

**McGowan v Lanigan**

2026 NY Slip Op 30033(U)

January 6, 2026

Supreme Court, New York County

Docket Number: Index No. 805387/2022

Judge: John J. Kelley

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**SUPREME COURT OF THE STATE OF NEW YORK  
NEW YORK COUNTY**

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

*Justice*

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MICHAEL MCGOWAN,

Plaintiff,

- v -

MICHAEL LANIGAN, M.D., YOUNG J. SUH, M.D.,  
and MOUNT SINAI WEST,

Defendants.

-----X

INDEX NO. 805387/2022

MOTION DATE 10/14/2025

MOTION SEQ. NO. 001

**DECISION + ORDER ON  
MOTION**

The following e-filed documents, listed by NYSCEF document number (Motion 001) 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48

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, and retention of healthcare employees, the defendants move pursuant to CPLR 3212 for summary judgment dismissing the complaint. The plaintiff opposes the motion. The motion is granted to the extent that the defendants are awarded summary judgment dismissing the complaint insofar as asserted against the defendant Young J. Suh, M.D., and dismissing the lack of informed consent and negligent hiring, training, supervision, and retention causes of action insofar as asserted against the defendants Michael Lanigan, M.D., and Mount Sinai West. The motion is otherwise denied.

The crux of the plaintiff's claim is that, on August 29, 2022, the defendant emergency medicine specialists Lanigan and Suh, while working in the emergency department of the defendant hospital Mount Sinai West, negligently failed to diagnose him with, and treat him for, testicular torsion, instead misdiagnosing him with passed kidney stones, and discharging him to his home.

In his bills of particulars, the plaintiff alleged that, although he presented to the Mount Sinai West emergency department with lower abdominal pain, Lanigan and Suh departed from good and accepted practice in failing to consider, order, perform, and/or recommend a genital examination, in failing to heed the complaints, signs, and symptoms of testicular torsion, and in failing to attempt to manually detour the testicular torsion. He further alleged that those physicians failed to recognize, appreciate, treat, and/or diagnose his lower-left quadrant abdominal pain, failed to perform a proper physical examination of his testicles, failed to order appropriate testing, and failed to formulate a proper differential diagnosis, thus misdiagnosing him because they failed to consider, investigate, and/or properly rule out testicular torsion. The plaintiff additionally alleged that the defendants failed to perform necessary surgery, instead prematurely discharging him, without treating him or rendering proper treatment. He also faulted the defendants for failing properly to refer him to appropriate specialists. The plaintiff alleged that, as a consequence of these departures from good and accepted practice, he continued to experience testicular torsion and, thus, suffered from the loss of his left testicle via a left orchiectomy, and had to undergo a right orchiopexy.

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-Sturup 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]).

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 *Roques v Noble*, 73 AD3d at 207; *Luu v Paskowski*, 57 AD3d 856, 857 [2d Dept 2008]; see also *Kristal R. v Nichter*, 115 AD3d 409, 411-412 [1st Dept 2014]; *Bacani v Rosenberg*, 74 AD3d 500, 501-502 [1st Dept 2010]). 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 bills of particulars, transcripts of the parties' deposition testimony, relevant medical and hospital records, relevant discovery orders, the note of issue, a statement of allegedly undisputed material facts, an attorney's affirmation, and the expert affirmation of board-certified emergency medicine specialist Gregory Mazarin, 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 claimed injuries.

As Dr. Mazarin summarized the relevant medical records, on August 29, 2022, the plaintiff first presented CityMD for an urgent care visit, complaining of abdominal pain that had begun just prior to his arrival, but not complaining of testicular pain. Rather, the CityMD records reported that the plaintiff, who was then 52 years old, made complaints of left lower-quadrant pain since that morning, as well as of mild nausea, albeit with no vomiting. The CityMD assessment and plan reported that the plaintiff was "visibly uncomfortable" with left flank pain, although his urinalysis and abdominal examinations were characterized as benign. CityMD personnel further reported that they were concerned that the plaintiff may have been experiencing mesenteric ischemia or diverticulitis and, thus, referred the plaintiff to the Mount Sinai West emergency department.

Shortly after his visit at CityMD, the plaintiff presented to the Mount Sinai West emergency department. In the triage unit, hospital personnel assessed the plaintiff with complaints of left-sided abdominal pain that had radiated to his left testicle over the course of the prior two days, not merely since earlier that morning. The triage nurse reported that the plaintiff appeared uncomfortable and bent over. After his encounter with that nurse, the defendant Suh, who was then a resident, and the defendant Lanigan, who was then the emergency department attending physician, saw and examined the plaintiff, and recorded the plaintiff's history of abdominal and testicular pain, noting that the pain waxed and waned. These defendants concluded that the plaintiff's genitourinary system was negative for dysuria and hematuria, although his gastrointestinal system was positive for abdominal pain, with all other systems reported as negative for concerning signs and symptoms. Suh and Lanigan both examined the plaintiff, including his testicles and genitourinary area. As Dr. Mazarin interpreted the plaintiff's chart, during these examinations, the plaintiff made no complaints of testicular pain, while Suh and Lanigan reported the presence of bilateral positive cremasteric reflexes,

and the absence of testicular or scrotal swelling. Suh and Lanigan formulated a differential diagnosis that identified kidney stones as the most likely cause of the plaintiff's symptoms. They concluded that it was less likely that the plaintiff was experiencing an acute intra-abdominal pathology, such as diverticulitis or small bowel obstruction, and they essentially ruled out a genitourinary pathology in light of the normal genitourinary examination, along with positive and intact bilateral cremasteric reflexes, a type of superficial reflex in males, in which stroking the inner thigh causes the cremaster muscle in the groin to contract, thus elevating the testicle on the same side.

According to Dr. Mazarin, a urinalysis performed at Mount Sinai West on August 29, 2022 revealed the presence of a moderate amount of blood in the plaintiff's urine, although blood tests were described as unremarkable, and a computed tomography (CT) scan of the abdomen and pelvis revealed no acute abdominopelvic pathology. The defendants prescribed the nonsteroidal anti-inflammatory drug Toradol, after which the plaintiff reported a decrease in abdominal pain. The Mount Sinai West chart also reported that the plaintiff evinced no scrotal tenderness, that his testicles were not enlarged, and that he had no erythema or swelling of the scrotum, although the hospital's urology department reported the presence of one larger structure on each side of the plaintiff's scrotum, identifying them as "testicular cysts." Consequently, Lanigan's initial impression was left lower-quadrant pain and likely bilateral hydroceles. Lanigan thus instructed the plaintiff to follow up with the urology department as an outpatient, and discharged the plaintiff to his home, with recommendations relevant to treatment of symptoms related to a patient who had just passed a kidney stone. In this respect, Lanigan instructed the plaintiff to seek prompt medical attention should he experience severe pain that was not relieved by pain medication, repeated vomiting, an inability to keep fluids down, blood in his urine, or an inability to pass urine for eight hours.

On August 31, 2022, or two days later, the plaintiff underwent an ultrasound scan at Lenox Hill Radiology that revealed the presence of left testicular torsion. Almost immediately

thereafter, he presented to the emergency department at NYU Langone Hospital (NYU), and reported his medical history referable to the prior several days, including the results of the ultrasound scan. Based on those results, the plaintiff underwent a left orchiectomy and right orchiopexy that date at NYU. He was discharged to his home on September 1, 2022.

Dr. Mazarin first noted that both Suh and Lanigan testified at their depositions that a passed kidney stone was part of their differential diagnosis. He adverted to Lanigan's testimony that, if a kidney stone has passed to the bladder, it is possible that there would be no complaints of pain, while complaints that are related to a kidney stone could be associated with pain in the flank, abdomen, or the genital or groin area, along with complaints of nausea or vomiting. Dr. Mazarin further summarized Lanigan's deposition testimony to the effect that a urinalysis may also be performed to assess the patient for a kidney stone, particularly where, as in the plaintiff's case, the presence of blood makes a kidney stone more likely. Lanigan further testified that a CT scan may not result in any findings, inasmuch as a kidney stone that already had passed to the bladder may not be seen on such a scan.

In light of the fact that the plaintiff's primary complaint at Mount Sinai West was left lower-quadrant abdominal pain that radiated to his left testicle, and in view of the impressions that Lanigan and Suh formed after examining the plaintiff, specifically the presence of bilateral positive cremasteric reflex, and the absence of any testicular pain, swelling, erythema, scrotal tenderness, and scrotal enlargement, Dr. Mazarin concluded that the plaintiff's presentation was atypical for testicular torsion. Dr. Mazarin explained that testicular torsion predominantly occurs in a younger population, and is accompanied by consistent, direct pain at the testicle, and not by radiating pain to the testicle or a complaint of waxing and waning pain. He further asserted that an examination in which testicular torsion is present typically results in a finding of negative cremasteric reflex, and is generally accompanied by scrotal swelling and/or enlargement, which was not present or observed during the defendants' examination of the plaintiff. Hence, Dr. Mazarin concluded that Lanigan and Suh had no reason to suspect testicular torsion.

In connection with the propriety of the examination that Lanigan and Suh performed, Dr. Mazarin concluded that it was appropriate and within the applicable standard of care, since it specifically included a visual observation as well as a physical palpation of the plaintiff's testicles. Dr. Mazarin opined that a finding of a positive cremasteric reflex "is a tell-tale sign that a patient is not experiencing testicular torsion as the cremasteric reflex is notably absent when a patient has testicular torsion." As he phrased it, "[b]ecause of this finding, coupled with the lack of scrotal tenderness, swelling or hardness, it was reasonable for Dr. Lanigan and Dr. Suh to consider alternative diagnoses other than testicular torsion," and that "[g]iven the lack of symptoms related to testicular torsion, . . . the standard of care did not require any further diagnostic testing, including an ultrasound, or a consultation from a specialist".

Dr. Mazarin further opined that it was consistent with the standard of care for Lanigan and Suh to consider a passed kidney stone as a potential diagnosis, inasmuch as the initial symptomology of a kidney stone may include left lower-quadrant pain that can radiate to the testicular area, and the pain associated with a kidney stone may wax and wane, while urinalysis in the plaintiff's revealed the presence of blood in the plaintiff's urine, a condition known as hematuria. In this respect, Dr. Mazarin opined that hematuria is not a finding consistent with testicular torsion. Additionally, Dr. Mazarin concluded that the performance of the abdominal and pelvic CT scan was in accordance with the standard of care for the purpose of assessing the potential diagnosis of a kidney stone. He averred that the negative findings from the CT scan did not rule out a kidney stone, and it was reasonable to continue to consider the diagnosis of a passed kidney stone, given the hematuria and decrease in pain with the administration of Toradol. Dr. Mazarin agreed with Lanigan's deposition testimony that a negative finding on CT of a kidney stone does not exclude the diagnosis since, if a kidney stone passes from the kidney to the bladder, the symptoms, including complaints of pain, may lessen or dissipate, and once a kidney stone passes from the kidney to the bladder, it may not be visible on a CT scan.

Dr. Mazarin additionally opined that, inasmuch as a genitourinary cause for the plaintiff's complaints was appropriately and reasonably ruled out, and the possibility that the plaintiff had experienced a passed kidney stone remained, it was consistent with the standard of care to discharge the plaintiff from the emergency department after his pain dissipated, with instructions to follow up with his urologist, but to return if his condition worsened.

In addition, Dr. Mazarin concluded that, based on the hospital chart and the parties' deposition testimony, Suh was a resident at the time that she and Lanigan examined and assessed the plaintiff, and that she was, at all times, acting under the direction of Lanigan.

In connection with the plaintiff's diagnosis of testicular torsion only two days after his discharge from Mount Sinai West, Dr. Mazarin opined that "the symptoms with which Mr. McGowan presented to NYU Langone had changed compared to when he presented to Mount Sinai West." He asserted that, in light of the lapse of that two-day period, "the actions of staff at Mount Sinai West, including Dr. Lanigan and Dr. Suh, did not cause or contribute to the injuries claimed by Mr. McGowan," since the relevant medical records reflected a comprehensive assessment that confirmed a "negative genitourinary cause" for his complaints.

In opposition to the defendants' motion, the plaintiff relied on many of the documents that the defendants had submitted. He also submitted a counterstatement of material facts, his amended bills of particulars, an attorney's affirmation, and the expert affirmation of a board-certified general surgeon, who has provided surgical on-call coverage to the emergency department of a major New York hospital for 40 years, and asserted that he or she was familiar with the standards of care in New York in 2022 as it applies to the diagnosis and treatment of testicular torsion. The plaintiff's expert opined that Lanigan departed from good and accepted practice and that his departures caused or contributed to the plaintiff's claimed injuries.

Initially, the plaintiff's expert recapitulated the relevant medical history of the plaintiff's visit to Mount Sinai West. Although the expert agreed with much of Dr. Mazarin's narrative, the expert pointed out that, at 4:48 p.m. on August 29, 2022, the Mount Sinai West chart reported

that relevant indications for performing a CT scan were “flank pain” and “kidney stone suspected,” but that the plaintiff never complained of flank pain, that such a complaint was not included in the defendants’ initial workup of the plaintiff, and that Suh confirmed at her deposition that there was never any mention of the plaintiff evincing flank pain.

The plaintiff’s expert surgeon further noted that the plaintiff had testified at his deposition that, over the 24 hours immediately following his discharge from Mount Sinai West, the plaintiff’s pain increased, but remained localized to the same area on his body, that is, from his abdomen radiating to his testicles. The expert further asserted that, on the morning of August 31, 2022, the plaintiff noticed discoloration in his left testicle, that he was still experiencing extreme pain from his abdomen to his testicle, and that he immediately sought medical attention within 36 hours after his discharge from Mount Sinai West. Specifically, the expert explained that the plaintiff presented to his primary care physician, Karen Thornton, M.D., on that morning, and that she examined his testicles and abdomen, performed a urinalysis test, and consulted with a urologist. Dr. Thornton instructed the plaintiff immediately to obtain an ultrasound scan, which he did at Lenox Hill Radiology. When Dr. Thornton received the results of the scan shortly thereafter, she called the plaintiff with the results, informing him that he was suffering from testicular torsion, and needed to have immediate emergency surgery. The plaintiff presented to NYU on August 31, 2022, at 4:23 p.m., where he was immediately examined, and was noted to have left testicular edema, erythema, and tenderness, while his chief complaint on admission was reported as “Testicle pain (Pt with confirmed L testicular torsion. Endorses testicle pain since Monday, was seen at OSH [sic] on Monday and was misdiagnosed with a kidney stone. Had US today that confirmed torsion.)” The NYU chart indicated that NYU healthcare personnel conducted another ultrasound that confirmed the diagnosis of testicular torsion, after which the plaintiff underwent a left orchiectomy and right orchiopexy surgery.

The plaintiff’s expert expressly opined that Suh and Lanigan deviated from the standard of care by improperly failing to consider and include testicular torsion as part of their differential

diagnosis, despite the symptomatology that the plaintiff presented, which the expert characterized as “an indication of” testicular torsion. The expert further faulted Suh and Lanigan for improperly ruling out testicular torsion based on positive cremasteric reflexes, and what they characterized as a “normal” genital examination, which the expert concluded did not properly rule out testicular torsion in light of the plaintiff’s other symptoms. In addition, the plaintiff’s expert asserted that Suh and Lanigan improperly determined the etiology of the plaintiff’s symptoms as a passed kidney stone, despite the results of the CT scan. The expert surgeon also concluded that Suh and Lanigan improperly discharged the plaintiff from Mount Sinai West without having determined the etiology of his symptoms, without properly diagnosing him, and without treating the etiology of his symptoms. The plaintiff’s expert further asserted that Suh and Lanigan departed from good and accepted practice by failing to order an ultrasound “as is required to rule out testicular torsion.”

The plaintiff’s expert physician explained that, upon a patient’s initial presentation to an emergency room, the attending physician and medical staff, including residents, must examine the patient, consider the patient’s medical history and symptoms, and determine what differential diagnoses are indicated by the patient’s presentation. The expert asserted that, based on the differential diagnoses, tests and examinations should be ordered and conducted to rule out each potential diagnosis until a diagnosis is properly confirmed for the patient. As the expert framed the issue,

“if a condition is on a patient’s differential diagnosis in the emergency room, the standard of care requires that condition must be either confirmed (diagnosed) or ruled out. It is a deviation in the standard of care to discharge a patient from the emergency room without determining the etiology of their symptoms and doing so can reasonably and foreseeably lead to the patient’s condition advancing and worsening.”

As applied to the plaintiff’s case, the expert asserted that, if a healthy male patient presents to a hospital emergency department with lower left-quadrant pain in the abdomen, radiating down to his testicle, as did the plaintiff here, “differential diagnoses are limited to testicular torsion,

kidney stones, hernia, and other like intra-abdominal conditions.” The expert explained that, accordingly, an emergency room physician treating that patient must take steps to definitively diagnose the patient

“as having kidney stones, hernia, other intra-abdominal condition, or testicular torsion or rule each one out. If all differential diagnoses are ruled out, further testing needs to be undertaken to determine the etiology of the pain. A patient must not be discharged with no diagnosis. Likewise, a patient must not be discharged with a guess as to what their diagnosis might be. It is also a deviation in the standard of care to discharge a patient with a symptom as a diagnosis, instead of properly diagnosing the patient.”

In connection with this opinion, the expert expressly concluded that the only way to diagnose or rule out testicular torsion is via an ultrasound scan, while the presence of kidney stones, a hernia, or any other abdominal-related diagnosis can be confirmed or ruled out by a CT scan.

In connection with the opinion that testicular torsion should have been included in Suh’s and Lanigan’s differential diagnosis, the plaintiff’s expert concluded that the symptoms that the plaintiff presented to Mount Sinai West healthcare personnel were “textbook testicular torsion: pain originating from the lower left quadrant of the abdomen flowing to the testicle and nausea.” The expert asserted that the plaintiff’s deposition testimony also supported a finding of testicular torsion, inasmuch as the plaintiff testified that the pain was so severe that he was lightheaded at times, and that he had reported severe nausea.

The plaintiff’s expert expressly disagreed with Dr. Mazarin that the area in which the plaintiff’s pain originated supported the latter’s conclusion that it was proper for Lanigan and Suh to exclude testicular torsion from their differential diagnosis. In this respect, the expert averred that the area described by the plaintiff as the pain’s point of origin---the lower left quadrant of the abdomen, radiating to his left testicle---is a known and common complaint of patients with testicular torsion because the pain follows the course of the ilioinguinal nerve, which supplies not only the testicle, but also the inguinal area and lower left abdomen. The expert further faulted the defendants for excluding testicular torsion even after the CT scan ruled out any other plausible explanation for the plaintiff’s condition.

The plaintiff's expert physician further rejected Dr. Mazarin's opinion that, inasmuch as the plaintiff manifested positive cremasteric reflexes and no testicular swelling or tenderness, Lanigan and Suh appropriately ruled out testicular torsion as a diagnosis. Specifically, the expert asserted that these observations and findings can all be present in patients with testicular torsion, which is why an ultrasound scan is required to rule it out. Moreover, the expert explained that, while testicular torsion can present as discoloration, swelling, or enlargement of the testicle, these conditions are more likely to occur if the testicular torsion has been present for a prolonged period of time. In any event, the expert opined that discoloration, swelling, and enlargement are not definitive symptoms of testicular torsion, and that the absence of them in a patient's presentation does not rule out testicular torsion as a diagnosis, as it is not a "reliable" method for ruling out that condition. The plaintiff's expert further asserted that the fact that the plaintiff's testicles were not yet swollen or discolored when he presented to Mount Sinai West only underscored the fact that his testicular torsion was at an earlier stage, and that his left testicle was still viable at the time of his presentation and admission to, and discharge from, the Mount Sinai West emergency department.

As the plaintiff's expert phrased it, "[t]he gold standard for the diagnosis of testicular torsion is an ultrasound examination," and the defendants' failure to order such a test, despite the availability of the necessary equipment and the ease in ordering and obtaining such a scan, was a deviation from the standard of care that "foreseeably and substantially caused Mr. McGowan to lose his left testicle." In this respect, the expert asserted that even Suh and Lanigan agreed that testicular torsion is diagnosed via an ultrasound. The expert explained that the medically accepted standard of care when a male patient presents to an emergency room with unilateral lower-quadrant pain in the abdomen that radiates to a testicle, is that the patient "must undergo an ultrasound to rule out testicular torsion," and that, in the plaintiff's case, the fact that this complaint of pain was coupled with nausea, warranted the conclusion that an ultrasound scan "was undoubtedly indicated here."

The plaintiff's expert additionally remarked that it was "notable" that the plaintiff presented to Mount Sinai West with hydroceles on both of his testicles, since hydroceles can be associated with an increased risk for testicular torsion.

Moreover, the plaintiff's expert expressly disagreed with Dr. Mazarin that kidney stones, or passed kidney stones, were a reasonable explanation for the plaintiff's symptoms, especially because the testing ordered by Suh and Lanigan actually ruled out kidney stones as the cause of those symptoms, as well as any other intra-abdominal cause of the plaintiff's specifically localized pain. The expert further asserted that, while the plaintiff's urine was positive for the presence of blood, "that fact itself does not confirm a diagnosis of kidney stones." The expert went on to explain that, "[i]n fact, when the urinalysis is positive for blood, but the CT scan is normal, kidney stones are ruled out as a differential diagnosis for that patient," and that, since the results of the CT scan ruled out kidney stones as a viable diagnosis almost three hours prior to the plaintiff's discharge, "kidney stones should not have been explained to Mr. McGowan to be the cause of his symptoms at discharge." The plaintiff's expert concluded that Lanigan and Suh, in providing this incorrect explanation upon the plaintiff's discharge, deviated from good and accepted medical practice. In this regard, the plaintiff's expert stated that once a patient passes a kidney stone, the pain associated with that condition terminates, while, in the plaintiff's case, the pain continued and he was prescribed Toradol to control it.

The plaintiff's expert also opined that Lanigan deviated from the standard of care by improperly and prematurely discharging the plaintiff from the emergency department to home, without a proper diagnosis. The expert framed the issue as follows:

"Unable to definitively and properly determine the root cause of Mr. McGowan's symptoms, he was diagnosed with unspecified abdominal pain—a symptom he first presented to the emergency department with—and was sent home. Mr. McGowan left Mt. Sinai Emergency Department more than eight hours after his arrival with no more than the diagnosis of the symptom he first presented with, no etiology as to that symptom, and the benefit of high strength pain medication to temporarily relieve one of his symptoms. He was also given information on kidney stones at his discharge—and told he likely passed a kidney stone even though he said he did not believe he did—due to the unconfirmed and

unindicated determination by Dr. Lanigan, Dr. Suh, and the Mt Sinai West medical staff that Mr. McGowan may have passed a kidney stone.”

The plaintiff's expert further rejected the partial dissipation of the plaintiff's pain during his stay at Mount Sinai West as a basis for concluding that he had passed a kidney stone, explaining that this outcome demonstrated only that the plaintiff was given effective pain medication while there. In this respect, the expert noted that the plaintiff was administered 15 milligrams of Toradol in a one-minute dose after he had been in the emergency department for five hours, and further explained that Toradol is a high-strength pain medication usually administered to relieve a patient's pain after he or she undergoes surgery. Accordingly, the expert concluded that it was not surprising that the plaintiff's pain subsided after taking Toradol, but that, although the drug treated his symptoms, it did not treat the etiology of his symptoms, and the subsidence of pain in no way indicated that the plaintiff had in any way improved, or that he should have been discharged from the emergency department.

In addition, the plaintiff's expert asserted that testicular torsion can occur and continue for days, especially if it is not properly diagnosed or treated, and that this is what occurred in the plaintiff's case. The expert concluded that the defendants' failure to diagnose and treat the plaintiff, and to prematurely discharge him, caused his testicular torsion to worsen, and his left testicle to manifest discoloration and become unviable. More specifically, the expert asserted that, as a proximate result of the defendants' departures from good and accepted practice, the plaintiff experienced progressive testicular torsion, loss of his testicle via a left orchiectomy procedure, and severe emotional, physical, and mental pain and suffering. The plaintiff's expert explicitly concluded that, had Lanigan and Suh properly examined the plaintiff, properly included testicular torsion in the differential diagnosis, properly and actually diagnosed him with testicular torsion, properly ruled out kidney stones, hernia, and other abdominal conditions as a cause of the plaintiff's pain, and properly ordered an ultrasound, the testicular torsion would have been

diagnosed in a timely fashion, and a simple minor surgery to untwist his testicle would have prevented testicular necrosis and the loss of his left testicle.

In connection with Suh's involvement, although the plaintiff's expert conceded that Lanigan was responsible for the plaintiff's diagnosis, plan of care, and determination to discharge the plaintiff with a diagnosis of a passed kidney stone, the expert asserted that Suh had authority as a resident to order an ultrasound, but failed to do so. The expert thus concluded that Suh's failure to order an ultrasound was a deviation from the standard of care that substantially and foreseeably caused and contributed to the plaintiff's injuries.

In reply, the defendants submitted an attorney's affirmation, in which counsel argued that the opinions of the plaintiff's expert were speculative, conclusory, and not supported by the medical records. He also challenged the qualifications of the plaintiff's expert to render opinions as to whether the defendants departed from good and accepted practice.

Although the defendants established their prima facie entitlement to judgment as a matter of law in connection with the medical malpractice cause of action, the court concludes that the opinions of the plaintiff's expert 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 (*Wiands v Albany Med. Ctr.*, 29 AD3d 982, 984 [2d Dept 2006]), particularly with respect to the appropriate formulation of a differential diagnosis based on a patient's complaints, signs, symptoms, and diagnostic test results, whether the defendants should have diagnosed the plaintiff with testicular torsion, whether they should have discharged him with a diagnosis of passed kidney stones, and whether they should immediately have referred him for surgery. The plaintiff's expert also explicitly opined that these departures delayed the proper treatment of the plaintiff, and that this delay caused or contributed to the need for surgery and the plaintiff's loss of his left testicle. 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).

The determination of whether a witness is qualified to give expert testimony is entrusted to the sound discretion of the trial court, the provident exercise of which will not be disturbed absent a serious mistake or an error of law (see *Guzman v 4030 Bronx Blvd. Assoc., LLC*, 54 AD3d 42, 49 [1st Dept 2008]). The courts of this State repeatedly have rejected the concept that only a specialist practicing in a defendant's particular specialty is competent to testify that another specialist departed from accepted practice in the specialty (see *Fuller v Preis*, 35 NY2d 425, 431 [1974]; *Bartolacci-Meir v Sassoon*, 149 AD3d 567, 572 [1st Dept 2017]; *Bickom v Bierwagen*, 48 AD3d 1247, 1248 [4th Dept 2008]; *Julien v Physician's Hosp.*, 231 AD2d 678, 680 [2d Dept 1996]; *Matter of Enu v Sobol*, 171 AD2d 302, 304 [3d Dept 1991]; *Joswick v Lenox Hill Hosp.*, 161 AD2d 352, 355 [1st Dept 1990]). Nonetheless, a practitioner who is put forward by a party as an expert qualified to support or oppose a summary judgment motion must assert that he or she possesses the necessary knowledge and training in the relevant specialty, or explain how he or she came to it, and also must articulate the standard of care that allegedly was applicable (see *Colwin v Katz*, 122 AD3d 523, 524 [1st Dept 2014]).

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

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

"the affidavit must be by a qualified expert who 'profess[es] personal knowledge of the standard of care in the field of . . . medicine [or dentistry at issue], whether acquired through his practice or studies or in some other way' (*Nguyen v Dorce*, 125 AD3d 571, 572 [1st Dept 2015] [pathologist not qualified to render opinion as to whether defendant deviated from the standard of care in the field of emergency medicine]; see also *Atkins v Beth Abraham Health Servs.*, 133 AD3d 491 [1st Dept 2015] [osteopath not qualified to render opinion on treatment of a geriatric patient with diabetes and other conditions]; *Udoye v Westchester-Bronx OB/GYN, P.C.*, 126 AD3d 653 [1st Dept 2015] [pathologist not qualified to render an opinion as to the standard of care in obstetrics or cardiology]; *Mustello v Berg*,

44 AD3d 1018 [2d Dept 2007] [general surgeon not qualified to render opinion as to gastroenterological treatment])”

(*Bartolacci-Meir v Sassoon*, 149 AD3d at 572-573 [emphasis added]). Stated another way, a “physician need not be a specialist in a particular field to qualify as a medical expert and any alleged lack of knowledge in a particular area of expertise goes to the weight and not the admissibility of the testimony” (*Moon Ok Kwon v Martin*, 19 AD3d 664, 664 [2d Dept 2005]; see *Stradtman v Cavaretta [appeal No. 2]*, 179 AD3d 1468, 1471 [4th Dept 2020]).

Consequently, where, as here, the physician proffering an allegedly expert affirmation attests to, and demonstrates familiarity with, training in, and experience with certain aspects of the defendants’ specialty<sup>1</sup>, specifically, the proper manner of diagnosing an emergency room patient with testicular torsion, and whether that patient should have been referred for emergent surgery, he or she will be deemed to have the requisite experience, training, and knowledge necessary to render an opinion as to whether that defendant departed from standards of good practice that proximately caused injury to the plaintiff (see *Fuller v Preis*, 35 NY2d at 431 [neurologist was permitted to give an opinion in the closely related specialty of psychiatry on the issue of whether an accident was the proximate cause of a subsequent suicide]; *Pace v Crouse Health Hosp., Inc.*, 240 AD3d 1418, 1419 [4th Dept 2025] [orthopedic surgeon qualified to render opinion as to whether physiatrist departed from accepted standards of care]; *Johnson v Harlem Hosp.*, 238 AD3d 412, 413-414 [1st Dept 2025] [gastroenterologist is qualified to render an opinion on the proper treatment of a perforated bowel, as surgical expertise was not required]; *Combs v Madejski*, 224 AD3d 1298, 1300 [4th Dept 2024] [general surgeon deemed qualified to render an opinion in connection with claims of medical malpractice against obstetrician/gynecologist, where he opined as to whether an open or laparoscopic procedure

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<sup>1</sup> The plaintiff’s expert expressly attested as follows: “I am frequently consulted for the exact presentation as plaintiff. I have diagnosed and treated the exact problem at issue in this case in emergency departments for decades. I am familiar with the standards of care in New York in 2022 as it applies to the diagnosis and treatment of testicular torsion. As such, I am qualified to render opinions in this action.”

was appropriate]; *Humphrey v Jewish Hosp. & Med. Ctr. of Brooklyn*, 172 AD2d 494, 494 [2d Dept 1991] [general surgeon was deemed to be qualified to render an opinion in the specialty of obstetrics and gynecology]; *Matter of Sang Moon Kim v Ambach*, 68 AD2d 986, 987 [3d Dept 1979] [opinion testimony of qualified neurosurgeon at a professional misconduct hearing was sufficient to permit a finding of gross negligence or gross incompetence of an orthopedic surgeon committed during spinal surgery]; *Matter of Lincoln v New York City Health & Hosps. Corp.*, 2018 NY Slip Op 34085[U], \*5, 2018 NY Misc LEXIS 14236, \*8 [Sup Ct, Bronx County, May 3, 2018] [internist is qualified to render opinion as to the standard of care governing medical care and treatment of patients who undergo breast examinations and breast imaging studies, despite not being a radiologist, oncologist, or breast surgeon]; *cf. Vargas v Bhalodkar*, 204 AD3d 556, 557 [1st Dept 2022] [(p)laintiff's expert, an internist and gastroenterologist with no apparent training or knowledge in cardiology, did not set forth sufficient qualifications to opine on whether (defendant) deviated from the relevant standard of care when she gave cardiac clearance for decedent to temporarily cease taking blood thinners and undergo a colonoscopy"]; *Newell v City of New York.*, 204 AD3d 574, 574 [1st Dept 2022] ["an internist who demonstrated no familiarity with surgery in general or abdominal surgery in particular, was not qualified to render an opinion that (defendant) departed from accepted standards of medical care in performing plaintiff's appendectomy"]; *Samer v Desai*, 179 AD3d 860 [2d Dept 2020] [general and vascular surgeon not qualified to render opinion as to orthopedics or family medicine]; *Bartolacci-Meir v Sassoon*, 149 AD3d at 572 [1st Dept 2017] [general surgeon lacked any experience in gastroenterology sufficient to qualify him as an expert]; *Steinberg v Lenox Hill Hosp.*, 148 AD3d 612, 613 [1st Dept 2017] [plaintiffs' expert was "not qualified to offer an opinion as to causation (,as h)e specializes in cardiovascular surgery, not neurology or ophthalmology (and) failed to 'profess the requisite personal knowledge' necessary to make a determination on the issue of whether (an arterial) perforation was responsible for plaintiff's visual impairment")].

Moreover, there is no requirement in New York that board certification is a prerequisite to the court's consideration of the expert testimony of a physician (see generally *Lyons v Tsadyk*, 225 AD3d 681, 683 [2d Dept 2024]).

Consequently, that branch of the defendants' motion seeking summary judgment dismissing the medical malpractice cause of action insofar as asserted against Lanigan must be denied. Moreover, "[i]n 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]). Since there is no dispute that Lanigan was acting in the course and scope of his employment with Mount Sinai West during the relevant examination, diagnosis, and discharge of the plaintiff, to the extent that there are triable issues of fact as to whether Lanigan committed malpractice, there are triable issues of fact as to whether Mount Sinai West may be held vicariously liable for Lanigan's malpractice.

Nonetheless,

"a hospital is sheltered from liability in those instances where its employees follow the directions of the attending physician (*Filippone v St. Vincent's Hosp. & Med. Ctr.*, 253 AD2d 616, 618; *Christopher v St. Vincent's Hosp. & Med. Ctr.*, 121 AD2d 303, 306, *appeal dismissed* 69 NY2d 707), unless that doctor's orders "are so clearly contraindicated by normal practice that ordinary prudence requires inquiry into the correctness of the orders" (*Warney v Haddad*, 237 AD2d 123, quoting *Toth v Community Hosp.*, 22 NY2d 255, 265 n 3; see also, *Somoza v St. Vincent's Hosp. & Med. Ctr.*, 192 AD2d 429, 431)"

(*Walter v Betancourt*, 283 AD2d 223, 224 [1st Dept 2001]; see *Irizarry v St. Barnabas Hosp.*, 145 AD3d 529, 530 [1st Dept 2016]; *MacDonald v Beth Israel Med. Ctr.*, 136 AD3d 516, 516-517 [1st Dept 2016]; *Suits v Wyckoff Hgts. Med. Ctr.*, 84 AD3d 487, 488 [1st Dept 2011]; *Sela v Katz*, 78 AD3d 681, 682 [2d Dept 2010]). In other words, where the resident or fellow did not

exercise independent judgment or make an independent decision with respect to a patient's care or treatment, neither that physician nor the facility for which he or she was working may be held liable (*see Groff v Kaleida Health*, 161 AD3d 1518, 1520 [4th Dept 2018]; *Bellafiore v Ricotta*, 83 AD3d 632, 633 [2d Dept 2011]). Where, however, a resident or fellow exercised independent judgment or made an independent decision with respect to such care, both that physician and the facility may be held liable (*see Burnett-Joseph v McGrath*, 158 AD3d 526, 527 [1st Dept 2018] [attending physician's deposition testimony raised triable issue of fact as to whether resident exercised independent judgment]). The defendants established that Suh, although she may have had authority to order an ultrasound scan, did not exercise any independent judgment as to the examination of the plaintiff, what tests should have been ordered, the diagnosis of a passed kidney stone, or the determination to discharge the plaintiff. Hence, that branch of the defendants' motion seeking summary judgment dismissing the medical malpractice cause of action insofar as asserted against Suh must be granted.

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]). As relevant here, “[a] failure to diagnose cannot be the basis of a cause of action for lack of informed consent unless associated with a diagnostic procedure that ‘involve[s] invasion or disruption of the integrity of the body’” (*Janeczko v Russell*, 46 AD3d 324, 325 [1st Dept 2007], quoting Public Health Law § 2805-d[2][b]; *see Lewis v Rutkovsky*, 153

AD3d at 456), and that invasion or disruption is claimed to have caused the injury. Since the defendants established, prima facie, that the plaintiff did not allege that any diagnostic procedure that they performed itself caused bodily disruption, and the plaintiff failed to rebut that showing, that branch of the defendants' motion seeking summary judgment dismissing the lack of informed consent cause of action insofar as asserted against each of them must be granted.

To establish a cause of action to recover for negligent hiring, supervision, training, and retention of healthcare personnel, a plaintiff must demonstrate that the defendants either "knew, or should have known," of their employees' "propensity for the sort of conduct which caused the [patient's] injury" (*Sheila C. v Povich*, 11 AD3d 120, 129-130 [1st Dept 2004]; see *Kuhfeldt v New York Presbyt./Weill Cornell Med. Ctr.*, 205 AD3d 480, 481-482 [1st Dept 2022]). The defendants established, prima facie, that all of their healthcare personnel were properly vetted, licensed, and credentialed. In opposition to that showing, the plaintiff did not address the issue and, hence, failed to raise a triable issue of fact in connection with that cause of action. Consequently, the court must grant that branch of the defendants' motion dismissing that cause of action insofar as asserted against each of them.

Accordingly, it is,

ORDERED that the defendants' motion for summary judgment dismissing the complaint is granted to the extent that summary judgment is awarded to them dismissing the entirety of the complaint insofar as asserted against the defendant Young J. Suh, M.D., and dismissing the lack of informed consent and negligent hiring, training, supervision, and retention causes of action insofar as asserted against the defendants Michael Lanigan, M.D., and Mount Sinai West, the complaint is dismissed insofar as asserted against the defendant Young J. Suh, M.D., the lack of informed consent and negligent hiring, training, supervision, and retention causes of action are dismissed insofar as asserted against the defendants Michael Lanigan, M.D., and Mount Sinai West, and the motion is otherwise denied; and it is further,


ORDERED that, on the court’s own motion, the action is severed against the defendant Young J. Suh, M.D.; and it is further,

ORDERED that the Clerk of the court shall enter judgment dismissing the complaint insofar as asserted against the defendant Young J. Suh, M.D.; and it is further,

ORDERED that, on the court’s own motion, the attorneys for all of the remaining 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 February 18, 2026, at 10:30 a.m., at which time they shall be prepared to discuss resolution of the action, the scheduling of a future two-hour settlement conference with the court, and the scheduling of a firm date for the commencement of jury selection.

This constitutes the Decision and Order of the court.

1/6/2026  
DATE

  
JOHN J. KELLEY, J.S.C.

CHECK ONE:	<input type="checkbox"/>	CASE DISPOSED	<input type="checkbox"/>	DENIED	<input checked="" type="checkbox"/>	NON-FINAL DISPOSITION	<input type="checkbox"/>	OTHER
APPLICATION:	<input type="checkbox"/>	GRANTED	<input type="checkbox"/>		<input checked="" type="checkbox"/>	GRANTED IN PART	<input type="checkbox"/>	
CHECK IF APPROPRIATE:	<input type="checkbox"/>	SETTLE ORDER	<input type="checkbox"/>		<input type="checkbox"/>	SUBMIT ORDER	<input type="checkbox"/>	REFERENCE
	<input type="checkbox"/>	INCLUDES TRANSFER/REASSIGN	<input type="checkbox"/>		<input type="checkbox"/>	FIDUCIARY APPOINTMENT	<input type="checkbox"/>	