SUPREME COURT OF THE STATE OF NEW YORK
NEW YORK COUNTY

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

Justice

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MEDHAT MICHAEL and ANGELA MICHAEL,

Plaintiffs,

- v -

PETER SCHLEGEL, M.D., and NEW YORK PRESBYTERIAN HOSPITAL,

Defendants.

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INDEX NO. 805388/2013

MOTION DATE 10/16/2025

MOTION SEQ. NO. 006

DECISION + ORDER ON MOTION

The following e-filed documents, listed by NYSCEF document number (Motion 006) 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 162, 163, 165, 166, 175, 176, 178, 179, 180

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

In this action to recover damages for medical malpractice based on alleged departures from good and accepted practice, lack of informed consent, and loss of spousal consortium, the defendants move for summary judgment dismissing the complaint. The plaintiffs do not oppose the motion. The motion is granted, and the complaint is dismissed.

The crux of the plaintiffs' claims is that the defendant urologist Peter Schlegel, M.D., while working for the defendant New York Presbyterian Hospital (NYPH), committed malpractice on June 14, 2011 when he improperly excised a testicle from the plaintiff Medhat Michael (the patient) instead of performing a microscopic extraction of sperm. In their complaint, the plaintiffs alleged that the defendants failed timely and properly to treat the patient's infertility. In this respect, they alleged that the defendants failed to obtain a proper history, failed to order or perform adequate and proper tests and examinations to determine the nature and extent of the patient's condition. They further alleged that the defendants failed to render the proper treatment to patient, and failed to take any effective and adequate measures or means to

prevent the patient from sustaining further harm or injury. More specifically, they averred that the defendants

> "wrongfully performing an excision of testis instead of a microscopic extraction of sperm by biopsy; improperly planned and administered treatments and surgeries to [patient], failed to properly follow up; [and] failed to take proper and reasonable precautions for the [patient's] safety and health."

They also claimed that the defendants failed properly to supervise and instruct personnel in the patient's diagnosis and treatment, failed to formulate a proper treatment plan, failed to "call upon physicians with adequate skill, experience and training to participate" in the patient's treatment, and failed properly to monitor and observe him. They also claimed that the defendants did not obtain the patient's fully informed consent to the procedure that was performed, since they failed to inform him of the risks and benefits thereof, and alternatives thereto.

In their bills of particulars, the plaintiffs reiterated many of the allegations that they articulated in their complaint and, more specifically, alleged that the defendants departed from good and accepted practice by failing properly to perform a testicular biopsy in accordance with the applicable standard of care, by removing an excessively large tissue sample during a biopsy procedure, by failing to perform a microsurgical or microdissection testicular sperm extraction (microTESE) procedure and instead performing a testicular excision, thus excising the entirety of one of the patient's testicles instead of performing a proper biopsy, and in failing to appreciate the risks, hazards, and dangers inherent in the procedure. They asserted that, as a result of these alleged departures from the standard of care, there was a delay in the injection of both the patient's and donors' spermatozoa into donor eggs, thus diminishing the opportunity for a successful fertilization. In addition, they alleged that the unwarranted testicular excision caused the loss of testosterone, the need for testosterone injections in perpetuity, impotence, fatigue, high blood pressure, diabetes, and the loss of a tooth secondary to intubation.

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]). 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]).

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, relevant medical and hospital records, the transcripts of the parties' and a nonparty witness's deposition testimony, a statement of allegedly undisputed material facts, the note of issue, an attorney's affirmation, and the expert affirmations of board-certified urologist Philip Werthman, M.D., and board-certified obstetrician/gynecologist (OB/GYN) and reproductive endocrinology and infertility medicine specialist Pinar Kodaman, M.D., Ph.D., both of whom opined that the 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 patient's injuries. The defendants also submitted an affirmation from embryologist Cihan Halicigil, Ph.D., who opined that all of the laboratory and embryology studies that were performed on behalf of the patient were performed in accordance with appropriate practice and did not cause or contribute to any of the patient's alleged injuries or damages.

Dr. Werthman explained that, prior to the treatment at issue, the patient, after unsuccessfully attempting to impregnate his wife, the plaintiff Angela Michael, for a period of more than two years, underwent an initial microTESE procedure with Schlegel in 2006. According to Dr. Werthman, the patient's prior medical and surgical history were significant for a congenital undescended left testis, hypogonadism, which is indicative of decreased testosterone production and sperm production, and a left orchiectomy, that is, the prior surgical removal of his left testicle. He noted that laboratory blood testing from October 2005 showed that the patient's testosterone level was 361 nanograms (ng) per deciliter (dL) of blood, with the accepted reference range set at 241 ng/dL to 827 ng/dL in adult males, but that his level of follicle stimulating hormone (FSH) was elevated, at 32.6 milli-international units (mIU) per milliliter (mL) of blood, with the normal range for adult males recognized as 1.6 mIU/mL to 8.0 mIU/mL. According to Dr. Werthman, elevated levels of FSH in men are indicative of abnormal sperm production or development of, and possibly primary, testicular failure. Dr. Werthman asserted that a 2005 sonogram of the patient's right testicle measured 3.9 centimeters (cm) by 1.2 cm by 2.5 cm. Based on these test results and this measurement, Dr. Werthman stated that Schlegel assessed the patient with non-obstructive azoospermia, that is, there were little-to-no sperm cells in his semen. He agreed with Schlegel that a microTESE procedure was an option for extracting at least some sperm cells from the patient's one testicle, and noted that the patient elected to undergo a right microTESE procedure with Schlegel on December 9, 2006.

As Dr. Werthman recounted it, spermatozoa were in fact identified in the dissected tubules and in the laboratory after that procedure, and eggs retrieved from the patient's wife were directly injected with the patient's sperm via intracytoplasmic sperm injection, which Dr. Werthman described as a form of in-vitro fertilization that had been developed for male factor infertility. He noted that, although pregnancy was achieved after the transfer and implantation of four embryos into Angela Michael's uterus, she suffered an early spontaneous miscarriage.

Dr. Werthman recounted that, in April 2010, the patient underwent a second microTESE procedure that was performed by urologist Larry I. Lipshultz, M.D., at Baylor St. Luke's Medical Center in Houston, Texas. According to Dr. Lipshultz's operative report, the patient's seminiferous tubules, which Dr. Werthman explained is where sperm cells are produced, were somewhat discolored and scarred, while microscopic visualization revealed the absence of sperm cells in those tubules. Dr. Werthman explained that additional samples from the upper pole of the patient's testis were sent to a laboratory for analysis, and, after an embryologist had searched the sample for several hours, one sperm cell apparently was found and employed in an attempt to fertilize a single mature egg, but fertilization was not successful.

As Dr. Werthman explained it, when the patient returned to see Schlegel on May 20, 2011, the patient was 52 years old, and his level of testosterone had significantly decreased to 156 ng/dL, despite being on the exogenous testosterone replacement therapy Arimidex and being administered 2,500 units of human gonadotrophin. He asserted that, according to the analysis of his ejaculated semen performed on May 20, 2011 by embryologist Gianpiero Palermo, M.D., no spermatozoa were found, but a "few germ cells" were seen, indicating that pre-sperm cells were present. Schlegel assessed the patient with suboptimal circulating testosterone levels, hypotesticular function, that is, the production of little-to-no testosterone, and progressive atrophy of the right testicle, as seen on a repeat scrotal sonogram. On that date, the patient's right testicle measured 3.6 cm by 1.1 cm by 1.5 cm, a decrease in size from 2005, upon which Schlegel advised the patient that he would require continuing testosterone replacement therapy. Based on Schlegel's chart, Dr. Werthman recounted that, on the morning of June 14, 2011, analysis of the patient's ejaculated semen found no sperm, after which the patient was admitted to NYPH, and, after a pre-anesthesia evaluation, was transferred to the operating room for a third microTESE procedure. The operative report indicated that anesthesia was started at 2:12 p.m. on June 14, 2011, and that the procedure began at 3:04 p.m., with a preoperative diagnosis of non-obstructive azoospermia. As Dr. Werthman interpreted the

operative report, following incision, the testis, epididymis, testicular blood supply, and vas deferens each were identified and preserved, while, under an operating microscope, Schlegel noted moderate adhesions between the tunica vaginalis and tunica albuginea. Schlegel made an equatorial wide incision in the tunica albuginea for examination of the seminiferous tubules under the microscope, which revealed that the tubules were encased in extensive scarring, which had replaced three quarters of the testicular parenchyma. Dr. Werthman explained that, to reach the seminiferous tubules intraoperatively, a sharp resection of the testicular scar tissue was necessary and, hence, Schlegel performed a microdissection of the superior and inferior poles of the testis, and reported that "very rare, definitively enlarged tubules were seen and dissected free with great difficulty from the sclerotic tissues enveloping most of the testis." At that juncture, using a phase-contrast microscope, Schlegel extracted tissue samples from the testis, examined them in the operating room, and concluded that no spermatozoa were present, while only some pre-sperm cells, that is, germ cells, were observed in solution. Dr. Werthman stated that, following a thorough examination, Schlegel closed the testis and placed the anesthetic Marcaine into the scrotum. He asserted that the operating time was two hours.

Dr. Werthman asserted that, after the procedure, the tissue samples obtained from the seminiferous tubules were transferred to the laboratory to permit embryologists to search for sperm, and that Schlegel was not involved in this phase of the patient's treatment. Dr. Werthman noted that separate tissue samples were sent to the pathology department, consisting of three pieces of soft tissue measuring 1.0 cm by 0.5 cm by 0.5 cm to 1.2 cm by 1.0 cm by 0.5 cm. The reported diagnosis was "few residual tubules with spermatogenic arrest at primary spermatocyte stage; and few Sertoli-only tubules. Scar of testis 0.7 cm with adjacent total tubular sclerosis [and] mild Leydig cell hyperplasia." According to Dr. Werthman, the patient tolerated the procedure well, was transferred to the post-anesthesia care unit in stable condition, and was discharged to his home later that day.

Dr. Werthman asserted that, on June 14, 2011, 22 eggs retrieved from the patient's wife had been fertilized with sperm both from the patient and other sperm donors, and that 18 of the 22 embryos created thereby evinced two distinct pronuclei and polar bodies, indicative of successful fertilization, including one of the embryos that had been fertilized with the patient's sperm. He averred that, when the patient returned to see Schlegel for a postoperative follow-up visit on June 17, 2011, the patient "confirmed" that he was healing well and had no complaints.

Dr. Werthman opined that any claim that the patient suffered from an improperly functioning testicle as a consequence of Schlegel's 2011 treatment "is undermined by evidence that his right, and only remaining, testicle was already small and not functioning properly long before he returned to see Dr. Schlegel in 2011." He reiterated that the patient had a preexisting history of hypogonadism, low testosterone, and low sperm count going back to 2005 and 2006, and that the patient's fertility was inherently compromised by his decreased testicular volume, which Dr. Werthman characterized as a byproduct of a congenital undescended testis, with respect to which the patient had undergone a left orchidectomy as a teenager, leaving him with only one testicle. Dr. Werthman further asserted that, in addition, the patient's right testicle was dysfunctional and unable to naturally produce sufficient testosterone, with his November 2010 testosterone levels "extremely low" at 90 ng/dL, and his FSH "very elevated" at 42 mIU/mL. He stated that, although these levels improved to 188 ng/dL and 46.3 mIU/mL, respectively, in March 2011, this was after the patient began a regimen of Arimidex and had been administered human gonadotrophin, which, in itself, was evidence of the patient's inability to produce testosterone on his own. Dr. Werthman concluded that it was because of the patient's testicular dysfunction in his remaining testicle that he had undergone the two prior microTESE procedures in the first instance. Thus, Dr. Werthman opined that there was no merit to the patient's claims that Schlegel's treatment caused him to suffer from a loss of testosterone and the resultant need for testosterone injections in perpetuity.

In addition, Dr. Werthman, based on the patient's history, including the results of the two prior microTESE procedures, and the presence of some germ cells in his semen on May 20, 2011, opined that the microTESE procedure that Schlegel performed on June 14, 2011 was appropriate, and that the patient was a suitable candidate for a third microTESE procedure. After explaining how a microTESE procedure is performed, he characterized it as the optimal method by which sperm can be surgically extracted from men who may have sperm-production issues or a low sperm count, and the optimal method for limiting scarring to the testicle. In this respect, he compared it unfavorably to standard TESE procedure, which he described as a testicular biopsy performed with the same objective in mind, but without magnification and microdissection technique.

Dr. Werthman concluded that Schlegel's work-up and evaluation ahead of the June 14, 2011 procedure, which included a thorough physical examination, a semen analysis, and preoperative laboratory and blood testing, were "well within the standard of care." Based on the patient's testosterone levels, and the decrease in testicular volume over a seven-year period, Dr. Werthman opined that Schlegel correctly assessed the patient with suboptimal circulating testosterone levels, hypotesticular function, and progressive atrophy, which, according to Dr. Werthman, reflected the patient's baseline testicular dysfunction and the likely accumulation of scar tissue in the testis after each subsequent microTESE procedure. He asserted that this history was significant, since scar tissue decreases the production of sperm and testosterone, and that the decrease in the size of the patient's right testicle, as observed on the May 20, 2011 sonogram, was an "inevitable result of his undergoing two prior testicular biopsies."

Based on his review of both the pathology and operative reports, Dr. Wertham expressly rejected the plaintiffs' contention that Schlegel performed a testicular excision. Rather, he asserted that Schlegel performed a proper testicular biopsy for sperm retrieval, while the greater portion of resected tissue was scar tissue, which was entirely proper to resect. Specifically, he asserted that, during the procedure, Schlegel encountered extensive scar tissue, which

extended the duration of the procedure, but that Schlegel carefully and properly resected to reach the seminiferous tubules before performing microdissection on the poles of the testis. He thus rejected any contention that the procedure could have been performed more quickly. Dr. Werthman explained that the objective of the procedure was to retrieve sperm for egg fertilization, "which the procedure succeeded in doing." He thus opined that,

> "[c]ontrary to the baseless allegation that Dr. Schlegel excised Mr. Michael's testicle, the pathology report confirms that of the specimen obtained, which measured 1.0 x 0.5 x 0.5 cm to 1.2 x 1.0 x 0.5 cm, scar tissue made up the majority, as much as 0.7 cm. Moreover, the fact that embryologists examining the biopsy samples intraoperatively with phase contrast microscopes were unable to find any spermatozoa and only some germ cells in solution is further evidence of just how difficult it was to find sperm. I will otherwise defer to an expert in embryology as to the timing of I[ntra] C[ytoplasmic] S[perm] I[njection] and the conduct of the involved embryologists and laboratory staff."

Dr. Werthman explained that, after the completion of the procedure and the provision of tissue samples to the embryology and laboratory staff, Schlegel played no role in the timing and process of the sperm injection, but limited his involvement to one postoperative visit, which he characterized as "uneventful." He noted that, in any event, after 2 embryos were transferred to Angela Michael's uterus, 10 of the 16 remaining embryos reached the blastocyst stage, meaning that the inner cell mass actually had formed, which he described as evidence of "timely and successful fertilization."

To the extent that the patient claimed to have developed high blood pressure as a result of the June 14, 2011 procedure, Dr. Werthman expressly disputed the claim, since there was no support for the claim, which he described "outlandish," since the patient had a family history of cardiac disease, and there is no physiological mechanism by which a testicular biopsy causes elevated blood pressure.

In her affirmation, Dr. Kodaman described in detail the techniques employed in performing an intracytoplasmic sperm injection procedure. She asserted that Isaac Kligman, M.D., an NYPH OB/GYN and reproductive endocrinology and infertility medicine specialist, appropriately examined and treated then 42-year-old Angela Michael during April and May

2011, and that, in this respect, the plaintiffs determined not to retrieve any oocytes, or eggs, from Angela Michael, but to proceed with the in vitro fertilization of donor oocytes with both the patient's sperm and donor sperm. She opined that, contrary to the plaintiffs' contention, the donor oocytes were not retrieved too far in advance of the injection of the patient's or donors' sperm, explaining that the timing of egg retrieval is not determined by when sperm might be retrieved and ready for injection, but by when the egg donor's follicles are of an optimal size following medical stimulation. Dr. Kodaman averred that, after administration of a hormonal trigger injection, retrieval of eggs is properly performed approximately 34 to 36 hours later, which ensures that the eggs are retrieved prior to ovulation, during which a woman naturally releases eggs. She explained that, in the plaintiffs' case, 22 eggs were safely retrieved from the donor prior to ovulation at 8:45 a.m. on June 14, 2011, the same date as the patient's microTESE procedure, and that the timing of donor egg retrieval thus was proper.

Dr. Kodaman further opined that the donor eggs were properly incubated for approximately four hours prior to denudation at 1:05 p.m. on June 14, 2011, and that the eggs thereafter were safely and properly stored in an incubator, in a Petri dish filled with contents of standard fertilization medium, during which time the eggs achieved a 100% maturation rate. Specifically, she asserted that, although 20 eggs were assessed as mature and 2 were assessed as immature after 1:05 p.m., over the next several hours, the 2 immature eggs were able to mature and were, therefore, useable in intracytoplasmic sperm injection. Dr. Kodaman asserted that, without this additional period of incubation after denudation, which she opined did not constitute an improper delay, only 20 of the 22 eggs would have been injected but, instead, all 22 were injected.

Dr. Kodaman reiterated the relevant timeline of events for June 14, 2011, as described by Dr. Werthman, and explained that, immediately after the professionals from NYPH's embryology and andrology laboratories found the first sperm cell in the patient's tissue sample at 7:35 p.m. on June 14, 2011, a donor egg was promptly injected, and that as soon as they

found a second sperm cell at 8:12 p.m. on that date, that cell was injected into another egg. Dr. Kodaman expressly opined that this timing was entirely appropriate, and did not diminish the plaintiffs' chances for successful fertilization. In this respect, she noted that there was not a consensus in the field of reproductive medicine as to the optimal time to inject eggs for intracytoplasmic sperm injection, but that peer-reviewed medical literature had reported that the outcomes in the injection of donor eggs would not be compromised where sperm is injected four to seven hours after denudation, and that there was no evidence that proper embryo development would be compromised by adhering to that timeline. Hence, she specifically concluded that embryo fertilization and development was not compromised by the timing of the injections here, that is, four hours after denudation with respect to donor sperm and six to seven hours after denudation in connection with the patient's sperm.

Dr. Kodaman also noted that, inasmuch as the microTESE procedure was taking an extended amount of time, with no viable sperm from the patient observed under the microscope intraoperatively, the embryologists and andrologists "were quick to act and to thaw frozen donor sperm," the use of which already had been approved by the plaintiffs. Thus, Dr. Kodaman asserted that, between 4:41 p.m. and 4:45 p.m. on June 14, 2011, while the microTESE procedure was ongoing, embryologists and andrologists "properly injected 20 of the 22 donor eggs with donor sperm." She noted that, of those 20 injections, 17 developed two distinct pronuclei and polar bodies "indicative of successful fertilization," yielding a fertilization rate of 85%, which she characterized as "unambiguous evidence of proper and timely injection given that the minimal acceptable standard nationally is a fertilization rate of 70%." She reiterated that the patient's own two sperm cells were promptly injected into two donor eggs at 7:35 p.m. and 8:12 p.m., concluding that these injections could not have been effectuated sooner due to the difficulties in locating and extracting those two cells. In any event, Dr. Kodaman repeated Dr. Werthman's assertion that one of the two donor eggs fertilized with the patient's own sperm developed two distinct pronuclei and polar bodies, establishing successful fertilization.

Dr. Kodaman further concluded that it was entirely appropriate to perform the transfer of two embryos, including one fertilized with the patient's sperm, to Angela Michael's uterus on June 17, 2011, particularly in light of how the embryo fertilized with the patient's sperm had developed to eight cells. Dr. Kodaman nonetheless explained that the transfer of embryos, whether on day 3 or day 5 after injection, even with perfect morphologic grading, does not guarantee successful implantation and subsequent live birth, since there are many factors that influence whether or not embryos implant, including the genetic health and potential of the embryo, synchronization of the embryo and the endometrium, endometrial thickness, and other uterine factors, such as fibroids, which may decrease chances of implantation or predispose the gestational carrier to miscarriage. In this respect, she suggested that it was possible that implantation chances were diminished by Angela Michael's fibroid uterus or the quality of the patient's sperm. She further noted that, , according to the 2020 Society for Assisted Reproductive Technology database, the national implantation rate with respect to the transfer of fresh donor egg-derived embryos was 57.1%. Dr. Kodaman concluded that, while pregnancy did not result in the plaintiffs' case, that outcome was not because of any issues with the manner and timing in which the donor eggs were retrieved or injected with sperm. Moreover, she asserted that 10 embryos had reached the blastocyst stage by June 20, 2011, indicating that these embryos had reached a milestone in development that was crucial for implantation. Dr. Kodaman explained that, if any NYPH healthcare employee committed negligence in the extraction of sperm, the thawing of donor sperm or eggs, the injection of sperm into eggs, or the storage of the resulting embryos, "then blastocyst formation would have been compromised," while, in the plaintiffs' case, 18 embryos were successfully created, including 2 that were transferred to Angela Michael's uterus and 10 that reached blastocyst stage, thus defeating the plaintiffs' claims of malpractice.

In his affirmation, Dr. Halicigil essentially reiterated the facts and opinions set forth in Dr. Kodaman's affirmation, except from an embryologist's perspective, and concluded that no

NYPH healthcare employee committed malpractice or was negligent in the timing and techniques referable to extraction of sperm, the thawing of donor sperm and eggs, the injection of sperm into eggs, or the storage of the resulting embryos.

The plaintiffs did not submit formal opposition to the instant motion. The court notes that the defendants made this motion on February 20, 2024 (*see* CPLR 2211), and designated the initial return date as May 1, 2024. At the plaintiffs' request, the court adjourned the return date until June 28, 2024. Instead of submitting opposition to the motion, on June 26, 2024, the law firm representing the plaintiffs at that time moved for leave to withdraw as counsel (MOT SEQ 007) (*see* CPLR 2211). The court scheduled oral argument on that motion for July 18, 2024, and adjourned the return date of the instant motion until July 19, 2024. On July 18, 2024, the plaintiffs' attorney appeared before the court with the plaintiffs, and explained to the court that he could not locate an expert or experts who could refute or rebut the opinions rendered by the defendants' experts, or who could render an opinion that the defendants departed from good practice, thus causing the patient's alleged injuries. In an order dated August 6, 2024, the court denied the law firm's motion for leave to withdraw as counsel to give both the firm and the plaintiffs an opportunity to identify prospective experts who could render opinions in support of the plaintiffs' claims. In that order, the court adjourned the return date of the summary judgment motion until October 21, 2024, directed the plaintiffs to serve opposition papers on or before October 10, 2024, and directed the defendants to serve reply papers, if any, on or before October 18, 2024.

At the plaintiffs' request, the court again adjourned the return date of the instant motion until December 20, 2024. Rather than submitting opposition papers, the law firm representing the plaintiffs again moved, on or about December 10, 2024, for leave to withdraw as counsel (MOT SEQ 008), again on the ground that, despite diligent efforts, and discussions with additional physicians and potential experts, it could not retain an expert to render an opinion in support of the plaintiffs' claims. The court initially scheduled the return date of that motion for

January 3, 2025, and also adjourned this motion to that date as well. At the plaintiffs' request, the court adjourned both of those motions, first to January 7, 2025, and then until January 21, 2025. In an order dated January 22, 2025, the court granted the law firm's second motion for leave to withdraw from representation of the plaintiffs, stayed the action until March 7, 2025, and adjourned the return date of this summary judgment motion until March 7, 2025 as well. At the plaintiffs' request, the court adjourned the return date of this motion until April 14, 2025. On April 4, 2025, the patient submitted email correspondence to the court, explaining that

> "[a]n expert witness has indeed confirmed to us that he has no conflict and is willing to study and file a report concerning my case, but he needs some time to prepare the report.
>
> "Please be advised that I although I currently am pro se in this case, I have hired an attorney for the limited purpose of communicating with this expert witness in order to produce the report."

He thus requested yet another adjournment of the return date of the motion. Over the defendants' objection, the court again adjourned the return date, this time until June 6, 2025. On the court's own motion, the return date of the motion was administratively adjourned until October 16, 2025. Despite adjourning the return date of this motion for more almost 18 months, the plaintiffs have not submitted any opposition to the motion.

The court concludes that, with respect to the medical malpractice cause of action, the defendants established their prima facie entitlement to judgment as a matter of law with their submissions, including their expert affirmations. Since the plaintiffs did not submit opposition to the motion, they have failed to raise a triable issue of fact in connection with that branch of the defendants' motion, and summary judgment must be awarded to the defendants dismissing the medical malpractice cause of action insofar as asserted against both of them.

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 its burden of demonstrating its 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 propriety 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]).

In their bills of particulars, the plaintiffs alleged that the defendants failed to impart necessary information to the patient concerning the microTESE procedure, failed to obtain his fully informed consent to a testicular excision, failed to warm him of the possibility that the microTESE procedure might be converted into a testicular excision, and failed to advise him of the consequences thereof.

In his affirmation, Dr. Werthman opined that the defendants did not, in fact, perform a testicular excision, and that they obtained the patient's fully informed consent to the microTESE procedure that they did perform by discussing with the patient all risks associated with that third microTESE procedure, including the general risks of bleeding, infection, decreased testosterone levels, and the need for testosterone replacement therapy, which the patient already was receiving, as well as increased scar tissue, and how scarring affects testicular function. Dr. Werthman further explained that the patient executed an informed consent document for the repeat microTESE procedure, and further consented to the use of donor sperm, with the caveat that he wished for only six donor sperm cells to be employed, and for the remaining eggs to be fertilized with his own sperm. According to Dr. Werthman, Schlegel completed a perioperative medical questionnaire, ordered preoperative testing, including a complete blood count, and provided written postoperative instructions. He concluded that the claim alleging lack of informed consent was untenable, given the patient's prior surgical and medical history, the parties' deposition testimony, and documentation in the medical records establishing that there was a thorough discussion of the risks and alternatives to the elective procedure. Dr. Werthman further asserted that Schlegel expressly informed the patient that, despite the performance of the third microTESE procedure, it was possible that medical professionals would "not obtain[ ] any sperm that could be used for fertility purposes." He asserted that, even after being properly advised of, and acknowledging these risks, the patient elected to proceed. He further noted

that, prior to the procedure, both of the plaintiffs properly executed consent forms allowing the defendants to employ donor eggs and donor sperm.

The defendants established their prima facie entitlement to judgment as a matter of law in connection with the lack of informed consent cause of action. Inasmuch as the plaintiffs did not oppose the motion, they failed to raise a triable issue of fact in opposition to the defendants' showing in this regard and, hence, summary judgment must be awarded to the defendants dismissing that cause of action.

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 Angela Michael, as the patient's wife, must also be summarily dismissed, inasmuch as the patient's 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]).

The court notes that, although CPLR 2106 was amended, effective January 1, 2024, to authorize the use of an affirmation in lieu of an affidavit by "*any person* wherever made," as long as the statement set forth therein had been "affirmed by that person to be true under the penalties of perjury" (L 2023, ch 559) (emphasis added), that statute did not repeal the requirement, set forth in CPLR 2309, that an

> "*affirmation* taken without the state shall be treated as taken within the state if it is accompanied by such certificate or certificates as would be required to entitle a deed acknowledged without the state to be recorded within the state if such deed had been acknowledged before the officer who administered the . . . *affirmation*."

(emphasis added). Although Dr. Werthman's affirmation was executed in California, and Dr. Kodaman's and Dr. Halicigil's affirmations were executed in Connecticut, none of these affirmations was accompanied by the certificate of conformity required by CPLR 2309. The certificate of conformity required by that statute is a written instrument, pursuant to which a person qualified by the laws of the state in which an affidavit or affirmation is executed and notarized, or by the laws of New York, certifies that the out-of-state affidavit or affirmation has indeed been drafted, executed, or notarized in conformity with the laws of that state. The absence of the certificate of conformity, however, does not require the court to disregard the defendants' expert affirmations, as the failure to include a certificate of conformity is a mere irregularity that may be cured by the submission of the proper certificate nunc pro tunc (*see Khurdayan v Kassir*, 223 AD3d 590, 591 [1st Dept 2024]; *Parra v Cardenas,* 183 AD3d 462, 463 [1st Dept 2020]; *Bank of New York v Singh*, 139 AD3d 486, 487 [1st Dept 2016]; *DaSilva v KS Realty, L.P.,* 138 AD3d 619, 620 [1st Dept 2016]; *Diggs v Karen Manor Assoc., LLC*, 117 AD3d 401, 402-403 [1st Dept 2014]; *Matapos Tech., Ltd. v Compania Andina de Comercio Ltda.*, 68 AD3d 672, 673 [1st Dept 2009]). The court thus directs the defendants to serve and file the necessary certificates of conformity on or before November 28, 2025.

In light of the foregoing, it is,

ORDERED that the defendants' motion for summary judgment dismissing the complaint is granted, without opposition, and the complaint is dismissed; and it is further,

ORDERED that the Clerk of the court shall enter judgment dismissing the complaint.

This constitutes the Decision and Order of the court.

10/16/2025
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**