly be unfortunate, "'a bad result does not, ipso facto, support a claim for medical malpractice'" (*Saliaris v D'Amelia*, 143 AD2d at 996-997; quoting *Schoch v Dougherty*, 122 AD2d 467, 468 [3d Dept 1988]; *see Nestorowich v Ricotta,* 281 AD2d 870, 871 [4th Dept 2001], *affd* 97 NY2d 393 [2002]; *Bobek v Crystal*, 291 AD2d 521, 523 [2d Dept 2002]; *Nabozny v Cappelletti*, 267 AD2d 623, 628 [3d Dept 1999]; *Zito v Friedman*, 77 AD2d 514, 515 [1st Dept 1980] [jury must be instructed that a bad result by itself is not proof of malpractice]). Although the court sympathizes with the patient's ordeal, the facts that the anastomosis ultimately failed several months after the subject procedure, and that he was caused to experience sepsis and the need for further surgery, do not, in and of themselves, establish that the defendants committed medical malpractice. Moreover, Cruz's otherwise factually unsupported "assurance" that the defendants committed malpractice is insufficient to preclude the award of summary judgment to the defendants. Consequently, that branch of the defendants' motion seeking summary judgment dismissing the medical malpractice cause of action must be granted.

Claims for loss of consortium or loss of services must arise from tortious conduct (*see Odell v Dalrymple*, 156 AD2d 967, 967-968 [4th Dept 1989]), and are asserted to recover for injury to the relationship between the injured plaintiff and the plaintiff who seeks to recover for those losses (*see Buckley v National Freight*, 90 NY2d 210, 214-216 [1997]). As a general rule, only a spouse may recover for loss of consortium (*see id.*; *Powell v City of New York*, 6 Misc 3d 1033[A], 2005 NY Slip Op 50282[U], *2-4, n 4, 2005 NY Misc LEXIS, *5, n 4 388 [Sup Ct, N.Y. County, Mar. 1, 2005]), As a derivative claim, the loss of consortium cause of action asserted by Cruz, as the patient's wife, must also be summarily dismissed, inasmuch as the patient's medical malpractice claims are being summarily dismissed (*see Clarke v City of New York*, 82 AD3d 1143, 1144 [2d Dept 2011]; *Kaisman v Hernandez*, 61 AD3d 565, 566 [1st Dept 2009]).

Accordingly, it is,

ORDERED that the defendants' motion for summary judgment dismissing the complaint is granted, and the complaint is dismissed; and it is further,

ORDERED that the Clerk of the court shall enter judgment dismissing the complaint insofar as asserted against all of the defendants.

This constitutes the Decision and Order of the court.

10/9/2025
DATE

JOHN J. KELLEY, J.S.C.

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