SUPREME COURT OF THE STATE OF NEW YORK
NEW YORK COUNTY

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

Justice

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MICHELLE RAJACIC,

Plaintiff,

- v -

STATEN ISLAND UNIVERSITY HOSPITAL and ASAF ASI GAVE, M.D.,

Defendants.

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INDEX NO. 805056/2021

MOTION DATE 10/14/2025

MOTION SEQ. NO. 002

DECISION + ORDER ON MOTION

The following e-filed documents, listed by NYSCEF document number (Motion 002) 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95

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 negligent hiring, training, supervision, retention, and credentialing of healthcare personnel, the defendants move pursuant to CPLR 3212 for summary judgment dismissing the complaint. The plaintiff opposes the motion. The motion is granted only to the extent that the defendants are awarded summary judgment dismissing the cause of action alleging negligent hiring, training, supervision, retention, and credentialing of healthcare personnel, and so much of the medical malpractice cause of action as was premised upon allegations that (a) the defendant critical care surgeon Asaf Asi Gave, M.D., negligently performed a Hartmann's procedure upon the plaintiff on May 23, 2018, and (b) the defendants negligently failed to refer the plaintiff for consultations with other specialists. The motion is otherwise denied.

The crux of the plaintiff's claim is that, on May 23, 2018 and August 25, 2018, Gave, while working for the defendant Staten Island University Hospital (SIUH), negligently performed abdominal surgery upon her by failing properly to close all of her abdominal/intestinal structures,

leading to a failed anastomosis which, in turn, caused her to develop abscesses and become infected, thus requiring additional treatments, including surgeries. In her complaint, the plaintiff asserted that, from approximately May 2018 through September 2018, she was under the defendants' continuous care. She asserted that, on both May 23, 2018 and August 25, 2018, Gave performed abdominal surgery upon her at SIUH, and that, during the course of the latter surgery, Gave "damaged and/or failed to properly close" her "abdominal/intestinal structures," resulting in the leakage of stool and other purulent matter into her abdomen which, in turn, caused her to develop abscesses and infections. The plaintiff further contended that she was prematurely discharged from SIUH on August 27, 2018, without being properly diagnosed as to the cause of her abdominal pain. As she described it, she presented to the emergency department at Lenox Hill Hospital (LHH) on September 3, 2018, where a computed tomography (CT) scan revealed that she was suffering from an anastomotic leak with abscess formation, upon which LHH surgeons performed emergency surgery to repair the defective anastomosis.

The complaint also particularized the plaintiff's allegations of malpractice against the defendants, as she asserted that they departed from good and accepted practice by failing to heed the nature of her condition, failing to diagnose and properly treat her condition, and failing to perform a proper work-up to assess her condition, in that they failed to order diagnostic tests necessary properly to diagnose her condition, and failed promptly and correctly to interpret the results of the diagnostic tests that they did perform. She further asserted that the defendants performed contraindicated procedures, since they took "an overly aggressive surgical approach to treating" her, "when a more conservative treatment plan could have been successfully employed." She contended that the defendants improperly performed the procedures that they in fact performed by failing to employ proper surgical technique and by failing to locate and protect important abdominal structures. Moreover, the plaintiff alleged that the defendants failed properly and timely to diagnose and treat her postoperative conditions by failing properly to perform appropriate diagnostic tests and procedures that would have detected leakage from the

anastomosis, and would have prevented the leakage from progressing to the point that she required extensive surgery to correct it, as well as by failing properly to administer antibiotics, including intravenous antibiotics.

The complaint reiterated that the defendants prematurely discharged the plaintiff from SIUH after her August 2018 surgery despite damage to her abdominal structures, and alleged that they failed to perform a computed tomography (CT) scan prior to that discharge, while also failing to provide her with necessary preoperative and postoperative medical monitoring, care, treatment, and proper instructions upon discharge. She further faulted the defendants for failing to maintain appropriate medical records, and to record all physical and medical findings in a proper fashion. In addition, the plaintiff asserted that the defendants were negligent in failing to promulgate appropriate standards for the discharge of patients, and in failing to follow the standards it actually had in place to determine when to discharge patients. She also contended that the defendant failed to order appropriate consultations with specialists. The plaintiff also asserted that the defendant failed properly to supervise hospital employees so that they could adequately monitor her condition, including failures properly to review her chart, to communicate important findings in a timely manner, and to record important findings in a timely manner, thus preventing them from detecting her abdominal leakage.

In her bill of particulars, the plaintiff essentially reiterated the specific allegations of malpractice that she articulated in her complaint, adding that the defendants did not properly formulate a differential diagnosis to assess the etiology of her postoperative pain. She averred that, as a consequence of the defendants' tortious conduct, she sustained an anastomotic leak with hemorrhagic ascites. She further asserted that, on September 5, 2018, and as a direct result of that condition, she was caused to undergo a reversal of colostomy and mobilization of splenic flexure that she had undergone on August 23, 2018, which included an exploratory laparotomy, drainage of intraabdominal collection of fluids, a takedown and resection of the existing colorectal anastomosis, and creation of a colostomy. The plaintiff further asserted that,

as a proximate result of the defective anastomosis that the defendants purportedly created and ignored, she also had to undergo a closure of ileostomy and small bowel resection on July 11, 2019, and an incisional hernia requiring surgery on April 26, 2021. She alleged that she also suffered from abdominal swelling, cramping, and pain, bloody stools, dizziness, severe disfigurement to her abdomen, and mental and emotional distress.

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,* 44 NY3d 57, 62-63 [2025]; *Vega v Restani Constr. Corp*., 18 NY3d 499, 503 [2012]). In other words, "[i]n determining whether summary judgment is appropriate, the motion court should draw all reasonable inferences in favor of the nonmoving party and should not pass on issues of credibility" (*Garcia v J.C. Duggan, Inc.*, 180 AD2d 579, 580 [1st Dept 1992]; *see Haymon v Pettit*, 9 NY3d 324, 327 n [2007]). Once the movant meets that burden, it is incumbent upon the non-moving party to establish the existence of material issues of fact (*see Vega v Restani Constr. Corp*., 18 NY3d at 503). A movant's failure to make a prima facie showing requires denial of the motion, regardless of the sufficiency of the opposing papers (*see id.; Medina v Fischer Mills Condo Assn*., 181 AD3d 448, 449 [1st Dept 2020]).

"The drastic remedy of summary judgment, which deprives a party of his [or her] day in court, should not be granted where there is any doubt as to the existence of triable issues or the issue is even 'arguable'" (*De Paris v Women's Natl. Republican Club, Inc.,* 148 AD3d 401, 403-404 [1st Dept 2017]; *see Bronx-Lebanon Hosp. Ctr. v Mount Eden Ctr*., 161 AD2d 480, 480 [1st Dept 1990]). Thus, a moving defendant does not meet the burden of affirmatively establishing

entitlement to judgment as a matter of law merely by pointing to gaps in the plaintiff's case, but must affirmatively demonstrate the merit of his or her defense (*see Koulermos v A.O. Smith Water Prods*., 137 AD3d 575, 576 [1st Dept 2016]; *Katz v United Synagogue of Conservative Judaism*, 135 AD3d 458, 462 [1st Dept 2016]).

"To sustain a cause of action for medical malpractice, a plaintiff must prove two essential elements: (1) a deviation or departure from accepted practice, and (2) evidence that such departure was a proximate cause of plaintiff's injury" (*Frye v Montefiore Med. Ctr*., 70 AD3d 15, 24 [1st Dept 2009]; *see Foster-Sturrup v Long,* 95 AD3d 726, 727 [1st Dept 2012]; *Roques v Noble*, 73 AD3d 204, 206 [1st Dept 2010]; *Elias v Bash*, 54 AD3d 354, 357 [2d Dept 2008]; *DeFilippo v New York Downtown Hosp*., 10 AD3d 521, 522 [1st Dept 2004]). Such a cause of action may be premised upon a claim that those departures allowed a patient's condition to worsen, and thus deprived him or her of an opportunity for a cure or a better outcome (*see Mortensen v Memorial Hosp.*, 105 AD2d 151, 156, 159 [1st Dept 1984]; *Kallenberg v Beth Israel Hosp.*, 45 AD2d 177, 178 [1st Dept 1974], *affd no op.* 37 NY2d 719 [1975]). Moreover, where a physician fails properly to diagnose a patient's condition, thus providing less than optimal treatment or delaying appropriate treatment, and the insufficiency of or delay in treatment proximately causes injury, he or she will be deemed to have departed from good and accepted medical practice (*see Perez v Fitzgerald,* 115 AD3d 177, 178 [1st Dept 2014]; *Perlin v King*, 36 AD3d 495, 495 [1st Dept 2007]; *see generally Zabary v North Shore Hosp. in Plainview,* 190 AD3d 790, 795 [2d Dept 2021]; *Lewis v Rutkovsky*, 153 AD3d 450, 451 [1st Dept 2017]; *Monzon v Chiaramonte*, 140 AD3d 1126, 1128 [2d Dept 2016] ["(c)ases . . . which allege medical malpractice for failure to diagnose a condition . . . pertain to the level or standard of care expected of a physician in the community"]; *O'Sullivan v Presbyterian Hosp. at Columbia Presbyterian Med. Ctr.*, 217 AD2d 98, 101 [1st Dept 1995]).

Even where an adverse outcome is a known risk of a surgical procedure, a plaintiff may raise a triable issue of fact as to whether a physician committed malpractice by showing that the

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

To make a prima facie showing of entitlement to judgment as a matter of law, a defendant physician moving for summary judgment must establish the absence of a triable issue of fact as to his or her alleged departure from accepted standards of medical practice (*Alvarez v Prospect Hosp*., 68 NY2d 320, 324 [1986]; *Barry v Lee*, 180 AD3d 103, 107 [1st Dept 2019]; *Frye v Montefiore Med. Ctr*., 70 AD3d at 24) or establish that the plaintiff was not injured by such treatment (*see Pullman v Silverman,* 28 NY3d 1060, 1063 [2016]; *see generally Kristie M. v. Mercy Hosp. of Buffalo,* 240 AD3d 1228 [4th Dept 2025]; *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]; *Jones v Ricciardelli*, 40 AD3d 935, 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 Pullman v Silverman,* 125 AD3d 562, 562 [1st Dept 2015], *revd other grounds* 28 NY3d 1060 [2016]; *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).

In support of their motion, the defendants submitted the pleadings, the plaintiff's bill of particulars, transcripts of party and nonparty deposition testimony, relevant medical and hospital records, the note of issue, an attorney's affirmation, a statement of allegedly undisputed

material facts, a memorandum of law, and the expert affirmation of board-certified general and colorectal surgeon Daniel Feingold, M.D., who 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 plaintiff's injuries.

As Dr. Feingold described the plaintiff's medical history, when the plaintiff was 40 years old, she presented to the SIUH emergency department on May 23, 2018, complaining of lower abdominal pain, nausea, and diarrhea since that morning, but she denied vomiting, fever, or chills, while her body temperature was 97.5 degrees Fahrenheit, her pulse rate was 70 beats per minute, her blood pressure was 105/54, and her blood oxygen saturation level was at 99%. According to the relevant chart, the plaintiff reported that she previously had sustained a ruptured ovarian cyst, and informed emergency department personnel that her current pain felt similar. Dr. Feingold asserted that an examination of the plaintiff in the emergency department revealed lower abdominal pain, with some guarding, while an abdominal CT scan performed that evening revealed the presence of diffuse colonic diverticulosis and an acute inflammatory process involving the sigmoid colon, which he stated was suggestive of acute diverticulitis, with associated perforation leading to pneumoperitoneum. Dr. Feingold averred that a contemporaneous chest x-ray revealed trace pneumoperitoneum in the upper abdomen. He explained that SIUH emergency department attending physician John Calabro, M.D., saw the plaintiff and reported that the CT scan had been read, and that the SIUH surgery department was being consulted, with plans to have a general surgeon examine the plaintiff.

Dr. Feingold stated that SIUH medical personnel performed transabdominal and transvaginal ultrasound scans, which ruled out ovarian torsion as the cause of the pain, after which Dr. Calabro wrote that the patient was being taken to an SIUH operating room, where Gave was to perform surgery. Although not entered in a note until early the next morning, SIUH personnel wrote in the plaintiff's chart that, as of May 23, 2018, her abdomen was diffusely tender with the focal point being in the lower abdomen, with guarding in the lower left quadrant

and in the suprapubic region. Hence, that note indicated that a plan had been formulated that included "OR emergently," "admit to Dr. Gave," "NPO, N[aso] G[astric] T[ube], Foley to be placed in OR," and "perforated sigmoid diverticulitis and peritonitis for exploratory lap and Hartmann's." According to the chart, the plaintiff was, in fact, taken to an operating room for an exploratory laparotomy, resection of her sigmoid colon, mobilization of splenic flexure, and a Hartmann's procedure, which is a type of colectomy, in which a part of the colon, and sometimes part of the rectum, is removed, while the remainder of the rectum is sealed, creating what is known as Hartmann's pouch, after which the remaining portion of the colon is redirected to a colostomy The operative report for the surgery, which began at approximately 11:30 p.m. on May 23, 2018, stated that the plaintiff lost approximately 30 milliliters (ml) of blood, and that there were no complications.

Dr. Feingold summarized Gave's description of the surgery, noting that Gave employed a size 15 blade to make an infraumbilical incision, which he carried down through the subcutaneous tissue and peritoneal fascia, after which, according to Gave, "eventually the peritoneum was entered to note a significant amount of murky fluid." Dr. Feingold asserted that Gave mobilized the plaintiff's sigmoid colon, which was found to have a free percolation at the antimesenteric border, and then divided the sigmoid colon at the peritoneal reflection using a Contour gastrointestinal anastomosis (GIA) device, after which Gave reported that the colon was taken down using a Ligasure, while the splenic flexure was taken down, with the colon divided, using GIA 80 device due to extensive diverticulosis. According to Dr. Feingold, hemostasis was then obtained using a Bovie cautery, after which the peritoneal cavity was then "copiously irrigated" and excess fluid was aspirated. He asserted that Gave next performed the colostomy by making a circular incision in the left paraumbilical area, and tacking the colon to the peritoneum, using 3-0 vicryl sutures. Dr. Feingold explained that the ostomy was then "matured" by means of "interrupted" 3-0 vicryl sutures after the peritoneal cavity was closed. Gave reported in the relevant chart that the plaintiff tolerated the procedure well, was extubated,

and was transferred to the recovery room in stable condition at approximately 2:09 a.m. on May 24, 2018. Dr. Feingold opined that the surgery was performed "appropriately" and that there were "no complications whatsoever."

As Dr. Feingold described it, the discharge note from the post-anesthesia care unit reported an uneventful intraoperative course, and stated that the plaintiff was stable upon her arrival thereat, with her blood pressure measuring 118/75, her heart rate measuring 97 beats per minute, her respiration rate measuring 12 breaths per minute, her body temperature measuring 98 degrees Fahrenheit, and her blood oxygenation level measuring 99%. He concluded that, due to the plaintiff's stable condition, she was appropriately discharged from that unit to the medical floor while awake and in stable condition. Dr. Feingold explained that a second operative note written by assistant surgeon Joseph Ferraro, M.D., reported a preoperative diagnosis of a perforated viscus, while the postoperative diagnosis was diverticulitis of the large intestine, with perforation, albeit without bleeding. The intraoperative findings were of purulent fluid throughout the abdomen, a perforated sigmoid, diverticulitis, and an estimated blood loss of 30 ml. As Dr. Feingold read the pathology report for the sigmoid colon, which was not returned to the surgeons until May 30, 2018, there was no perforation, although multiple diverticula were seen, two of which were at or close to the surgical margin.

Dr. Feingold further asserted that, on May 25, 2018 at 5:44 a.m., nonparty surgical resident Nicholas Champion, M.D., authored a progress note, which was co-signed by Gave, stating that the plaintiff was "status post Hartmann's procedure and left lower quadrant colostomy without output," that her pain was "well-controlled with medications," her vital signs were "within normal limits," her abdomen produced "positive bowel sounds," and she evinced "positive peri-incisional tenderness." The note further reported that the plaintiff's abdomen was non-distended, that the incision and wound were clean, dry, and intact, that there were no signs of infection, that she was "voiding freely" and "passed T[rial] O[f] V[oid] yesterday." According to Dr. Feingold, SIUH medical personnel developed an "entirely appropriate" plan that included

laboratory blood and urine testing in the morning, pain control, encouragement of ambulation, encouragement of employment of an incentive spirometer, and monitoring for bowel function. Gave added to the note that the plaintiff was "doing well by mouth," that the ostomy was viable, that the plaintiff was able to pass gas, and that her pain was well-controlled. Gave further included in the plan of care that the plaintiff should remain on an oral diet while an intravenous lock (IVL) was being employed to the extent that she could tolerate it, that she should be administered antibiotics orally rather than intravenously, that she should get out of bed and ambulate, that she should continue the ingestion of a stool softener, and that she should be discharged to her home the next morning. According to Dr. Feingold, as of that date, SIUH hospital medical personnel had given standing medication orders to administer 650 milligrams (mg) of acetaminophen to the plaintiff every 4 hours, the antibiotic cipro via intravenous infusion every 12 hours, ibuprofen every 6 hours, and morphine as needed.

As Dr. Feingold explained the May 26, 2018 progress notes, the plaintiff had by then been advanced to a regular diet, tolerated an IVL, and had been switched to oral administration of antibiotics. He asserted that a physical examination reflected that the plaintiff was in no acute distress, that the ostomy was functioning well, with stool and gas present, and that she evinced normal bowel sounds, while her abdomen was non-tender and non-distended. Dr. Feingold asserted that she was administered 650 mg of acetaminophen every 4 hours, 500 mg of cipro every 12 hours, and stool softener twice per day. He further stated that cultures taken on May 24, 2018, the results of which were returned on May 26, 2018, were negative for bacteria and growth. He explained that, in light of these findings, the plaintiff was "appropriately deemed stable for discharge home," with home nursing care to be provided by Visiting Nurse Services. According to Dr. Feingold, SIUH personnel educated the plaintiff as to colostomy care, after which she was "appropriately and timely discharged home on May 26, 2018, with instructions to follow up with Dr. Gave in two weeks for a wound check." He asserted that she also was instructed that, if she experienced fever, chest pain, shortness of breath, dizziness, abdominal

pain, bleeding, or drainage from the wound, she was to call her primary care physician or return to the SIUH emergency department. Upon her discharge, she was provided with oral doses of cipro and the antibacterial and anti-protozoal drug Flagyl.

As Dr. Feingold described it, on June 5, 2018, the plaintiff presented to Gave's office for a follow-up visit, after which Gave reported that the ostomy was pink and functioning, and that the wound had healed. Gave thereafter removed surgical staples and affixed sterilization strips. Gave wrote in the plaintiff's chart that there were no abdominal masses or tenderness, concluded that the plaintiff was "doing well" while on a regular diet, instructed her to avoid heavy lifting, and directed her to return to see him in two months. On August 7, 2018, the plaintiff again met with Gave, who reported that the plaintiff was "doing well," her ostomy was functioning, and her midline incision had healed, with no abdominal masses or tenderness present. Dr. Feingold opined that, in light of these findings, as well as the plaintiff's age and overall health, Gave appropriately scheduled a reversal of the Hartmann's procedure.

As Dr. Feingold explained the plaintiff's chart, on August 23, 2018, the plaintiff again presented to Gave for a scheduled colostomy reversal. Gave performed the procedure, assisted by nonparty surgeon Amandeep Juneja, M.D. According to Dr. Feingold, the estimated blood loss was 20 ml. He asserted that Gave's operative report recited that the plaintiff had returned for an "elective reversal of the colostomy performed 3 months earlier," that the plaintiff had undergone a "chemical prep" on the previous evening, receiving three doses of oral antibiotics, and that 2 grams of the antibiotic Cefotetan also had been administered prior to making the incision for greater protection from infection. Dr. Feingold averred that, during the surgery, Gave made the incision along the old scar, carried the incision down through subcutaneous tissues, entered the peritoneal cavity, and performed lysis of adhesions. Dr. Feingold opined that Gave appropriately and correctly made a circular incision around the colostomy and carried the incision down through the subcutaneous tissue, upon which the colostomy was delivered to the intra-peritoneum and was dissected off the peritoneal wall, and

that the splenic flexure thereafter was mobilized using a Ligasure device. According to Dr. Feingold, after Gave noted some "diverticula from the ostomy stump proximal," he and his surgical team then divided the colon around the splenic flexure, mobilized the splenic and transverse colon, placed a suture at the ostomy stump, and placed 25 millimeter anvil assembly on the colon stump. Dr. Feingold also asserted that Gave and his surgical team then employed an end-to-end anastomotic stapler to transrectally perform an end-to-end circular anastomosis, which was checked with a sigmoidoscope and was "found to be water and airtight." He described this process as "important," since it demonstrated that the plaintiff's bowel was patent and free of leaks at the conclusion of the surgery, and that hemostasis was then attained.

Dr. Feingold further described Gave's operative report as including a notation that the plaintiff's small bowel had been inspected, with the inspection running from the ligament of Treitz to the terminal ileum, which Dr. Feingold characterized as "appropriate care," since it confirmed that there were no leaks from the bowel at the conclusion of the surgery. Dr. Feingold asserted that the chart indicated that the plaintiff's peritoneal cavity was copiously irrigated, and that hemostasis was "ascertained," after which the incision was then closed, while Gave used a 4 centimeter by 4 centimeter "Tegaderm" patch to dress the wound and closed the ostomy site and peritoneum. He stated that the plaintiff was then transferred to the recovery room in satisfactory condition.

According to Dr. Feingold, nursing notes that had been entered into the plaintiff's SIUH chart during the days following the reversal surgery reported that the plaintiff was healing well, that she was in no apparent distress, that her pain was well-controlled with the painkiller hydromorphone, that she was frequently described as being alert and responsive, and that the wound was clean, dry, and intact. He asserted that, on August 24, 2018, nonparty surgery resident Zachery Garcia, M.D., examined the plaintiff, and wrote a note, co-signed by Gave, which reported that the administration of the painkiller hydromorphone had been discontinued, and that the plaintiff was eating by mouth, doing well, out of bed, ambulating, and awaiting the

return of her bowel function. Dr. Feingold stated that, on August 25, 2018, at 2:12 a.m., a complete blood cell (CBC) test reflected that the plaintiff's hemoglobin level was 6.6 grams per deciliter of blood (g/dL) and 7.1 g/dL at 3:10 a.m. According to Dr. Feingold, SIUH personnel alerted nonparty postgraduate general surgery resident Meghan Flessa, M.D., who wrote in the plaintiff's chart at 7:35 a.m. on August 25, 2018, that the plaintiff's hemoglobin level had dropped from 10.7 g/dL to 6.4 g/dL. The chart reflected that Dr. Flessa examined the plaintiff, who purportedly denied any pain and stated that she was feeling well. Dr. Flessa's plan was to perform another CBC test at approximately 11:00 a.m. on that date, and to perform a blood transfusion if necessary. Dr. Flessa authored another note at 8:16 a.m., which was co-signed by Gave, and reported that the plaintiff's pain was being controlled by the administration of non-steroidal anti-inflammatory drugs acetaminophen and ibuprofen. Although Dr. Flessa reported that the plaintiff had felt dizzy when ambulating on the previous day, Dr. Flessa attributed it to dehydration due to the plaintiff's refusal to drink water because of experiencing pain upon urination. The chart reported that SIUH personnel administered a saline bolus to the plaintiff, although it also reflected a normal abdominal examination, with the wounds appearing clean, dry, and intact. Gave's note at that time reported that the plaintiff was doing well, and that he planned to advance the plaintiff's diet as tolerated, and to have the plaintiff ambulating, although it reported that, at 1:02 p.m., the plaintiff's hemoglobin level was 6.6 g/dL.

Dr. Feingold averred that, on August 26, 2018, at 1:10 a.m., the plaintiff's hemoglobin level had decreased to 5.8 g/dL, and that, by 2:35 a.m., it had further decreased to 5.3 g/dL. According to Dr. Feingold, SIUH staff appropriately recognized this low value and appropriately and promptly transfused the plaintiff with two units of blood later that day. The plaintiff's chart further reported that, on August 27, 2018, at 11:04 a.m., nonparty resident Ian Provancha, M.D., recorded the previous two days' laboratory results for hemoglobin levels, as well as the blood transfusion, an entry that was co-signed by Gave. According to this entry, the plaintiff's hemoglobin level had increased to 8.7 g/dL after the transfusion, and she was tolerating her

diet, having bowel movements, and presenting with normal vital signs, which Dr. Feingold characterized as "important signs" of returning to normal bowel function and "important metrics and pre-requisites" necessary to discharge the plaintiff. Gave thus planned to discharge the plaintiff to her home, and follow up with him in one week. Dr. Feingold further stated that, later on August 27, 2018, Gave and nonparty resident Thomas Kania, M.D., reported that the plaintiff experienced no acute events overnight and that her pain was "well-controlled," thus discharging the plaintiff to home that day, accompanied by family, with home care services. According to Dr. Feingold, discharge medications included 325 mg of acetaminophen every eight hours and 500 mg of the antibiotic erythromycin one time per day, and she was permitted to go on a regular diet. Gave requested the plaintiff to see him again within 10 to 14 days.

On September 3, 2018, however, the plaintiff was admitted to Lenox Hill Hospital (LHH), where medical personnel performed a CT scan and, at approximately 10:20 a.m. on that date, diagnosed an anastomotic leak, even though the plaintiff's hemoglobin level was measured that morning at 10.8 g/dL. On September 4, 2018 at 10:15 a.m., the plaintiff underwent an exploratory laparotomy at LHH, along with the drainage of an intraabdominal collection of fluids, a takedown and resection of the prior colorectal anastomosis, and an end-colostomy creation, all performed by LHH surgeon Joseph Martz, M.D. According to Dr. Feingold's interpretation of the LHH chart, on May 9, 2019, the plaintiff returned to LHH, where Dr. Martz performed reversal of the colostomy and created a loop ileostomy, which Dr. Feingold characterized as free from complications. He further asserted that, on July 11, 2019, the plaintiff returned to LHH, where Dr. Martz performed a scheduled, elective reversal of the ileostomy, with respect to which he concluded that she tolerated the procedure well, and noted that she was discharged from LHH on July 13, 2019. Dr. Feingold asserted, however, that the plaintiff subsequently developed an incisional hernia at the site of the former ileostomy, and that, on April 21, 2021, she returned to LLH, where surgeon Robert Andrews, M.D., performed a scheduled hernia repair surgery, which Dr. Feingold characterized as successful and flee from complications.

As Dr. Feingold framed the issue, when the plaintiff presented to SIUH in May 2018, she was suffering from a condition known as Hinchey III diverticulitis, which he described as a life-threatening condition that required surgical intervention. He opined that SIUH medical personal appropriately worked her up, and correctly developed an appropriate differential diagnosis, ruling out, via ultrasound and CT scans, various other possible etiologies of her abdominal pain, such as an ovarian torsion, and determining that the CT scan revealed the presence of multiple diverticula and a perforated viscus. Dr. Feingold thus concluded that it was within the standard of care and completely appropriate for Gave and SIUH surgical staff to transfer the plaintiff to an operating room to perform an exploratory laparotomy and a Hartmann's procedure, which he characterized as "medically necessary." Dr. Feingold further opined that Gave appropriately performed the exploratory laparotomy and Hartmann's procedure, and ultimately saved the plaintiff's life. He also asserted that he did not identify any departures from the standard of care during the plaintiff's May 2018 hospitalization, and concluded that there were no complications from the Hartmann's procedure.

Dr. Feingold rejected what he described as "unspecified" allegations of negligent postoperative management of the plaintiff, and concluded that the plaintiff was not prematurely discharged from SIUH in May 2018, particularly in light of the SIUH chart, which "documented an uneventful intraoperative course" and indicated that the plaintiff was in stable condition, with stable vital signs, when she was admitted to the post-anesthesia care unit. He further concluded that the plaintiff was timely and appropriately discharged to a medical floor while she was awake and in stable condition, while the surgical pathology report for the sigmoid colon documented no perforation, and that the plaintiff was appropriately administered painkillers and antibiotics, explaining that her postsurgical pain was typical and not indicative of any larger issue or complication. Because he concluded that the plaintiff's vital signs were within normal limits, and her abdomen emitted positive bowel sounds and was not distended, while the incision and wound were clean, dry, and intact, and there were no signs of infection, the plan

that Gave and SIUH developed was entirely appropriate and within the standard of care. Dr. Feingold also asserted that, inasmuch as the plaintiff was doing well eating by mouth, the ostomy was viable, and the plaintiff was able to pass gas, and the plaintiff was by then returning to normal bowel function, there thus was no bowel obstruction, rendering her discharge appropriate. Since he explained that there were no signs of infection upon tissue and fluid culturing, and no concerning signs or symptoms that would support retaining the plaintiff in the hospital, he state that SIUH and Gave correctly discharged her to her home on May 26, 2018, with nursing assistance and colostomy education. Dr. Feingold stated that it also was appropriate for Gave to have met with the plaintiff postoperatively within two weeks after the surgery, and that SIUH personnel provided the plaintiff with appropriate instructions if she developed any concerning symptoms during that two-week interval. He also opined that Gave adhered to the applicable standard of care during the plaintiff's postoperative visits of June and August 2018, since Gave properly examined the plaintiff, determined that the surgical wounds were healing well, and found that the conditions presented by the plaintiff, including her complaints of pain, were normal and typical for a patient who had undergone a Hartmann's procedure. Dr. Feingold concluded that Gave ordered appropriate imaging, and appropriately discussed his plan to perform a Hartmann's reversal procedure, while the determination to schedule that procedure for late August 2018 was appropriate, since, among other things, it allowed for a sufficient interval of time between the initial Hartmann's surgery and the reversal.

Dr. Feingold opined that Gave executed and performed the Hartmann's reversal procedure in a correct manner, and concluded that, based on the operative report, the technical performance of the surgery itself was entirely proper. He further asserted that Gave appropriately administered a chemical preparation regimen the night before the reversal surgery, and he approved of the administration of three doses of oral antibiotics and 2 grams of Cefotetan prior to commencement of surgery. Dr. Feingold stated that Gave correctly made the

surgical incision along the old scar and properly carried it down through subcutaneous tissues, appropriately entered the peritoneal cavity, and correctly performed lysis of adhesions. He also asserted that Gave appropriately and correctly made a circular incision around the colostomy and carried it down through the subcutaneous tissue, properly delivered the colostomy to the intra-peritoneum, correctly dissected it off of the peritoneal wall, and appropriately mobilized the splenic flexure with a Ligasure device. Based on his review of the operative report, Dr. Feingold opined that the anastomosis was created correctly, that Gave satisfied the standard of appropriate surgical technique and care, and properly checked the patency of the anastomosis with a sigmoidoscope after pumping a limited amount of air and water into the plaintiff's bowel, and finding it to be watertight and airtight, thus ensuring the absence of leaks. He further approved of Gave's inspection of the small bowel from the ligament of Treitz to the terminal ileum, as well as what he described as the copious irrigation of the peritoneal cavity.

Dr. Feingold additionally rejected the plaintiff's claims of inappropriate postoperative management in connection with her August 2018 admission to SIUH for the reversal of the Hartmann's procedure, that she was correctly and appropriately discharged on August 27, 2018 because she was in no apparent distress, her pain was well controlled, she was alert and responsive, and her surgical wound was clean, dry, and intact. He asserted that the discontinuation of the administration of hydromorphone on August 24, 2018 was appropriate, since the plaintiff was eating by mouth and doing well, she was out of bed and ambulating, and was awaiting the return of normal bowel function.

In connection with the steep decrease in the plaintiff's hemoglobin levels during her August 2018 admission to SIUH, Dr. Feingold concluded that laboratory personnel properly alerted Dr. Flessa, and that Dr. Flessa appropriately examined the patient, and properly ordered a repeat CBC panel, while considering the need for a blood transfusion. He further opined that Gave's plan for follow-up was entirely appropriate and within the standard of care. In addition, Dr. Feingold explained that when the plaintiff's hemoglobin level dropped to 5.3 g/dL on August

26, 2018, from 10.7 g/dL in the early morning of August 24, 2018, the drop signified that the plaintiff had experienced bleeding beginning sometime after the earlier reading, and that this "degree of bleeding is commonly experienced after Hartmann's reversal surgery and is not considered a departure from the standard of care." He concluded that the plaintiff most likely bled in a "raw area" where the surgery had taken place, and the degree of decrease warranted transfusion of two units of blood, which SIUH staff appropriately recognized, and thereupon appropriately and promptly transfused two units of blood on August 26, 2018. According to Dr. Feingold, the transfusion had the intended effect, as it resulted in an increase in the plaintiff's hemoglobin level to 8.7 g/dL, which did not represent an "inherently acute event," and reflected that the plaintiff had not experienced ongoing bleeding after the transfusion. He opined that, under these circumstances, the standard of care did not require further investigation or treatment of bleeding. As he explained it, "[t]he idea that bleeding like Ms. Rajacic experienced would act as an irritant and cause dehiscence of a colorectal anastomosis is not supported by modern surgical practice." Dr. Feingold asserted that, in this respect, the plaintiff was tolerating her diet, having bowel movements, and evincing normal vital signs, while, on August 27, 2018, she was documented to have had no acute events overnight and her pain continued to be well-controlled. Based on these postoperative findings, Dr. Feingold concluded that it was appropriate at that time to discharge the plaintiff to her home. He further noted that, in fact, the further increase in the plaintiff's hemoglobin level to 10.7 g/dL by September 3, 2018, when she was at LHH, was "significant," since it meant that she was stable at the time of her discharge from SIUH and was not actively bleeding more than one week after her discharge.

Dr. Feingold described as "unfounded" the plaintiff's claim that the bleeding that she experienced after her August 23, 2018 surgery at SIUH somehow increased the risk of an anastomotic leak. He reiterated that tissue at the site of an anastomosis is inherently at risk for leakage due to its compromised nature, but that the bleeding such as that experienced by the plaintiff did not independently elevate this risk. He further repeated that an anastomotic leak is

a known and accepted risk of Hartmann's reversal surgery. In this regard, Dr. Feingold asserted that leak rates for Hartmann's reversals vary widely in the medical literature and range between about 3% or even lower and as high as 15% or even higher. He concluded that the plaintiff's anastomotic leak

> "likely developed after her discharge from SIUH, based on the records reviewed, as the anastomosis was patent at the conclusion of the surgery and Ms. Rajacic's symptoms, vital signs and bloodwork were not concerning for a patient with anastomotic leak during the remainder of her hospitalization at SIUH,"

and that no evidence supported her claim that her discharge from SIUH or postoperative management at SIUH contributed to the development of the leak. Dr. Feingold further concluded that, even had the anastomotic leak begun at SIUH and been diagnosed there, the treatment for it would have been the same as that provided by Dr. Martz and LHH, namely, the performance of an exploratory laparotomy, drainage of intraabdominal collection, takedown and resection of prior colorectal anastomosis, and end colostomy creation.

In opposition to the motion, the plaintiff relied on many of the same documents that the defendants had submitted, and also submitted a counterstatement of material facts, a memorandum of law, an attorney's affirmation, her own affidavit, and the affirmation of board-certified surgeon Kenneth Lewis Brayman, M.D., Ph.D., who opined that the defendants did indeed depart from good and accepted medical practice, and that these departures caused or contributed to the plaintiff's injuries, including leakage from the anastomosis and the need for additional surgery to repair defects caused by the Hartmann's reversal procedure.

Although Dr. Brayman did not contest the facts adduced by the defendants in support of their motion, he first opined that the defendants departed from the standard of care on May 23, 2018 by failing to perform an abdominal and pelvic CT scan, with oral contrast, prior to recommending and performing the initial surgery on the plaintiff. With respect to this opinion, Dr. Brayman asserted that, when a patient presents with the complaints that the plaintiff had

presented on May 23, 2018, which was suggestive of diverticulitis, and a CT scan is suggestive of viscal (intestinal) perforation, the standard of care requires that a CT scan of the abdomen and pelvis be administered with oral contrast. He noted that, although the defendant obtained a CT scan of the plaintiff's abdomen and pelvis using intravenous contrast, they did not obtain a CT scan using oral contrast, which he characterized as a departure from the standard of care. Dr. Brayman explained that the purpose of using oral contrast is to identify any active perforations and ongoing leakage. He asserted that

> "[t]he presence of free air in the abdomen is indicative of a perforation, but it does not indicate whether the perforation is active or whether it has sealed itself off, as perforations often do. When you drink the oral contrast, it goes through the lumen of the intestines (the hollow space within the intestinal walls) and if there is a perforation in the viscus, it will leak through the perforation indicating an active leak. Thus, an active/ongoing perforation would have been seen on a CT with oral contrast. The CT with oral contrast would also provide an indication of the size of the perforation."

Upon his review the CT scan taken at SIUH on May 23, 2018, Dr. Brayman concluded that there was very little extra luminal free air present, suggesting that the perforation had sealed already, that a CT with oral contrast, "more likely than not, would have confirmed that," and that such a finding "would weigh against performing such an invasive, complicated procedure as Dr. Gave performed here." Dr. Brayman further averred that, regardless of whether a CT scan with oral contrast had showed a sealed perforation, in light of the fact that the plaintiff was then 40 years old, her vital signs were stable, she had no prior history of diverticulitis, her white blood count of 11.82 thousand cells or microliter of blood (K/μL) was only "slightly elevated," her neutrophils were elevated, he lymphocyte level was low, and there was no indication of sepsis, a more conservative treatment plan should have been considered and presented to the plaintiff.

Dr. Brayman further opined that the defendants departed from the standard of care in failing to perform a CT scan, colonoscopy, and sigmoidoscopy prior to performing the reversal of the Hartmann's procedure in August 2018, as required by the standard of care. He explained that a Hartmann's procedure involves the division of the colon, in which a segment of the colon

is frequently removed, after which the proximal colon is brought to the skin surface to create a colostomy, also known as a stoma, for the removal of waste, and the other end of the colon is closed off, and is then referred to as the distal colonic or rectal stump. Dr. Brayman stated that the reversal of a Hartmann's procedure reconnects the colon to the distal colon or rectal stump, and that this connection is referred to as an anastomosis. He also explained that a sigmoidoscopy is a procedure in which a thin, flexible tube with a camera and light is inserted into the rectum to examine the lining of the rectum and the sigmoid colon, while a colonoscopy similarly examines the ascending and transverse colon. He asserted that the purpose of these examinations, including a contemporaneous CT scan, is to look for pathologies in the remaining segment of colon that might complicate the reversal procedure, such as ulcers, inflammatory conditions, hemorrhoids, and diverticula, which he described as weaknesses in the wall of the colon that form extruding pouches. He stated that any complications that would be observed via these examination procedures might need to be addressed prior to or during the reversal, or might even warrant a postponement of the reversal procedure.

Dr. Brayman conceded that Gave's June 5, 2018 note, which indicated that the plaintiff "will need CT prior to reversal" reflected an appropriate diagnostic plan, but noted that this CT was never performed. He nonetheless concluded that, since Gave's August 23, 2018 operative report noted the presence of "diverticula from the ostomy stump proximal," had the planned diagnostic procedures and tests actually been performed, these diverticula would have and should have been identified *prior to surgery,* and could have been planned for, thereby reducing the complexity and risk of the surgery. As Dr. Brayman explained it, these diagnostic procedures also are performed to ensure that there is adequate blood supply both to the tissue in the colon and the rectal stump that will form the anastomosis, and that, if the tissue is not provided with a proper blood supply, and, thus, is not supplied with sufficient amount of oxygen and nutrients, the risk of a leak in the anastomosis, as well as damage and death to that tissue, is significantly increased.

According to Dr. Brayman, the LHH CT scans and operative report demonstrated that the plaintiff developed an anastomotic leak after the August 23, 2018 reversal procedure that Gave had performed, and he concluded that the leak developed because the tissue forming the anastomosis was not adequately vascularized. Again, he opined that had Gave performed a sigmoidoscopy, colonoscopy, and CT scan *prior* to performing the reversal, more likely than not, Gave would have discovered that the tissue for re-anastomosis was not suitable for primary anastomosis, in that it was not adequately vascularized or presented other pathology that increased the likelihood of an anastomotic leak, which should have caused Gave to delay the reversal procedure or to perform a protective ileostomy, as Dr. Martz ultimately performed at LHH on May 9, 2019. Dr. Brayman explained that a protective ileostomy is a procedure in which the small intestine is employed to create a stoma to divert intestinal fluid from the large intestine and colon, so that the anastomosis formed during the reversal of the Hartmann's procedure can heal without the risk of leak of intestinal fluid into the newly created anastomosis, since such a leakage would inflame and undermine its ability to heal.

In addition, Dr. Brayman concluded that Gave departed from the standard of care in discharging the plaintiff from SIUH on August 27, 2018. As he explained it,

> "[a]ccording to Dr. Gave's operative report, after creating the anastomosis, he inspected it with a sigmoidoscope and found it to be water and airtight – i.e. it was not leaking at that time. . . . This is consistent with the standard of care. However, the fact that a leak was not present at the time that Dr. Gave closed Ms. Rajacic's abdomen does not mean that the leak did not develop due to Dr. Gave's departures from the standard of care. An anastomotic leak is a well-known complication of this surgery. This is why the standard of care requires the procedures discussed . . . above to be done prior to reversal."

As relevant to his conclusion that discharging the plaintiff on August 27, 2018 was inappropriate, Dr. Brayman opined that the standard of care requires that a surgeon be vigilant to the possibility that such a leak may develop postoperatively, and that Gave failed to appropriately consider the possibility of bleeding and anastomotic leaks in this case, particularly because, after the August 25, 2018 surgery, the plaintiff was experiencing significant abdominal pain,

dizziness, fainting, and a general sense that something felt wrong, while her blood pressure was low on the day before and the day of her discharge (94/56 and 93/51), as compared to her baseline blood pressure (118/66 and 118/70). Dr. Brayman explained that low blood pressure undermines the healing of an anastomosis because it reduces the perfusion necessary for the healing of tissue.

Moreover, after restating the extent of the fluctuation in the plaintiff's hemoglobin levels in the days prior to and after the August 25, 2018 procedure, and the volume of blood that the plaintiff reportedly lost during that surgery, Dr. Brayman asserted that, while Dr. Feingold correctly attributed the decrease in the plaintiff's hemoglobin level to postoperative bleeding, he criticized Dr. Feingold for dismissing the significance of that bleeding. Moreover, while Dr. Brayman agreed with Dr. Feingold that "because a degree of bleeding is commonly experienced after a Hartmann reversal surgery," it is not necessarily a departure from the standard of care when such bleeding occurs, he nonetheless faulted Gave for the failure to investigate whether that blood had pooled around the anastomosis, as it did in the plaintiff's case. As Dr. Brayman framed the issue, the fact that the plaintiff may have stopped bleeding immediately after the surgery was "beside the point," since she had experienced significant postoperative surgical bleeding, and nothing was done to determine whether or where that blood had pooled. He concluded that, in light of the signs and symptoms that the plaintiff presented postoperatively, along with the concededly well-known risk of an anastomotic leak associated with a Hartmann's reversal procedure, "an accumulation of blood around the anastomosis and an anastomotic leak should have been on Dr. Gave's differential diagnosis" on August 27, 2018, and that Gave should have ruled out these conditions before discharging the plaintiff.

In light of this opinion, Dr. Brayman expressly disagreed with Dr. Feingold's opinion that the plaintiff's presentation between August 24, 2018 and August 27, 2018 was "not concerning for a patient with anastomotic leak," explaining that anastomotic leaks can present in various ways, including abdominal pain, low blood pressure, dizziness, and malaise, all of which the

plaintiff testified to at her deposition, and all of which are set forth in the SIUH chart. He also rejected Dr. Feingold's conclusion that any unaddressed postoperative bleeding did not increase the chances of an anastomotic leak, explaining that even if the anastomosis had not yet developed a leak, an accumulation of blood around the anastomosis should have been ruled out because such an accumulation will inflame, and possibly infect, the tissue forming the anastomosis, diminishing its capacity to heal and making a leak more likely. Hence, Dr. Brayman concluded that Gave should have performed a postoperative CT scan to rule out the pooling of blood around the anastomosis, and, if such pooling were observed, the proper course of treatment would have been to drain the blood, and to continue to monitor the plaintiff in the hospital for continued bleeding and signs of infection. Since Dr. Brayman explicitly concluded that the leakage actually was present on August 27, 2018, he opined that, had Gave undertaken these diagnostic tests and engaged in proper monitoring, as required by the standard of care, the bleeding and anastomotic leak would have been detected on that date.

Dr. Brayman further expressly disagreed with Dr. Feingold's opinion that "even had the anastomotic leak started at SIUH and been diagnosed there, the treatment for it would have been the same," asserting that, if a CT scan had identified blood around the anastomosis on or before August 27, 2018, the blood could have been drained before it damaged the tissue forming the anastomosis, while, if such a CT scan identified an anastomotic leak, the fluid in the plaintiff's abdomen could have been drained at an earlier time, and the leakage could have been treated conservatively with percutaneous drainage and the creation of a controlled fistula. Alternatively, Dr. Brayman asserted that the leak could have been surgically repaired before the surrounding tissue deteriorated to the point that it was inflamed, infected, and could no longer repair itself, and could likely have been effectuated without the necessity of completely taking down the reversal and reinstall the colostomy, thereby avoiding numerous additional surgeries, including the takedown of the colostomy and creation of a loop ileostomy on May 9, 2019, the reversal of the ileostomy on July 11, 2019, and the hernia repair on April 21, 2021.

Dr. Brayman's averred that Gave's purported recommendation that the plaintiff remain one additional day in the hospital to investigate the status of the bleeding did not relieve him of the consequences of actually discharging her on August 27, 2018. As he explained it, patients often want to leave a hospital before it is safe, and a physician's responsibility is to keep a patient in the hospital until they can be safely discharged. Dr. Brayman asserted that, if a patient chooses to leave against the physician's advice, the standard of care requires that this determination be documented in the chart, but that neither Gave nor any other medical staff member documented that the plaintiff was leaving against medical advice.

In addition, Dr. Brayman contended that Gave departed from the applicable standard of care by failing to advise the plaintiff to present to a hospital emergency room on August 30, 2018, when she claimed that she had advised him of severe abdominal pain and rectal bleeding. Based upon both the plaintiff's prior symptoms, as well as her reports to Gave of new symptoms, Dr. Brayman concluded that it was

> "clear that by August 30, Ms. Rajacic had developed an anastomotic leak. The fluid that comes out of an anastomotic leak includes serous fluid (a clear, watery substance), turbid fluid (fluid that may contain white and red blood cells, bacteria and fungi) and fecal matter."

He asserted that an anastomotic leak is a medical emergency that must be addressed promptly, and that the longer that these fluids sit in the abdominal cavity, the more damage they do to the surrounding tissue since, if not treated, the patient will develop sepsis and die. As Dr. Brayman explained it, with each passing day, the amount of fluid and fecal matter leaking into the plaintiff's abdomen increased the further irritation, inflammation, and infection of, and damage to, the surrounding tissue, decreasing the likelihood that it would be able to heal, thus reducing a patient's chances for a better outcome. He asserted that the defendants' failure to diagnose and treat the plaintiff's anastomotic leak on August 30, 2018 increased the chances that it would be necessary to completely take down the Hartmann's reversal and reinstall another colostomy.

Dr. Brayman ultimately opined that the departures from the standard of care that he described were a substantial factor in causing the plaintiff to undergo the May 23, 2018 surgery to which she consented, which was not indicated based on her presentation, further requiring the complete take down of the anastomosis at LHH on September 7, 2018, the subsequent surgeries that she underwent to reverse that procedure, the incisional hernia that she developed, and the permanent scarring he described. He stated that, had these departures not occurred, more likely than not, she would not have undergone the May 23, 2018 surgery in the first instance. Further, he concluded that, even if she ultimately had to undergo the Hartmann's procedure, the leak that she experienced after the August 23, 2018 reversal procedure would have been identified by August 27, 2018 had the defendants not departed from the standard of care, the leak could have been drained before the leaking fluid inflamed and damaged the tissue to the point where it could not heal itself. According to Dr. Brayman, these alleged departures, including the failure to direct the plaintiff to an emergency room on August 30, 2018, diminished the plaintiff's chances for a better outcome.

In reply, the defendants submitted an attorney's affirmation, in which counsel argued that the court should disregard the plaintiff's opposition papers since they were served 11 days after a court-extended deadline. He further argued that Dr. Brayman's opinion was conclusory, speculative, and not supported by the facts in the medical records or deposition testimony. Rather, counsel argued that Dr. Brayman based his opinion solely on hindsight.

The court notes that, although the plaintiff's opposition papers were required to have been served on or before May 9, 2025, in accordance with a so-ordered stipulation dated March 12, 2025, and she did not serve those papers until May 20, 2025, the parties stipulated, and the court approved, a further adjournment of the return date of the motion from May 30, 2025 until June 19, 2025. This provided the defendants with additional time within which to serve reply papers, which they did on June 17, 2025. Since there was no prejudice to the defendants, the

court excuses the plaintiff's otherwise late service of opposition papers, and considers them in determining this motion.

Although the defendants established their prima facie entitlement to judgment as a matter of law in connection with the medical malpractice cause of action insofar as asserted against Gave, the court concludes that the opinions of the plaintiff's experts were "neither conclusory nor speculative, as [they] established the elements of a medical malpractice claim by specific factual references to the care and treatment" of the plaintiff's decedent (*Wiands v Albany Med. Ctr.*, 29 AD3d 982, 984 [2d Dept 2006]), particularly with respect to allegations that the May 23, 2018 surgery was not indicated, that the August 25, 2018 surgery did not create a patent anastomosis, and that that Gave prematurely discharged the plaintiff from SIUH on August 27, 2018 without having first tested for pooling of blood around the anastomosis, or having diagnosed the plaintiff with a failed anastomosis, along with the various related failures to document whether the plaintiff was being discharged against medical advice and to inform the plaintiff of likely etiology of her post-August 27, 2018 complaints. It is well settled that a battle of experts, such as presented here, raises credibility issues which must be resolved by a fact finder and which preclude summary judgment (*see Frye v Montefiore Med. Ctr.*, 70 AD3d at 25). Nonetheless, since Dr. Brayman failed to address the issue of whether the May 23, 2018 procedure, whether indicated or not, was properly performed, or whether the defendants departed from good practice by failing to refer the plaintiff for consultations with other specialists, the defendants must be awarded summary judgment dismissing so much of the medical malpractice cause of action against Gave as was premised upon those claims. That branch of the defendants' motion seeking summary judgment dismissing the remainder of the medical malpractice cause of action against Gave must otherwise be denied.

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 619, 620 [3d Dept 1999], quoting *Hylick v Halweil*, 112 AD2d 400, 401 [2d Dept 1985]; *see* CPLR 4401-a; *Gardner v Wider*, 32 AD3d 728, 730 [1st Dept 2006]). Hence, where a defendant establishes his or her prima facie entitlement to judgment as a matter of law in connection with a lack of informed consent cause of action by submitting an expert affirmation from a physician, a plaintiff can only raise a triable issue of fact by submitting "an expert affirmation stating with certainty that the information defendant[ ] allegedly provided to plaintiff before the [medical] procedures at issue departed from what a reasonable practitioner would have disclosed" (*Leighton v Lowenberg*, 103 AD3d 530, 530 [1st Dept 2013]). Expert testimony, however, is not necessary with respect to the issue of whether a reasonably prudent person, fully informed, would not have consented to the treatment (*see Gray v Williams*, 108 AD3d 1085, 1086-1087 [4th Dept 2013]; *Hugh v Ofodile*, 87 AD3d 508, 509 [1st Dept 2011]; *Andersen v Delaney*, 269 AD2d 193, 193 [1st Dept 2000]; *Hardt v LaTrenta*, 251 AD2d 174, 174 [1st Dept 1998]; *Osorio v Brauner*, 242 AD2d 511, 511-512 [1st Dept 1997]).

"'The mere fact that the plaintiff signed a consent form does not establish the defendants' prima facie entitlement to judgment as a matter of law'" (*Huichun Feng v Accord Physicians*, 194 AD3d 795, 797 [2d Dept 2021], quoting *Schussheim v Barazani*, 136 AD3d 787, 789 [2d Dept 2016]). Nonetheless, a defendant may satisfy the burden of demonstrating a

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

Contrary to the defendants' contention, they did not establish their prima facie entitlement to judgment as a matter of law in connection with the lack of informed consent cause of faction. Dr. Feingold asserted only that, on May 23, 2018, at 10:13 p.m., the plaintiff signed an informed consent form permitting Gave to perform an exploratory laparotomy, possible bowel resection, and possible ostomy, that a May 24, 2018 note reported that the risks and benefits were "discussed extensively with patient, sister and parents," and that an informed consent form was signed on August 7, 2018 in connection with the August 25, 2018 reversal procedure. Nowhere did Dr. Feingold expressly opine that the discussions between Gave, the plaintiff, and her relatives were qualitatively sufficient, let alone enumerate the particular risks and benefits of, and alternatives to, either of those two procedures. Even had the defendants made the necessary prima facie showing, Dr. Brayman opined that Gave failed adequately to explain these risks, benefits, and alternatives with respect to the May 23, 2018 procedure. He explicitly disagreed with Dr. Feingold that the plaintiff was experiencing a "life-threatening condition that required surgical intervention," since the relevant operative report did not detail a life-threatening emergency. Dr. Brayman asserted that, while surgical intervention at that juncture may have been one appropriate pathway of treatment, it was not the only option available to the plaintiff on May 23, 2018. He opined that Gave should have presented and explained an alternative treatment plan to the Hartmann's procedure, which the plaintiff, in her own affidavit and deposition testimony, averred was never done. Dr. Brayman opined that Gave should have advised the plaintiff that a viable, alternative treatment option was to commence the plaintiff on an non-oral intake diet, insert a catheter drain near the area of inflammation to drain the infected fluid, administer intravenous antibiotics, and closely monitor her in the hospital over the next 24

to 48 hours to ascertain if her condition improved. He came to this conclusion based on his understanding that small perforations often will seal themselves, the purulent fluid can be removed via catheter drain, and any infection can be cleared up with intravenous antibiotics. Consequently, that branch of the defendants' motion seeking summary judgment dismissing the lack of informed consent cause of action against Gave must be denied.

"'In general, under the doctrine of respondeat superior, a hospital may be held vicariously liable for the negligence or malpractice of its employees acting within the scope of employment, but not for negligent treatment provided by an independent physician, as when the physician is retained by the patient himself'" (*Valerio v Liberty Behavioral Mgt. Corp*., 188 AD3d 948, 949 [2d Dept 2020], quoting *Seiden v Sonstein*, 127 AD3d 1158, 1160 [2d Dept 2015]; *see Hill v St. Clare's Hosp*., 67 NY2d 72, 79 [1986]; *Dupree v Westchester County Health Care Corp*., 164 AD3d 1211, 1213 [2d Dept 2018]). There is no dispute as to whether Gave was employed by, and acting within the scope of his employment with, SIUH on the dates in question. Hence, to the extent that there are triable issues of fact as to whether Gave committed malpractice, as described above, or failed to obtain the plaintiff's fully informed consent to the two subject procedures, there are triable issues of fact as to whether SIUH is vicariously liable therefor.

To establish a cause of action to recover for negligent hiring, supervision, training, and retention of health-care personnel, a plaintiff must demonstrate that the defendants either "knew, or should have known," of their employees' "propensity for the sort of conduct which caused the [patient's] injury" (*Sheila C. v Povich*, 11 AD3d 120, 129-130 [1st Dept 2004]; *see Kuhfeldt v New York Presbyt./Weill Cornell Med. Ctr*., 205 AD3d 480, 481-482 [1st Dept 2022]). In opposition to the defendants showing that all of its medical and healthcare personnel were properly hired, trained, supervised, and retained, Dr. Brayman rendered no opinion. Hence, that branch of the defendants' motion seeking summary judgment dismissing the negligent hiring, training, supervision, retention, and credentialing cause of action must be granted.

The defendants' remaining contentions are without merit or do not require a different outcome.

Accordingly, it is,

ORDERED that the defendants' motion for summary judgment dismissing the complaint is granted only to the extent that they are awarded summary judgment dismissing the cause of action alleging negligent hiring, training, supervision, retention, and credentialing of personnel, and so much of the medical malpractice cause of action as was premised upon allegations that the Hartmann's procedure performed upon the plaintiff by the defendant critical care surgeon Asaf Asi Gave, M.D., on May 23, 2018 was improperly performed and that the defendants failed to refer the plaintiff for consultations with other specialists, that cause of action and those claims are dismissed, and the motion is otherwise denied; and it is further,

ORDERED that, on the court's own motion, the attorneys for all of the parties shall appear for an initial pretrial settlement conference before the court, in Room 204 at 71 Thomas Street, New York, New York 10013, on December 18, 2025, at 11:00 a.m., at which time they shall be prepared to discuss resolution of the action and the scheduling of a firm date for the commencement of jury selection.

This constitutes the Decision and Order of the court.

11/20/2025
DATE

JOHN J. KELLEY, J.S.C.

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