Briggs v Binetti
2025 NY Slip Op 35490(U)
January 9, 2025
Supreme Court, Dutchess County
Docket Number: Index No. 2022/50514
Judge: Michael G. Hayes
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SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF DUTCHESS

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KATHERINE BRIGGS,

Plaintiff,

- against -

BRIAN BINETTI, M.D.,

Defendant.

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DECISION & ORDER

Index No.: 2022/50514
Motion Seq.: 1

HON. MICHAEL G. HAYES, Acting Supreme Court Justice

The Court read and considered the following documents upon this motion:

	PAPERS NUMBERED
Notice of Motion	**1**
Affirmation	**2**
Exhibits	**3**
Statement	**4**
Memorandum of Law	**5**
Affirmation in Opposition	**6**
Exhibits	**7**
Statement	**8**
Affirmation in Reply	**9**

This medical malpractice action arises from surgery and post-surgical treatment that plaintiff received under defendant's care, and plaintiff's subsequent readmission to two different hospitals six times for complications.

Background

Plaintiff Katherine Briggs commenced this action on April 8, 2022, alleging that defendant Dr. Brian Binetti committed medical malpractice by and after performing surgery on plaintiff at Northern Dutchess Hospital ("NDH") on June 9, 2021. The parties had planned the procedure to be a laparoscopic revision of plaintiff's prior weight-loss (gastric sleeve) surgery plus a hiatal hernia repair. During surgery Dr. Binetti found excessive scar tissue that contraindicated the revision; instead, he repaired plaintiff's hernia. Plaintiff claims[1] that Dr.

[1] Plaintiff withdrew her informed consent claim (*see* Pl's Aff in Opp [NYSCEF 40], at 1).

Binetti caused or contributed to a bowel obstruction and intestinal fistula that he then failed to diagnose and treat. Defendant answered with general denials.

Plaintiff's verified bill of particulars, dated December 27, 2022, alleged that defendant's malpractice caused severe infection, bowel ischemia and intestinal leakage that required multiple hospitalizations at NDH during June and July 2021, and then secondary hospitalization at Albany Medical Center ("AMC") for an additional month (NYSCEF 18). The alleged malpractice specifically included "delaying necessary surgical procedures" (*id.*, at 3) and "carelessly and negligently worsening the plaintiff's condition by failing to timely perform surgery" to address plaintiff's post-surgical complications (*id.*, at 4). Defendant now moves for summary judgment dismissing the action.

In support, defendant adduces plaintiff's NDH and AMC medical records, deposition transcripts of plaintiff and defendant, defendant's office records relating to plaintiff's care, and an expert affirmation from surgeon Dr. Daniel Herron.

Dr. Herron attests, based on review of the medical records and deposition transcript, that plaintiff had undergone a prior bariatric surgery but remained morbidly obese, and that defendant properly diagnosed plaintiff's hiatal hernia and need for revision surgery. Dr. Herron continues, based on the surgical records, that defendant performed the subject surgery appropriately and in conformity with the standard of care. He opines that defendant properly abandoned the gastric sleeve revision surgery in view of safety concerns arising from extensive adhesions he found intra-operatively, and that defendant then properly repaired the hiatal hernia, lysed plaintiff's adhesions, and examined the operative field for inadvertent injury and damage before closing (*see generally* Herron Aff [NYSCEF 30]), at ¶¶ 43-46, 49).

The NDH medical records memorialize that plaintiff post-operatively developed abdominal pain in the left lower quadrant, nausea, vomiting, and low-grade fever, and a rising white blood count. Dr. Herron narrates that, in response, defendant properly examined plaintiff, finding distension and mild guarding in the affected quadrant, and based on those findings properly ordered laboratory studies and a CT scan of the abdomen and pelvis (*see* Herron Aff, at ¶ 47). Dr. Herron continues that defendant correctly interpreted the results as positive for suspected small bowel obstruction, perforation and/or ischemia. Based on defendant's medical narrative reports, Dr. Herron opined that defendant properly recommended and conducted an emergent diagnostic laparoscopy on June 11, 2021, to confirm that complication (*see id.*, at

¶¶ 48-49). Dr. Herron specifically concluded that defendant "adhered to proper surgical technique and did not deviate from the standard of care in his performance of plaintiff's [surgeries of] June 9 and 11, 2021" (*id.*, at ¶ 49). Dr. Herron explained that plaintiff's original weight-loss surgery likely caused the abdominal adhesions that Dr. Herron found intra-operably, which, according to Dr. Herron, "can increase post-operative complications and make performance of surgery more difficult" (Herron Aff, at ¶ 12)[2] – as occurred in plaintiff's case.

As to the pre-surgical, surgical and immediate post-surgical period until plaintiff's discharge from NDH on June 15, 2021, Dr. Herron opined that defendant was not negligent and that defendant did not cause or contribute to plaintiff's post-surgical complications. Of plaintiff's complications during this immediate post-operative period, Dr. Herron noted that:

> The complications suffered by plaintiff – i.e. a small bowel obstruction, seroma, wound infection, and enterocutaneous fistulas – are all known and accepted complications of abdominal surgery which can occur even in the absence of negligence and in the strictest adherence to proper surgical technique in accordance with the standard of care"

(Herron Aff, at ¶ 49). Dr. Herron narrated that defendant opted to treat those complications medically rather than surgically – a conservative approach, defendant narrated, to accommodate plaintiff's demonstrated susceptibility to develop post-surgical adhesions. This conservative treatment plan, Dr. Herron opined, was within the applicable standard of care, appropriate and successful as evidenced by plaintiff's lack of infection symptoms by June 15, 2021, at which time defendant properly discharged plaintiff with instructions (*see id.*, at ¶¶ 20, 49),

On June 21, 2021, plaintiff re-presented to NDH complaining of "bad odor" drainage from the umbilical wound where defendant had placed her surgical drain (*see* Herron Aff, at ¶ 21). Based on the medical records, Dr. Herron narrated that defendant opened the wound bedside but found no signs of infection or abscess (*see id.*, at ¶ 22); cultures performed at that time also were negative for infection (*see id.*, at ¶ 23). Nevertheless, defendant prescribed prophylactic antibiotics and directed plaintiff to follow up within three days (*see id.*, at ¶ 22). At plaintiff's follow-up appointment on June 24, 2021, plaintiff complained of continuing drainage

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[2] Dr. Herron narrated from the medical records that, in view of this heightened risk, defendant properly ordered a pre-operative endoscopy for plaintiff, and three times discussed with plaintiff the risks of proceeding with surgery (*see id.*, at ¶¶ 12-14).

from the wound but reported "no fever, nausea, vomiting, abdominal pain or difficulty with oral intake" (*see id.*, at ¶ 23); on physical examination, Dr. Herron found no signs of infection (*see id.*). Defendant's care of plaintiff during these times, Dr. Herron opined, was within the standard of care and not negligent (*see id.*, at ¶ 52).

The following day, on June 25, 2021, plaintiff again returned to NDH with abdominal symptoms and abnormal drainage; a CT scan confirmed a partial bowel obstruction. Plaintiff was readmitted to NDH for treatment, and defendant again treated her (*see* Herron Aff, at ¶ 25). Dr. Herron narrated, based on his review of plaintiff's medical records, that plaintiff presented with no sign of fistula connecting bowel to umbilical wound, such as cellulitis, succus or stool drainage – a negative finding confirmed by multiple CT scans (*see id.*, at ¶ 26) – but, found that she did have a "subcutaneous abscess" (*id.*, at ¶ 53). Defendant "performed a bedside incision and drainage of plaintiff's umbilical wound to promote healing and try to prevent worsening infection, draining 20ml of pus and blood and irrigating the wound cavity" (*id.*, at ¶ 26). In response to this procedure and other medical treatments, plaintiff demonstrated "significant symptomatic improvement" and improved bowel function (*see id.*, at ¶ 27). When a wound culture nevertheless grew out "negative rods and rare E. coli" on July 2, 2021, defendant prescribed antibiotics suitable for those results (*see id.*). The next day, defendant discharged plaintiff with wound-care instructions and continued antibiotics (*see id.*). Dr. Herron concluded that those treatments were within the standard of care and not negligent (*see id.*, at ¶ 53).

Plaintiff's third return to NDH was July 6, 2021, when she complained of foul-smelling drainage and abdominal pain. A CT scan found what Dr. Herron narrated to be a "persistent, stable, partial small bowel obstruction, and thickening/enhancement of the left anterior mid-abdominal wall musculature with stranding of the surrounding fat adjacent to an apparent superficial fistula" (Herron Aff, at ¶ 28). Plaintiff was re-admitted, at which time defendant determined that plaintiff had developed a subcutaneous fistula between her umbilical wound and small bowel. Defendant continued to believe, however, that plaintiff did not require surgical intervention because plaintiff was not septic and presented with stable vital signs, ability to tolerate oral intake, and the ability to have bowel movements (*see id.*, at ¶¶ 29-30). Dr. Herron narrated that "[m]ost fistulas heal or resolve on their own with conservative treatment and do not require surgical intervention. Moreover, surgical treatment of plaintiff's fistula carried a high risk of injury to other parts of the bowel, especially in light of her hostile abdomen with

extensive adhesions" (*id.*, at ¶ 30). On that basis, Dr. Herron opined that defendant's choice to treat the fistula conservatively with wound care, continued intravenous hydration, antibiotics and related adjuvant and supportive care – after which plaintiff improved and was discharged on July 10, 2021 – was within the standard of care and not negligent (*see id.*, at ¶ 54).

Plaintiff's fourth return to NDH was the next day, July 11, 2021, when she presented in abdominal distress. A CT scan confirmed a partial small bowel obstruction, and plaintiff again was admitted (*see* Herron Aff, at ¶¶ 33-34). As during the preceding admission, defendant opined that the risks of surgical repair outweighed the benefits and again opted to treat plaintiff conservatively with wound care, medications, topical treatments, and strict monitoring of wound output (*see id.*, at ¶ 34). When plaintiff had difficulty maintaining nutritional status orally, defendant started plaintiff on total parenteral nutrition (*see id.*, at ¶ 35). By July 16, 2021, despite treatment, plaintiff's follow-up CT scan indicated a further internal wound below the surgical incision. Yet again, because plaintiff was non-septic, had stable vital signs, continued to have bowel movements and tolerated oral intake, defendant opined that the surgical risks exceeded the benefits and opted to treat this second wound conservatively. Defendant discharged plaintiff on July 23, 2021, with home wound care, continued parenteral nutrition, a medication regimen and a follow-up schedule. Dr. Herron opined, based on the medical records, that defendant did not cause or contribute to the further internal wound, and that defendant appropriately treated it within the standard of care and without negligence (*see id.*, at ¶ 55). Dr. Herron specifically opined that:

> "In my opinion, to a reasonable degree of medical certainty, the standard of care did not require Dr. Binetti to recommend or perform surgery to treat plaintiff's fistulas. As correctly noted by Dr. Binetti, surgical intervention would expose plaintiff to a significant risk of further injury/damage to the bowel. This is especially so, as plaintiff had extensive matted abdominal adhesions which significantly increased her risk of surgical complications. As such, the risk of surgical intervention significantly outweighed any potential benefit of performing the same. In other words, surgical treatment of plaintiff's fistulas was not only not required, but actually contraindicated, by the standard of care. Accordingly, there is no merit to plaintiff's claim that Dr. Binetti was negligent in failing to perform surgery to treat or prevent a worsening of these fistulas"

(*id.*, at ¶ 56). As further support for this opinion, Dr. Herron noted that "the evidence confirms plaintiff's fistulas resolved completely with the exact conservative treatments recommended by

Dr. Binetti" – albeit at AMC instead of NDH. According to Dr. Herron, plaintiff made a fifth return to NDH on July 30, 2021, in abdominal distress. Defendant being out of town, plaintiff was readmitted for medical monitoring, at which time a CT scan found that "plaintiff's small bowel obstruction had resolved, and her left abdominal fistulas remained stable" (*id.*, at ¶ 39). Nevertheless, plaintiff requested transfer to another hospital, and was transferred to AMC the next day, on July 31, 2021 (*id.*), where she remained until August 31, 2021. Dr. Herron narrated, based on his review of plaintiff's AMC medical records, that AMC treated plaintiff with the same conservative non-surgical regimen that defendant undertook at NDH rather than surgery (*see id.*, at ¶ 40). AMC then discharged plaintiff with home nursing care, wound care and continued nutrition support (*see id.*). Plaintiff's fistulas "healed completely on their own, without the need for surgical intervention," by "approximately November of 2021" (*id.*).

From the foregoing, Dr. Herron concludes that, "in my opinion, to a reasonable degree of medical certainty, no departure from the standard of care by Dr. Binetti caused or contributed to plaintiff's development of [her] post-operative complications" (Herron Aff, at ¶ 49), and "Dr. Binetti appropriately and timely recognized, diagnosed, and treated these post-operative complications in accordance with the standard of care" (*id.*, at ¶ 50; *see* ¶ 55). "The fact that plaintiff developed these fistulas – despite appropriate treatment – is simply not evidence of negligence or malpractice by Dr. Binetti. Rather, again, such fistula development is a known and accepted surgical complication which occurs even in the absence of negligence. In my opinion, to a reasonable degree of medical certainty, the standard of care simply did not require Dr. Binetti to take any further action to evaluate, diagnose, prevent, or treat these fistulas" (*id.*, at ¶ 55).

In opposition, plaintiff adduces an expert medical affirmation from an anonymous board-certified surgeon.[3] After reviewing the medical records, defendant's deposition transcript and Dr. Herron's affirmation, the expert opined to a reasonable degree of medical certainty that defendant "departed from accepted medical practices" to an extent that "was a substantial factor in causing and contributing to [plaintiff's] injuries … including additional hospitalizations as

[3] Plaintiff having submitted *in camera* an unredacted version, the Court admits the anonymous affirmation into evidence upon finding that the expert's stated experience, board certifications and academic positions suffice to support an inference that the expert's opinions are reliable (*see Bell v Ellis Hosp.*, 50 AD3d 1240 [3d Dept 2008]; *cf. Romano v Stanley*, 90 NY2d 444, 452 [1997]; *see also* CPLR 3101[d][1]).

well and unnecessary pain and suffering" (Expert Aff [NYSCEF 41], at ¶ 6). According to plaintiff's expert, plaintiff's CT results, blood tests and exploratory surgery results of June 11, 2021, should have alerted defendant as of then that plaintiff was suffering from a functional ischemic bowel (*see id.*, at ¶¶ 8-15). Though the expert concurs that plaintiff appeared to improve with conservative treatment through June 21, 2021, when plaintiff first returned to NDH, defendant failed to properly diagnose her symptoms as ischemic bowel (*see id.*, at ¶ 17).

This failure, the expert asserts, continued despite the CT scan of June 25, 2021, reading as positive for ischemic bowel and the radiologist's impression specifically narrating so (*see* Expert Aff., at ¶ 21). "Had Dr. Binetti reviewed the findings on [that] CT scan," plaintiff's expert opined, "and given the [exploratory] surgery he performed which essentially ruled out a mechanical obstruction and [plaintiff's] clinical course post-surgery, he should have considered bowel ischemia as part of his differential diagnosis … and re-operated to inspect the area again. The failure to do so was departure from accepted medical/surgical practice" (*id.*, at ¶ 23; *see id.*, at ¶ 27 [As of June 25, 2021, plaintiff "required an operative procedure, in this case, an exploratory laparotomy with assessment of the mesenteric blood supply to the malfunctioning portion of the bowel. The failure of Dr. Binetti to do so was a departure from the standard of care"]). Plaintiff's expert concluded:

> "Had Dr. Binetti performed such a surgery on June 25 or before, [p]laintiff would have spent a few more days in the hospital and would have been discharged and avoided the additional pain and suffering she went through and avoided the additional [NDH] hospitalizations of July 6-10, 2021, July 11-23, 2021, July 30-31, 2021, and the extensive 1 month [AMC] admission of July 31 – August 31, 2021 as well as her many, many months of recovery. This is because removing the ischemic portion of the small bowel would have restored functionality of the small bowel and corrected the perforation"

(*id.*, at ¶¶ 28-29).

Plaintiff's expert disputes Dr. Herron's view that plaintiff presented with no evidence of fistula during her NDH admission of June 25 to July 3, 2021. The anonymous expert asserts that the radiology report, combined with a wound that "grew out E. coli," should have caused defendant to "have suspected a fistula…. Therefore, to dismiss the possibility of a fistula with this evidence is not clinically appropriate and a departure from good and accepted

medical/surgical practice" (Expert Aff, at ¶ 25). The expert continues that the CT results of July 6, 2021, showed dilated bowel loops, and "[t]here was NO clinical reason for this to occur except ischemia related to the loop of small bowel. The radiologist also suggested the presence of a fistula. This should have been addressed previously to avoid the ongoing pain and suffering of the [p]laintiff" (*id.*, at ¶ 32 [emphasis original]).

The expert continued that, by the time of plaintiff's transfer to AMC on July 31, 2021:

> "too much time had elapsed [for corrective surgery] to be performed safely, as extensive inflammatory adhesions would have formed. The excessive delay by Dr. Binetti in properly addressing the bowel ischemia committed the patient to an indirect non-surgical alternative which unnecessarily prolonged her recovery and necessitated extensive hospital time and suffering. While it is true that with good surgical judgment, surgery was not performed at [AMC], it was the missed opportunity by Dr. Binetti in June 2021 to recognize and properly treat the [p]laintiff's post-surgery complication by performing a laparotomy which would have obviated the necessity of the subsequent multiple hospitalizations and protracted recovery period and unnecessary pain and suffering endured by the [p]laintiff"

(Expert Aff, at ¶ 44). The expert concluded that it was more likely than not that, had Dr. Binetti timely performed a surgery to diagnose and treat plaintiff's ischemic bowel, "plaintiff would not have continued to experience her pain and would not have had to undergo the additional hospitalizations and the extended pain and suffering" (*id.*, at 47). The expert specifically disagreed with Dr. Herron that "the risks of surgical intervention significantly outweighed any potential benefit of performing same" (Herron Aff, at ¶ 56), instead asserting that the "benefit was not potential, but actual in the [p]laintiff being able to avoid 5-6 months of pain and suffering including draining bowel materials from her abdomen and avoiding multiple hospitalizations. The 'conservative' treatment of 5-6 months of draining fistulas and multiple hospitalizations and extensive suffering can be contrasted with a surgical procedure which is well within the capability of a general surgeon that would have resolved the issue" (Expert Aff, at ¶ 51).

In reply, defendant asserts that plaintiff's anonymous expert did not dispute defendant's showing of non-culpability for plaintiff's post-surgical complications, and therefore that he is entitled to summary judgment dismissing all claims in plaintiff's bill of particulars arising from defendant's evaluation of plaintiff for, recommendation of, and performance of the June 9 and

11, 2021 surgeries. As to the anonymous expert's assertion that defendant negligently failed to perform a further surgery as of June 25, 2021, defendant asserts that plaintiff never asserted this claim in her bill of particulars and therefore she cannot assert it at this late hour in opposition to summary judgment. In any event, defendant argues, the anonymous affirmation is insufficient to establish that alternative basis for liability because it did not opine that defendant's conservative measures deviated from the standard of care or were unsuccessful in treating plaintiff's condition – albeit over a longer period – and instead merely speculates that surgical treatment would have resolved plaintiff's complications sooner.

Analysis

A movant seeking summary judgment must tender evidentiary proof in admissible form sufficient to show that there remains no reasonably disputable triable issue of material fact such that judgment should be directed in its favor as a matter of law (*see Giuffrida v Citibank Corp.*, 100 NY2d 72 [2003], *citing Alvarez v Prospect Hosp.*, 68 NY2d 320 [1986]; *Winegrad v New York Univ. Med. Ctr.*, 64 NY2d 851, 853 [1985]; *Zuckerman v City of New York*, 49 NY2d 557, 562 [1980]). Only upon the movant's sufficient *prima facie* showing does the burden shift to the respondent to rebut such showing (*see id.*). If defendant then adduces record evidence or other materials creating any triable issue of material fact – giving the party adverse to the motion the benefit of every reasonable favorable inference – then the motion must be denied (*see id.*).

The essential elements of a medical malpractice claim are: "(1) deviation or departure from accepted medical practice and (2) evidence that such departure was a proximate cause of injury" (*Mendoza v Maimonides Med. Ctr.*, 203 AD3d 715, 716 [2d Dept 2022] [internal citations omitted]; *see Duvidovich v George*, 122 AD3d 666 [2d Dept 2014]; *DiMitri v Monsouri*, 302 AD2d 420, 421 [2d Dept 2003]). Where a defendant makes this *prima facie* showing, "the burden shifts to the plaintiff to rebut the defendant's showing by raising a triable issue of fact as to both the departure element and the causation element" (*Mendoza*, 203 AD3d at 716, *quoting Stukas v Streiter*, 83 AD3d 18, 25 [2d Dept 2011]; *see Shahid v N.Y. City Health & Hosps. Corp.*, 47 AD3d 800 [2d Dept 2008). "Summary judgment is not appropriate in a medical malpractice action where the parties adduce conflicting medical expert opinions" (*id.*, *quoting Feinberg v Feit*, 23 AD3d 517, 519 [2d Dept 2005]). "General and conclusory allegations of medical malpractice, however, unsupported by competent evidence tending to establish the

essential elements of medical malpractice, are insufficient to defeat a defendant physician's summary judgment motion" (*id.*, *quoting Myers v Ferrara*, 56 AD3d 78, 84 [2d Dept 2008]). Thus, nonspeculative expert testimony "is necessary to prove a deviation from accepted standards of medical care and to establish proximate cause" (*Hudler v Reddy*, 226 AD3d 654, 656 [2d Dept 2024], *quoting Navarro v Ortiz*, 203 AD3d 834, 836 [2d Dept 2022]; *see Burns v Goyal*, 145 AD3d 952, 954 [2d Dept 2016]; *Koehler v Schwartz*, 48 NY2d 807 [1979]).

Dr. Herron's expert affirmation carries defendant's burden to establish that defendant's care of plaintiff was non-negligent and did not cause or exacerbate plaintiff's post-surgical complications. Dr. Herron attested that defendant did not deviate from the standard of care in his treatment of plaintiff, that plaintiff's complications are routine sequelae of abdominal surgery, and that plaintiff manifested those complications – and demonstrated a propensity to develop them again – based on her abdomen's response to the original gastric sleeve surgery. Dr. Herron also attested that defendant's conservative non-surgical treatment of those complications was within the standard of care, particularly given plaintiff's pre-existing abdominal adhesions, corresponding heightened risks of re-opening the abdomen and plaintiff's responsiveness to beside wound care, antibiotics and other medical approaches. Accordingly, the burden shifts to plaintiff to raise a triable issue of fact.

As an initial matter, this Court declines to reject plaintiff's opposition on the grounds that plaintiff fails to rebut defendant's Statement of Material Facts ("SMF") in proper form. Uniform Rule 202.8-g states that the court "may direct" the party making a motion to annex an SMF to the notice of motion. Neither this Court's rules nor any prior Order of this Court directed the moving party to file an SMF, and therefore Rule 202.8-g does not apply. Even if it did, the record is not so complex that this Court cannot otherwise readily discern the issues in chief, and therefore this Court credits this State's strong public policy to resolve cases on their merits when possible (*see e.g. Matter of Goldstein v N.Y. State Urban Dev. Corp.*, 13 NY3d 511, 521 [2009]). Accordingly, the Court reaches the merits of plaintiff's opposition.

Plaintiff's expert raises no triable issue of fact as to whether defendant caused or contributed to plaintiff's complications themselves. Nor does plaintiff's expert identify any test or non-surgical treatment that defendant should have undertaken to prevent or treat them or dispute the ultimate efficacy of the conservative measures that defendant undertook. On those grounds, defendant is entitled to summary judgment to the extent that all claims in the bill of

particulars *other* than defendant's failure to treat the complications timely or surgically are dismissed.

Turning to those remaining claims, defendant fails to establish that plaintiff's theory of liability is novel and thus not cognizable on summary judgment. Plaintiff's bill of particulars specifically alleges that defendant was negligent in "delaying necessary surgical procedures…; in carelessly and negligently failing to consider a differential diagnosis of a fistula and bowel ischemia requiring re-anastomosis; in carelessly and negligently worsening the plaintiff's condition by failing to timely perform surgery; [and] in carelessly and negligently causing and/or contributing to deterioration in the plaintiff's systemic condition requiring multiple hospitalizations" (Bill of Particulars, at 4). While defense counsel asserts that "re-anastomosis" was not appropriate (*see* Def Reply Mem, at ¶ 20), defendant offers no expert affirmation to that effect and, even if he had, plaintiff's bill of particulars clearly indicated an alleged basis for liability grounded in the contention that defendant's failure to perform surgery to remove the allegedly ischemic portion of plaintiff's bowel unnecessarily prolonged plaintiff's hospitalizations, suffering and recovery.

Defendant also fails to establish that plaintiff's expert relies only on impermissible hindsight analysis to support his opinion. Construing the record in the light most favorable to plaintiff in opposition to summary judgment, plaintiff's expert specifically disputed Dr. Binetti's assertion that the risks of potentially curative surgery outweighed the benefits on and after June 25, 2021. Plaintiff's expert goes further to assert that the benefits far outweighed the risks, and therefore it was malpractice for defendant not to perform surgical correction on and after June 25, 2021. To support that conclusion – and contrary to defendant's argument – plaintiff's expert specifically analyzed the facts in the medical record then available to defendant, including radiological impressions and plaintiff's continuing distress despite the conservative non-surgical treatment plan, to opine that defendant should have by then diagnosed an ischemic bowel for which the standard of care was surgery. Plaintiff's expert also opined that, had defendant proceeded surgically, the surgery would have been curative, thereby averting plaintiff's subsequent months of suffering and hospitalizations. These contentions were not retrospective or otherwise speculative because plaintiff's expert grounded them specifically in the radiological reports and laboratory results available to defendant at the time of his continuing election not to operate. As such, defendant's reliance on medical malpractice cases disapproving retrospective

analysis (*see e.g. Longhi v Lewit*, 187 AD3d 873 [2d Dept 2020]; *Brown v Bauman*, 42 AD3d 390 [1st Dept 2007]; *Henry v Bronx Lebanon Med. Ctr.*, 53 AD2d 476 [1st Dept 1976]) are unresponsive to plaintiff's remaining theory of liability.

Also without merit is defendant's contention that plaintiff's expert failed to assert the medical insufficiency of defendant's conservative treatment measures. Again, construing the record in the light most favorable to plaintiff in opposition to summary judgment, plaintiff's expert opined that surgery as of June 25, 2021, was medically necessary based on the test results and plaintiff's continuing symptoms, and that defendant's failure to proceed surgically negligently prolonged plaintiff's complications, hospitalizations, pain, suffering and recovery. Defendant's contrary reliance on AMC allegedly continuing conservative treatment measures through plaintiff's discharge on August 31, 2021 – and on the ultimate resolution of plaintiff's complications by late autumn 2021 – does not eliminate these triable questions of fact.

For the foregoing reasons, the balance of defendant's summary judgment motion must be denied.

Dr. Herron and plaintiff's expert dispute, to a reasonable degree of medical certainty, the standard of care applicable to plaintiff on and after June 25, 2021 – particularly whether the risks of corrective surgery then outweighed the benefits, or the opposite. While Dr. Herron deemed corrective surgery to be contraindicated for plaintiff, plaintiff's expert deemed it necessary and negligent not to provide based on her condition and the medical records then available to defendant, and that this failure was a substantial factor in causing extra months of illness. Though a reasonable finder of fact could well conclude otherwise, summary judgment is untenable based on this specific and record-supported dispute (*see Mendoza*, 203 AD3d at 716; *Stukas*, 83 AD3d at 25).

The Court has considered the parties' remaining contentions and deems them to lack merit or to be moot considering the foregoing. Accordingly, it is hereby

ORDERED that defendant's summary judgment motion is granted to the extent that all claims in the bill of particulars not alleging failure to treat plaintiff's complications surgically or otherwise more timely, i.e. "delaying necessary surgical procedures…; in carelessly and negligently failing to consider a differential diagnosis of a fistula and bowel ischemia requiring re-anastomosis; in carelessly and negligently worsening the plaintiff's condition by failing to timely perform surgery; [and] in carelessly and negligently causing and/or contributing to

deterioration in the plaintiff's systemic condition requiring multiple hospitalizations", is granted, but to these latter extents is denied; and it is further

ORDERED that all counsel shall appear in person on March 7, 2025, at 10:00 a.m. for a pre-trial conference. Adjournments are only granted with leave of the Court.

The foregoing constitutes the Decision and Order of this Court.

Dated: January 9, 2025
Poughkeepsie, New York

HON. MICHAEL G. HAYES, A.J.S.C.