Brogan v Steinbrech
2026 NY Slip Op 31420(U)
April 8, 2026
Supreme Court, New York County
Docket Number: Index No. 805263/2023
Judge: John J. Kelley

SUPREME COURT OF THE STATE OF NEW YORK
NEW YORK COUNTY

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

Justice

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INDEX NO. 805263/2023

LEWIS SCOTT BROGAN,

Plaintiff,

MOTION DATE 02/03/2026
02/03/2026

MOTION SEQ. NO. 001, 002

- v -

DOUGLAS STEINBRECH, M.D., MARSHALL GARLAND, M.D., NIMA MAGHAMI, M.D., THE NEW YORK AND PRESBYTERIAN HOSPITAL, doing business as NEW YORK-PRESBYTERIAN HOSPITAL/WEILL CORNELL MEDICAL CENTER, and GOTHAM PLASTIC SURGERY, PLLC,

DECISION + ORDER ON MOTION

Defendants.

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The following e-filed documents, listed by NYSCEF document number (Motion 001) 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 100, 102, 104, 106, 108, 110, 115, 116, 117, 118

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

The following e-filed documents, listed by NYSCEF document number (Motion 002) 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 101, 103, 105, 107, 109, 111, 112, 113, 114, 119

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, the defendant anesthesiologist Marshall Garland, M.D., moves pursuant to CPLR 3212 for summary judgment dismissing the complaint insofar as asserted against him (MOT SEQ 001). The plaintiff opposes that motion. The defendant general surgeon Nima Maghami, M.D., and The New York and Presbyterian Hospital (NYPH), doing business as New York-Presbyterian Hospital/Weill Cornell Medical Center (together the NYPH defendants), separately move for the same relief as to them (MOT SEQ 002). The plaintiff opposes that motion as well. Garland's motion is granted only to the extent that he is awarded summary judgment dismissing so much of the medical malpractice cause of action insofar as asserted against him as was premised upon his placement the plaintiff under

anesthesia for a 9-to-11-hour surgery despite preoperative laboratory results from November 22, 2021 indicating that the plaintiff had been experiencing moderate kidney failure and kidney disease, his failure to obtain medical clearance, his administration of excessive amounts of lidocaine, neo-synephrine, and epinephrine to the plaintiff during the subject surgery, his failure properly to monitor the plaintiff's blood pressure, pulse rate, creatinine and potassium levels, venous pH, and partial pressure carbon dioxide (pCO2) levels during the surgery, his failure obtain a full and complete medical history, his administration of anesthesia during surgery even after the plaintiff's blood pressure was not detectable, and his repositioning or acquiescence in the repositioning of the plaintiff an excessive number of times while under anesthesia. Garland's motion is otherwise denied, since there are triable issues of fact as to whether Garland departed from good and accepted practice by failing to insert, or insist on the insertion of, a Foley catheter to regulate fluid buildup during the surgery, by administering 6.5 liters of fluid to the plaintiff during the surgery in addition to a separate 2.5 liters administered by the defendant plastic surgeon Douglas Steinbrech, M.D., despite the absence of a Foley catheter, and as to whether those departures caused or contributed to fluid overload and concomitant organ failure that required the plaintiff to be admitted to NYPH for more than seven days to address such fluid overload and organ failure. The NYPH defendants' motion is denied, since there are triable issues of fact as to whether they prematurely discharged the plaintiff from the hospital on December 29, 2021, whether they failed to suspect, appropriately examine, test for, and diagnose an infection at the plaintiff's gluteal implant surgical site, whether they failed properly to treat that infection, and whether those alleged departures caused or contributed to the progression of the infection and the necessity of the removal of that implant.

The crux of the plaintiff's claims against the defendant Gotham Plastic Surgery, PLLC (Gotham), Gotham's anesthesiologist Garland, and Gotham's plastic surgeon Steinbrech, is that, on December 22, 2021, Garland and Steinbrech committed malpractice in the course of their employment with Gotham by improperly performing a lengthy plastic surgery procedure

upon the plaintiff under anesthesia, despite preoperative test results that required these physicians to forego the procedure. The gist of his claims against the NYPH defendants is that, between December 22, 2021 and December 29, 2021, the defendant general surgeon Maghami committed malpractice while working for NYPH by providing substandard care, failing to diagnose the plaintiff with an infection, and discharging the plaintiff while he remained infected.

In his complaint, the plaintiff averred that, on December 22, 2021, Gotham, Steinbrech, and Garland (collectively the Gotham defendants) performed, among other things, a gluteal implant upon him while he was under anesthesia, and departed from good practice by performing an 11-hour elective cosmetic procedure upon him despite the fact that preoperative laboratory blood testing that had been undertaken on November 22, 2021 which indicated that he was suffering from moderate kidney failure and kidney disease. In this respect, the plaintiff additionally alleged that, notwithstanding their knowledge of his kidney failure, the Gotham defendants committed malpractice by performing this procedure without employing a Foley catheter, and without ensuring that they were able to monitor the plaintiff's fluid intake and output. The plaintiff contended that, as a consequence of these departures, he suffered significant interoperative cardiac and pulmonary insults, injuries, and stresses that prevented him from being extubated following the surgery, and had to be emergently transferred to NYPH's intensive care unit (ICU). He faulted the NYPH defendants for discharging him postoperatively only nine days after the surgery, despite the fact that, four days after the surgery, his white blood cell (WBC) count had been trending upwards by approximately 60%, and failing to ascertain the etiology of this abnormal WBC count. The plaintiff additionally asserted that the NYPH defendants departed from good practice by discharging him, despite his ongoing excruciating surgical pain from his gluteal implant wound and failing properly to re-examine his gluteal implant wound over the 72-hour period prior to his discharge. He contended that, as a proximate result of these departures from good practice, he sustained severe injuries, including severe pain and severe injury to his kidneys and heart, and, since he

was also thereby forced to spend several days in an ICU, and sustained a "massive" infection of his gluteal implants at NYPH that had to be surgically removed, that he suffered from severe depression and "financial ruin."

In his bill of particulars as to Garland, the plaintiff specifically alleged that Garland departed from good and accepted medical practice by placing him under anesthesia for 11 hours in connection with the subject December 22, 2021 elective cosmetic surgery, despite preoperative laboratory results from November 22, 2021 indicating that he had been experiencing moderate kidney failure and kidney disease, and that Garland did so despite failing to obtain medical clearance and without inserting a Foley catheter. He further faulted Garland for placing him under anesthesia and, without having any way to monitor his fluid intake and output, administered more than six liters of fluid during the surgery without any means to discharge any of the fluid. In addition, the plaintiff asserted that Garland committed malpractice by administering excessive amounts of lidocaine, neo-synephrine, and epinephrine, and failing to properly monitor his blood pressure, pulse rate, creatinine, potassium, venous pH, pCO2, and fluid levels during the subject surgery. In his amended bill of particulars addressed to Garland, the plaintiff averred that Garland failed to obtain his full and complete medical history, asserted that Garland negligently continued administering anesthesia and performing surgery even after his blood pressure was not detectable, and allowed him to be turned an excessive number of times while under anesthesia. The plaintiff alleged that, as a consequence of these purported deviations from good practice, he sustained significant interoperative injuries, including, but not limited to, massive fluid shifts, hypotension, elevated creatinine and troponin levels, hyperkalemia, stress-induced cardiomyopathy, respiratory acidosis, renal compromise, and multiple organ failure, the result of which was that he could not be extubated following the surgery, and had to be rushed to a hospital ICU.

In his bills of particulars addressed to the NYPH defendants, the plaintiff alleged that they negligently failed to respond in an adequate fashion to his postoperative complaints of

excruciating pain in the area of his buttocks/gluteal implant incision, the abnormal appearance of the gluteal implant incision wound, and an increasing WBC count, which consequently led them prematurely to discharge him from NYPH, despite these signs and symptoms of a severe, progressive infection in and around the gluteal implant. He alleged that they departed from good practice by failing timely and appropriately to treat him with intravenous antibiotic therapy, specifically claiming that they failed to treat him with more potent, broader-spectrum antibiotics than the oral antibiotics that they actually administered. In this respect, he asserted that the NYPH defendants negligently discharged him prior to a proper re-examination of the surgical wound, that that they should have performed a blood culture to ascertain the precise nature of the infection so that they could administer an appropriate antibiotic at an appropriate dosage.

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]; *Prendergast v New York City Tr. Auth*., 220 AD3d 583, 584 [1st Dept 2023]). Once the movant meets that burden, it is incumbent upon the non-moving party to establish the existence of material issues of fact (*see Vega v Restani Constr. Corp*., 18 NY3d at 503). A movant's failure to make a prima facie showing requires

denial of the motion, regardless of the sufficiency of the opposing papers (*see id.; Medina v Fischer Mills Condo Assn*., 181 AD3d 448, 449 [1st Dept 2020]).

"The drastic remedy of summary judgment, which deprives a party of his [or her] day in court, should not be granted where there is any doubt as to the existence of triable issues or the issue is even 'arguable'" (*De Paris v Women's Natl. Republican Club, Inc.,* 148 AD3d 401, 403-404 [1st Dept 2017]; *see Bronx-Lebanon Hosp. Ctr. v Mount Eden Ctr*., 161 AD2d 480, 480 [1st Dept 1990]). Thus, a moving defendant does not meet his or her burden of affirmatively establishing entitlement to judgment as a matter of law merely by pointing to gaps in the plaintiff's case, but must affirmatively demonstrate the merit of his or her defense (*see Koulermos v A.O. Smith Water Prods*., 137 AD3d 575, 576 [1st Dept 2016]; *Katz v United Synagogue of Conservative Judaism*, 135 AD3d 458, 462 [1st Dept 2016]).

"To sustain a cause of action for medical malpractice, a plaintiff must prove two essential elements: (1) a deviation or departure from accepted practice, and (2) evidence that such departure was a proximate cause of plaintiff's injury" (*Frye v Montefiore Med. Ctr*., 70 AD3d 15, 24 [1st Dept 2009]; *see Foster-Sturrup v Long,* 95 AD3d 726, 727 [1st Dept 2012]; *Roques v Noble*, 73 AD3d 204, 206 [1st Dept 2010]; *Elias v Bash*, 54 AD3d 354, 357 [2d Dept 2008]; *DeFilippo v New York Downtown Hosp*., 10 AD3d 521, 522 [1st Dept 2004]). 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]).

Moreover, 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, 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] [plaintiff failed 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 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 his motion, Garland submitted the pleadings, the plaintiff's bills of particulars, copies of the parties' deposition transcripts, relevant medical and hospital records, the note of issue, a statement of allegedly undisputed material facts, an attorney's affirmation, and the expert affirmation of board-certified anesthesiologist Herbert Edward Jaspan, M.D., who opined that Garland did not depart from good and accepted medical practice, and that nothing that Garland did or did not do caused or contributed to any of the plaintiff's claimed injuries.

Dr. Jaspan asserted that Garland, as an anesthesiologist, had no involvement in deciding the type or number of plastic surgery procedures that would be performed upon the plaintiff, let alone how they would be performed, explaining that these determinations were within the province Steinbrech, as the treating plastic surgeon, the latter of whom also determined the need for preoperative testing and medical/cardiac clearance. According to Dr. Jaspan, Steinbrech obtained the plaintiff's informed consent to the surgery, and referred to Steinbrech's testimony to the effect that the plaintiff wanted more aggressive treatment in connection with the entirety of the procedure, and that the plaintiff was made aware that the placement of pectoral implants with upper fullness would place him in a "very high risk category," while placement of gluteal implants would also place him in a "high risk" category. Dr. Jaspan noted that Steinbrech testified at his deposition that these elective procedures generally would collectively take approximately seven hours to perform.

As Dr. Jaspan recounted the course of the plaintiff's treatment by the Gotham defendants, the plaintiff underwent preoperative blood testing on November 22, 2021, which revealed elevated creatinine levels of 1.57 milligrams per deciliter (mg/dL) of blood, a low estimated glomerular filtration rate (eGFR), which measures the kidney filtration rate, of 50

milliliters (mL) per minute per 1.73 square meters, low alkaline phosphatase level of 34 International Units per liter (IU/L) of blood, an elevated red blood cell (RBC) distribution of 16%, indicating a somewhat significant size difference between such cells, and an elevated absolute monocyte count of 1,234 cells per microliter (µL) of blood. According to Dr. Jaspan, Garland first saw the plaintiff when he presented to Gotham for the subject surgery on December 22, 2021, and performed a preoperative anesthesia evaluation, consisting of obtaining information regarding the plaintiff's medical, surgical, and anesthesia history, reviewing his recent laboratory results, obtaining information regarding the medication that the plaintiff was then taking and information concerning allergies, and measuring or obtaining information concerning the plaintiff's vital signs. Based on his review of the relevant chart, Dr. Jaspan asserted that Garland obtained information regarding the plaintiff's height and weight, calculated his body mass index, listened to the plaintiff's heart and lungs, and evaluated the size and functionality of his airway. Dr. Jaspan asserted that, as of that date, the plaintiff had no history of anesthesia complications, and reported that he then was taking the proton pump inhibitor Nexium and angiotensin-converting enzyme inhibitors for hypertension. According to Dr. Jaspan, the plaintiff failed to disclose his surgical history of a penile implant to either Garland or Steinbrech.

Garland wrote in the plaintiff's chart that the plaintiff was then a 52-year-old male whose medical history included hypertension and asymptomatic gastro-esophageal reflux disease, and that the plaintiff's blood pressure measured 130/70, his pulse rate was 76 beats per minute, his breath rate was 16 respirations per minute, he was afebrile, and he weighed 190 pounds, and that the plaintiff had nothing to eat or drink for the previous eight hours. As Dr. Jaspan explained it, Garland reviewed the plaintiff's preoperative test results, noting in the chart that the plaintiff's urine, hemoglobin, potassium, sodium, and blood urea nitrogen (BUN) results were within normal limits, while an electrocardiogram (EKG) revealed that the plaintiff's heart was in a sinus rhythm. Garland assessed the plaintiff as a Class II, according to the classification system used by the American Society of Anesthesiologists (ASA) to evaluate a patient's health prior to

surgery, which Dr. Jaspan explained was a category that included individuals with a mild, well-controlled systemic disease that did not significantly impact the patient's functioning.

Dr. Jaspan asserted that Garland then devised an anesthesia treatment plan that involved the administration of general endotracheal anesthesia with a breathing tube, and concluded that Garland "had no involvement in the formulation of any other aspect of Mr. Brogan's treatment plan." The anesthesia plan included the administration of the inhalation anesthetic gas Isoflurane, the analgesic Fentanyl, the anesthetic Midazolam, the sedative Propofol, the analgesic Demerol, the antibiotic Ancef, and lactated ringers, and also called for monitoring the plaintiff's intraoperative hemodynamic status, specifically his blood pressure, heart rate and rhythm, oxygen saturation, and end tidal carbon dioxide levels, employing tools such as an EKG, an oscillometric blood pressure device, an oxygen analyzer, a temperature monitor, and an end tidal carbon dioxide monitor.

Dr. Jaspan explained that the plaintiff was taken to the operating room at 10:14 a.m. on December 22, 2021, that Garland commenced the administration of anesthesia at 10:16 a.m., and that Steinbrech commenced the surgical procedure at 10:38 a.m. As Dr. Jaspan further explained it, the plaintiff was preoxygenated, inducted without difficulty, placed on a ventilator, and had his eyes taped closed, while, at that juncture, the plaintiff was wearing compression boots that were "confirmed" to be working properly. He asserted that Garland performed a direct laryngoscopy using a MacIntosh 3 blade, and thereupon was able to identify the vocal cords and glottic opening, after which Garland placed a #8.0 endotracheal tube easily between the plaintiff's vocal cords, and inflated the cuff, which sealed the tube in place. Garland wrote in the relevant chart that, at that time, the plaintiff evinced bilateral breath sounds that were equal, upon which Garland secured the tube and confirmed the presence of end tidal carbon dioxide.

Steinbrech testified at his deposition that he made the determination to forego the placement of a Foley catheter at the commencement of the surgery, explaining that he did not want a catheter placed at that time due to the risk of infection, such as a urinary tract infection or

urethral trauma, which are associated with repositioining a patient intraoperatively. Garland himself testified that he did not deem it necessary to place a Foley catheter at the beginning of the surgery. As Dr. Jaspan interpreted the operative report, at 10:30 a.m. on December 22, 2021, Garland intravenously administered 10 milligrams (mg) of the anti-inflammatory drug Decadron, 4 mg of the anti-nausea medication Zofran, and 10 mg of the blood pressure medication Labetalol, and reported that all pressure points were padded. He further stated that, in addition to general anesthesia, Steinbrech determined to administer local anesthesia intraoperatively, and that either Steinbrech administered the anesthesia himself or directed other medical staff to do so. According to Dr. Jaspan, Garland did not administer any local anesthesia or tumescent fluid to the plaintiff. Dr. Jaspan also stated that Steinbrech made all of the decisions regarding the type and amount of local anesthesia and tumescent fluid---a solution of lidocaine, epinephrine, and saline that is used to remove fat---that were administered during the procedure, and averred that Garland had no involvement in deciding where or when the injections of this medication would be administered or their amount or concentration. According to the chart, throughout the course of the entire surgery, Garland administered 6.5 liters of fluid to the plaintiff, and Steinbrech administered approximately 2,500 mL (2.5 L) of tumescent fluid, but memorialized that the plaintiff “had no urine output during the surgery.”

As Dr. Jaspan interpreted the relevant records, the plaintiff’s surgery was uneventful until approximately 5:35 p.m. on December 22, 2021, when the plaintiff started to experience a slight downward trend in blood pressure, and at 5:45 p.m., when Garland noted that the plaintiff’s non-invasive blood pressure cuff was not registering a reading. Dr. Jaspan asserted that Garland informed the surgical team of this occurrence, at which time the surgery was immediately suspended to address this issue. He reported that Garland responded by administering 300 µg of neo-synephrine, 1 liter of lactated ringers, and 30 µg of epinephrine, after which the plaintiff’s blood pressure measurements could again be read. Dr. Jaspan asserted that the plaintiff maintained a palpable carotid pulse, an oxygen saturation level of 100%, and a heart rate of 85

beats per minute throughout this episode. He further asserted that, at 5:50 p.m., Garland reported that the plaintiff's blood pressure was 80/40 and that, at 6:00 p.m., it was 100/50, after which the plaintiff's condition "continued to remain stable with no acute complications for the remainder of the surgery." According to Dr. Jaspan, the plaintiff's oxygen saturation level remained at 100% throughout the entire surgery, while his respirations were being controlled with a ventilator, and he asserted that the plaintiff manifested no signs of fluid overload or congestive heart failure during the surgery.

Dr. Jaspan adverted to Garland's deposition testimony, which was to the effect that Garland started turning off the anesthesia medication when "Dr. Steinbrech headed into the final procedures or procedure in the series," that Garland "started to emerge Mr. Brogan from the anesthesia by lowering the Isoflurane at around 6:00 p.m.," and that Garland "believes he attempted to initiate Mr. Brogan's spontaneous breathing between 7:00-7:30 p.m., based on when he turned off certain medications." According to Dr. Jaspan, Garland changed the ventilator settings and turned off the pumping mechanism to allow the plaintiff to attempt to breathe on his own, "essentially breathing off the ventilator with the breathing tube in place," which, as Dr. Jaspan described it, allowed Garland to observe the plaintiff's breathing, which was fast, shallow, and with a small tidal volume. At that juncture, Garland formed the impression that the plaintiff breathing was not satisfactory and did not satisfy the respiratory criteria for extubation. Steinbrech wrote in the operative report that, at emergence, the plaintiff was unable to generate sufficient tidal volume to meet extubation criteria, despite the reversal of muscle relaxation that was generated by the administration of maximum dosages of neostigmine and glycopyrrolate. Dr. Jaspan averred that Garland's examination of the plaintiff revealed the plaintiff to have a firm lower abdomen, possibly due to a full bladder, which Garland "suspected" may have been limiting the plaintiff's ability to take deep breaths. Between 7:30 p.m. and 8:00 p.m. on December 22, 2021, Garland determined to place a Foley catheter to empty the plaintiff's bladder, but the initial attempt was unsuccessful, according to Dr.

Jaspan, "due to the presence of an implanted penile device which obstructed the insertion." At 8:00 p.m., Garland administered 5.0 mg of neostigmine to reverse the effects of the previously administered muscle relaxant, and 1.0 mg of the anticholinergic glycopyrrolate. Dr. Jaspan asserted that Garland "noted 4 twitches, tidal equals 150 milliliters, minute ventilation 2 liters."

As set forth in the relevant operative report, at 8:30 p.m. on December 22, 2021, Garland informed the surgical team that the plaintiff had failed at spontaneous ventilation and that sedatives were being administered, at which time Steinbrech, Garland, and the surgical team determined to transfer the plaintiff to the NYPH hospital emergency department. Garland reported that, at 9:00 p.m., the plaintiff was suctioned, and explained that he had cleaned out the inside of the breathing tube and secured the endotracheal tube to prepare the plaintiff for transport, after which Garland purportedly performed a final re-evaluation, and wrote in the chart that the plaintiff was stable and warm, with no obvious signs of pain, and that his surgical drains generated minimum output. Dr. Jaspan opined that, aside from the blood pressure variability described above, the plaintiff remained hemodynamically stable throughout the surgery.

Emergency medical technicians transferred the plaintiff by ambulance to NYPH at 9:10 p.m. on December 22, 2021. According to Dr. Jaspan, both Garland and Steinbrech met the plaintiff at NYPH, purportedly to "ensure continuity of care throughout the transfer." At NYPH, the "full' emergency room team reportedly evaluated the plaintiff, while a workup at NYPH revealed that the plaintiff was experiencing leukocytosis, an acute kidney injury, and hyperkalemia, with peaked T waves. An initial excess post-exercise oxygen consumption (EPOC) test was "notable for arterial gases" which manifested a pH of 7.21, barometric oxygen pressure of 66 mm/Hg, barometric carbon dioxide pressure of 35 mm/Hg, and a bicarbonate reading of 28 milliequivalents per liter (mEQ/L) of gas. Dr. Jaspan did not explain the meaning of the "2.2" measurement to which he referred. In any event, laboratory blood testing revealed a WBC count of 19,780 cells per microliter (μL) of blood, a potassium level of 7.3 mEQ/L of blood, a troponin level of 0.352 nanograms per milliliter (ng/mL) of blood, and a creatinine level of 2.64

mg/dL of blood. According to Dr. Jaspan, an EKG revealed peaked T waves, while computed tomography (CT) scans of the plaintiff's head, maxillofacial area, and chest were negative, except for subcutaneous emphysema, which was treated with insulin, dextrose, and two doses of calcium gluconate.

NYPH medical staff purportedly thought that the plaintiff's hyperkalemia was obstructive in etiology since he had a known penile implant, which, according to Dr. Jaspan, complicated the placement of a Foley catheter. Hospital emergency department personnel obtained an emergency consultation with a urologist, who inserted a catheter, and achieved drainage of dark yellow urine. According to Dr. Jaspan, the plaintiff was diagnosed with respiratory acidosis while still in the emergency department, which nonetheless improved after ventilator settings were adjusted. The plaintiff was admitted to NYPH's surgical intensive care unit (SICU) for resuscitation and ongoing management, and remained at NYPH until December 29, 2021.

As Dr. Jaspan interpreted the NYPH chart, a chest x-ray of the plaintiff at NYPH reflected low lung volumes and increased interstitial markings, which suggested to Dr. Jaspan the presence of mild interstitial edema or crowding of broncho vascular markings, as well as retrocardiac opacities that were "concerning" for focal consolidation, probably atelectasis, small left and trace right pleural effusions, and no pneumothorax, but soft tissue emphysema in the bilateral chest wall, which Dr. Jaspan concluded was consistent with a known recent surgery. He further asserted that a CT scan of the plaintiff's head revealed no evidence of acute infarct or hemorrhage, albeit with diffuse skin thickening and subcutaneous facial edema, with multiple areas of emphysema, which, according to Dr. Jaspan, likely reflected a postoperative change, along with age-indeterminate nasal bone fractures. Meanwhile, he averred that a chest CT scan revealed no pulmonary embolism, noting that there was a "partially limited evaluation of the lower lobe subsegmental arteries," and bilateral lower lobe airspace disease "most likely representing atelectasis," along with subcutaneous emphysema involving the bilateral chest walls and surrounding bilateral pectoral implants, "likely expected post-surgical changes."

According to Dr. Jaspan, the plaintiff's serial creatine kinase (CK) levels that were obtained during the plaintiff's admission to NYPH were significantly elevated above the reference range of 46.0 to 171.0 IU/L, ranging from a high of 27,880 IU/L on December 23, 2021 to a low of 5,683 IU/L on December 27, 2021, with 12 of the 14 test results measuring above 11,000 IU/L and 6 of the 14 test results above 20,000 IU/L. Moreover, Dr. Jaspan asserted that a December 23, 2021 urine test revealed a significantly elevated myoglobin level of 175 mg/L of urine, while the applicable reference range is 0 to 1.0 mg/L.

Dr. Jaspan expressly opined that Garland's preoperative anesthesia examination and assessment of the plaintiff were consistent with the applicable standard of care, in that Garland obtained all of the information necessary to determine whether the plaintiff was an appropriate candidate for the subject surgery from an anesthesia standpoint, specifically obtaining information as to the plaintiff's vital signs, chronic medical conditions, anesthesia history, surgical history, current medications, and recent laboratory results. He thus rejected the plaintiff's claims that Garland failed to provide the plaintiff with standard medical history forms to complete, failed to obtain a full and complete medical history, or failed to document that history. In this respect, he concluded that, whether the plaintiff was asked to fill out written forms which asked the plaintiff for the same information that was provided orally would not have changed the plaintiff's responses to the questions posed, since Garland requested the necessary information and obtain full responses. Dr. Jaspan further concluded that the plaintiff was not experiencing any medical conditions which, if disclosed by him, would have made the surgery contraindicated from an anesthesia standpoint, or would have prevented any of his alleged injuries. Moreover, he opined that the applicable standards of good and accepted anesthesia care did not require a medical or cardiac preoperative clearance for a patient such as the plaintiff, who was undergoing elective cosmetic surgery expected to last approximately seven hours. In any event, Dr. Jaspan explained that Steinbrech, as the plastic surgeon, made the decision as to whether to obtain medical or cardiac clearance for the surgery, and that

Garland's preoperative examination, review of the preoperative test results, and questioning of the plaintiff constituted an adequate basis to make this determination, with no additional information necessary.

Dr. Jaspan additionally asserted that the plaintiff was an appropriate anesthesia candidate for the subject surgery, and that there were no contraindications to the surgery from an anesthesia standpoint, specifically averring that the plaintiff's history of "well-controlled" hypertension was not a contraindication to the surgery from an anesthesia perspective. Dr. Jaspan further opined that, although the plaintiff's "slightly abnormal preoperative kidney function values" were consistent with mild or moderate kidney disease, "they would not have been a contraindication to the surgery from an anesthesia standpoint." In this respect, he asserted that "[w]hether a patient with mild kidney disease is at greater risk of experiencing a complication from general anesthesia depends on the type of anesthesia given," and that, inasmuch as Garland administered Isoflurane, which has no effect on the kidneys, there could be no departure from accepted care in administering this type of anesthesia. Additionally, Dr. Jaspan explained that the anticipated length of the surgery, which was six to eight hours, was not a contraindication from an anesthesia perspective. Dr. Jaspan also concluded that the type and amount of anesthesia medications that Garland administered to the plaintiff were consistent with the standard of care, and that the plaintiff did not experience any problems or complications as a result of the medications that Garland administered. Moreover, he approved of Garland's anesthesia plan, which included "continual" monitoring of the plaintiff's heart rate with an EKG, and asserted that, in any event, Garland documented a sinus rhythm throughout the entire procedure. More specifically, Dr. Jaspan asserted that Garland properly monitored the plaintiff's hemodynamic stability, in accordance with ASA guidelines, by employing a standard patient monitoring system during the entire procedure, which included the monitoring of the plaintiff's heart rate, blood pressure, oxygen saturation, end-tidal carbon dioxide levels, and EKG results

to ensure that adequate oxygenation, ventilation, and circulation had been maintained throughout the procedure.

With respect to the incident occurring at 5:45 p.m. on December 22, 2021, when the surgical team was unable to detect the plaintiff's blood pressure, Dr. Jaspan asserted that Garland timely and appropriately responded thereto by administering 300 µg of neo-synephrine and 30 µg of epinephrine with a liter of intravenous fluid, after which the plaintiff's blood pressure was effectively and expeditiously restored, while the plaintiff's other vital signs, such as pulse rate and oxygen saturation levels, remained stable throughout this episode, thus suggesting that there was no indication for any further intervention. He rejected the plaintiff's claim that it was a departure for Garland to continue the anesthesia after the surgical team failed to detect the plaintiff's blood pressure, since the plaintiff "rapidly responded to resuscitative measures" and his blood pressure and other vital signs returned to normal. He also asserted that there was no merit to the plaintiff's contentions that Garland administered excessive amounts of lidocaine, neo-synephrine or epinephrine, since he concluded that Garland himself did not administer any lidocaine or tumescent fluid to the plaintiff, but that these drugs were administered by Steinbrech or at Steinbrech's direction.

Dr. Jaspan concluded that the timing of Garland's administration of neo-synephrine and epinephrine, which was in response to the blood pressure episode, meant that it could not have been the cause of that episode. He further concluded that the administration of these drugs did not cause or contribute to the inability to extubate the plaintiff at the end of the procedure. Dr. Jaspan also opined that, notwithstanding the plaintiff's preoperative laboratory results, there was no departure from the standard of care in connection with the determination to forego insertion of a Foley catheter preoperatively or intraoperatively. Nor, according to Dr. Jaspan, was the insertion of such a catheter required solely because of the plaintiff's moderate kidney failure or kidney disease. He rejected the plaintiff's contention that the failure to insert a Foley catheter placed the plaintiff at an increased risk of fluid overload. Dr. Jaspan further rejected

the plaintiff's claim that Garland moved the plaintiff too many times while the latter was under anesthesia, attributing to Steinbrech all decisions regarding what surgical procedures would be performed, in what sequence they would be performed, and when and how often the plaintiff's position needed to be changed during the surgery. In any event, he opined that there were no contraindications to the intraoperative turning of the plaintiff from an anesthesia standpoint, and that none of the plaintiff's claimed injuries was causally related to the number of times he was turned during the surgery or, for that matter, to any other of Garland's claimed departures.

Dr. Jaspan fully approved of Garland's fluid management of the plaintiff for hydration and introduction of medications, including the volume of intravenous fluids that Garland administered, that, in any event, the plaintiff did not experience fluid overload, known as hypervolemia, during the surgery, and that the plaintiff was "in fact, euvolemic at the end" of the surgery, that is, the plaintiff was experiencing a proper balance of fluids. Contrary to the plaintiff's contention, Dr. Jaspan asserted that there were several avenues of fluid output during the surgery. He further opined that the plaintiff's clinical status was not consistent with fluid overload during or after the surgery since there was no swelling in plaintiff's extremities, and the plaintiff did not experience hypertension, tachycardia, or distended neck veins. He explained that the 6.5 L of fluid that Garland administered intravenously during the procedure was an appropriate amount, given the plaintiff's weight, the duration of the surgery, the plaintiff's intraoperative blood loss, fluid seepage into the interstitial spaces, and evaporation loss from the surgical sites, and provided calculations based on these factors to support his conclusion, which he characterized as "near perfect fluid management." Dr. Jaspan explained that the fact that the plaintiff's bladder was full, and that a liter of fluid was subsequently drained when a Foley catheter ultimately was inserted at NYPH, "is not evidence of fluid overload." In addition, Dr. Jaspan noted that the plaintiff's initial blood test results after transfer to NYPH revealed a normal blood sodium level and, had the plaintiff experienced a fluid overload, the sodium levels likely would have been abnormal.

Dr. Jaspan opined that all of the plaintiff's claimed injuries were caused by muscle breakdown and rhabdomyolysis

> "due to the performance of the plastic surgery procedures; which led to the development of hyperkalemia; resulting in his post-operative kidney, cardiac and respiratory complications; which were the indication for his one-week post-operative hospitalization,"

and that none of the plaintiff's claimed injuries was causally related to the anesthesia services that Garland rendered. Dr. Jaspan explained that rhabdomyolysis is a complex medical condition involving the rapid breakdown of muscle tissue, which results in the direct release of intracellular muscle components, including myoglobin and CK, into the bloodstream. Since the plaintiff evinced a positive urine myoglobin test, high CK levels, and dark-colored urine upon admission to NYPH, which Dr. Jaspan described as diagnostic markers and strong indicators of rhabdomyolysis, he concluded that the plaintiff sustained muscle damage in the context of rhabdomyolysis. As he described it, it is characteristic of rhabdomyolysis that a patient's CK levels will peak approximately 24 to 36 hours after experiencing muscle breakdown, and then decrease by approximately half every 36 hours thereafter. Dr. Jaspan asserted that the plaintiff's CK levels were so high that it took over one week for his CK levels to return to normal. He further explained that the muscle damage characteristic of rhabdomyolysis can also cause a significant increase in potassium levels, known as hyperkalemia, which, in turn, can cause respiratory depressions, since high potassium levels can weaken the muscles involved in breathing, resulting in difficulty breathing or shallow respirations and, in severe cases, respiratory failure. Dr. Jaspan asserted that the plaintiff's initial blood potassium level at NYPH was extremely elevated, and, thus, a further indication of rhabdomyolysis, and opined that the reason that the surgical team was unable to extubate the plaintiff was "hyperkalemia due to rhabdomyolysis secondary to muscle breakdown in connection with performance of the plastic surgery procedures." Nonetheless, Dr. Jaspan explained that the only way to detect hyperkalemia intraoperatively is via the presence of peaked T waves on an EKG, that the

evidence here suggested no such changes on the intraoperative EKGs, and that, In the absence of these changes, there would be no way for Garland to have diagnosed this complication intraoperatively.

Dr. Jaspan also opined that the fluid identified on the NYPH chest x-ray was due to cardiac depression secondary to muscle breakdown, and was not evidence of fluid overload. In this respect, he explained that rhabdomyolysis can also cause elevated levels of troponin, a protein found in the cells of the heart muscle that is released when heart muscle is severely damaged, which he concluded also had occurred in the plaintiff's case. Dr. Jaspan concluded that the cardiac conditions that the plaintiff developed were completely unrelated to the anesthesia services that Garland had rendered, but instead were caused by the severe muscle damage that the plaintiff sustained in connection with the performance of the surgical procedures. He nonetheless opined that the "prompt and aggressive treatment" that NYPH medical personnel rendered to the plaintiff prevented any permanent cardiac damage secondary to rhabdomyolysis, "as evidenced by the significant improvement in his ejection fraction during this admission." He further opined that the plaintiff's abnormal kidney function values, which he described as "suggestive of an acute kidney injury at the time of his admission to NYPH," were also secondary to rhabdomyolysis due to muscle breakdown that was caused by the surgical procedures.

In support of their motion, the NYPH defendants relied on many of the documents that Garland had submitted, and also submitted additional medical records, relevant bills of particulars, an attorney's affirmation, and the expert affirmations of board-certified critical care surgeon Marc J. Shapiro, M.D., and board-certified internist and infectious disease specialist Bernard Camins, M.D., both of whom opined that the NYPH defendants did not depart from good and accepted practice, and that nothing that they did or did not do caused or contributed to the plaintiff's injuries.

After recounting the numerous voluntary cosmetic surgeries that the plaintiff had undergone prior to the subject procedure, Dr. Shapiro explained that the procedure performed by Steinbrech consisted not only of a bilateral gluteal augmentation with placement of bilateral silicone implants, but an upper and lower blepharoplasty, a bilateral brow lift, a face lift, a jaw implant, a neck lift, bilateral chest augmentation with placement of bilateral pectoral implants, and abdominal and flank liposuction and sculpting to create the appearance of abdominal muscles, necessitating surgery at approximately 15 surgical sites and requiring 5 cosmetic implants. He reiterated the facts surrounding the plaintiff's transfer to NYPH, as well as his condition upon arrival at the NYPH emergency department.

Dr. Shapiro also provided a description of the care that the NYPH defendants rendered to the plaintiff between his admission there on December 22, 2021, and his discharge on December 29, 2021. He noted that, at the time of admission to the NYPH emergency department, the plaintiff was critically ill, and noted that the defendant Maghami was the attending physician on duty that night. According to Dr. Shapiro, the differential diagnosis at that time was "broad," since it then was unclear what had happened during the subject procedure. Maghami formulated a plan to obtain a cardiology consultation, which, as Dr. Shapiro explained it, was the only time when Maghami was assigned as the critical care surgery attending physician for the plaintiff. He asserted that, on December 23, 2021, a different surgical critical care attending physician noted that the plaintiff was responding well to resuscitation and medications, and was able to be extubated, while, later that day, a plastic surgery team was consulted in order to examine the plaintiff's surgical wounds. According to Dr. Shapiro, the chart reported that Penrose drains from the surgery remained in place as of that date, with one in the peri-abdomen and one in the gluteal area, with serosanguinous drainage continuing, but no purulent drainage, indicative of infection, observed or noted.

According to Dr. Shapiro, the plaintiff's pain was uncontrolled and significant, in response to which NYPH staff administered Dilaudid intravenously and via injections, and

provided oral oxycodone, although the plaintiff was afebrile, his vital signs were "acceptable," and he did not manifest chills or night sweats. As did Dr. Jaspan, Dr. Shapiro noted the plaintiff's extremely high CK and troponin levels, and his "mildly elevated" WBC count of 15,140 cells/μL of blood. Dr. Shapiro also stated that, during the plaintiff's seven-day admission to NYPH, Steinbrech visited the plaintiff on two, three, or four occasions, and that Steinbrech never identified any signs of infection in or near the gluteal implant.

Dr. Shapiro reported that, on December 24, 2021, the plaintiff remained afebrile, with acceptable vital signs, and no chills or night sweats, and remained on intravenous Dilaudid via patient-controlled administration. According to Dr. Shapiro, the plaintiff's surgical sites were examined by NYPH plastic surgeons, who reported that the Penrose drains remained in place, with serosanguinous output and no purulent drainage. Although the plaintiff's blood test results remained abnormal in many respects, Dr. Shapiro asserted that the plaintiff's WBC counts that day were 10,460 and 12,850 cells/μL of blood. According to Dr. Shapiro, these conditions remained constant through December 25, 2021 and December 26, 2021, although, by then, the plaintiff was able to sit in a chair, and, by December 26, 2021, the plaintiff's pain management medications were supplemented with oral Tylenol and oxycodone, and his WBC count was still mildly elevated at 12,400 cells/μL of blood. As Dr. Shapiro described it, on December 26, 2021, an NYPH nurse who was concerned that the plaintiff's gluteal surgical wounds might be hardening requested a plastic surgery consultation, after which an NYPH plastic surgeon wrote in the plaintiff's chart that "Gluteal implants examined this AM due to concern for abnormal hardening. Assessment revealed expected post op. edema. Nothing to do for now." Dr. Shapiro further asserted that the plaintiff's condition on December 27, 2021 essentially was the same as it had been on the prior two days, except that the gluteal pain had subsided somewhat. The plaintiff then was transferred from the SICU to a step-down surgical floor, where NYPH personnel reported that the plaintiff's pain was well-controlled without intravenous pain

medication. In addition, Dr. Shapiro asserted that the plaintiff continued to have many abnormal blood laboratory values, with the WBC count increasing that day to 13,220 cells/μL of blood.

According to Dr. Shapiro, as of December 28, 2021, the plaintiff was still afebrile, his vital signs were still acceptable, and there were no chills or night sweats, although laboratory blood values such as CK remained abnormal, and the plaintiff's WBC count had increased to 15,150 cells/μL of blood. Dr. Shapiro referred to the chart entries made on that date by critical care attending physician Mayur Narayan, M.D., and resident Don Li, M.D., which reported that the plaintiff was appearing well and not in acute distress. Dr. Shapiro explained that Drs. Narayan and Li then determined that the plaintiff was ready for discharge, pending confirmation of acceptable laboratory results. At that juncture, the plaintiff was no longer being administered intravenous pain medication, but was instead being administered oral oxycodone, oral Tylenol, and a 0.2 mg shot of Dilaudid. According to Dr. Shapiro's reading of the plaintiff's chart, the plaintiff reported a general body pain at a level of 5 on a scale of 10 at 10 p.m. on December 28, 2021, but that the pain was not localized to the buttocks. NYPH nurses reported that morning and nighttime examinations of the plaintiff's gluteal implant wounds revealed some edema, but no evidence of purulent drainage, pus, or foul smells. Dr. Shapiro noted that Steinbrech already had prescribed 500 mg of Cephalexin, four times per day, and 500 mg of Ciprofloxacin, two times per day as prophylactic antibiotics, and that NYPH administered the Cephalexin to the plaintiff at 8:00 p.m. and 11:39 p.m. on December 28, 2021, but did not administer the Ciprofloxacin because it had been dispensed by an outside pharmacy on Steinbrech's orders.

The NYPH chart reported that, on December 29, 2021, at approximately 1:00 a.m., a NYPH nurse had examined the plaintiff's gluteal wounds, and had concluded that the wounds were healing, without signs or symptoms of infection. The chart further reflected that, as of that day, the plaintiff was still afebrile, his vital signs were acceptable, and he did not have chills or night sweats. At 7:20 a.m. on that date, Drs. Narayan and Li examined the plaintiff, after which they reported that the plaintiff's pain was well-controlled, the plaintiff appeared well, and the

plaintiff was not in acute distress, and they thereupon cleared him for discharge, pending the results of laboratory testing. NYPH personnel performed a complete blood count (CBC) panel, a basic metabolic panel, magnesium and phosphorous level tests, and an eGFR study. Although some of the results were abnormal, and the plaintiff's WBC count was slightly elevated at 16,330 cells/μL of blood, in accordance with the discharge summary written by nurse practitioner Caroline A. Ugbogbo, NYPH medical personnel, apparently including Maghami, determined that the plaintiff was ready for discharge to his home.

Nonetheless, Dr. Shapiro adverted to Maghami's deposition testimony, in which the latter averred that, most likely, Ugbogbo mistakenly used his name solely because he was the admitting attending physician on December 22, 2021. Maghami further testified that it also was possible that Dr. Narayan had been called into an emergency surgery and that someone else asked Maghami to review the relevant laboratory results. Maghami testified, however, that it ultimately did not matter whether he was involved in the discharge determination because the surgical critical care attending physicians work as a team, and they are often pulled away from floor rotations, since their specialty involves being routinely called into emergency surgery. In any event, according to Dr. Shapiro, Maghami fully supported the determination to discharge the plaintiff on December 29, 2021, and, in light of the plaintiff's clinical condition, adamantly disagreed with the suggestion that a WBC count of 16,330 cells/μL of blood should have prevented discharge. In any event, Dr. Shapiro noted that NYPH personnel again examined the plaintiff's gluteal wounds at 9:00 a.m. and 11:22 a.m. on December 29, 2021, that there remained no evidence of purulent drainage, pus, or foul smells, and that medical personnel administered Cephalexin twice to the plaintiff on December 29, 2021. Dr. Shapiro further pointed out that the plaintiff's pain medication was further decreased to oral oxycodone and Tylenol only, while the plaintiff's pain remained well controlled.

Referring to Steinbrech's deposition testimony, Dr. Shapiro asserted that Steinbrech arranged for the plaintiff to stay in a hotel in New York for two days after discharge so that he

could further recuperate before flying home to Texas, and that Steinbrech assigned an experienced medical assistant to stay with the plaintiff to monitor the latter for signs of post-surgical infection, which reportedly did not develop, a conclusion that Steinbrech reputedly corroborated via video examinations of the plaintiff. Steinbrech apparently approved the plaintiff to fly home to Texas after "a few days" in the hotel. According to Dr. Shapiro, the plaintiff returned to Texas on either January 1, 2022 or January 2, 2022, and spoke with Steinbrech over the telephone. On January 4, 2022, the plaintiff presented to plastic surgeon Bob Basu, M.D., in Texas, complaining that, although he was stable for several days after his discharge from NYPH, he had more recently developed excruciating pain to his right buttocks, was unable to sit, and was experiencing continuous drainage. As Dr. Shapiro described it, Dr. Basu's physician's assistant palpated the plaintiff's right gluteal implant, upon which "frothy purulent serous fluid" discharged from the incision. On January 5, 2022, Dr. Basu examined the plaintiff's buttocks, and reported a murky, frothy, foul smelling serous drainage of the right gluteal incision site upon palpation. Since, according to Dr. Shapiro, the plaintiff was hesitant to have the gluteal implants removed, the plaintiff agreed to be treated with oral and intravenous antibiotics. Dr. Shapiro explained that, when the gluteal implant infection did not resolve, the plaintiff had the implants removed on March 28, 2022 by plastic surgeon Vasileios Vasilakis, M.D., in Texas. He asserted that the plaintiff's gluteal areas thereafter healed well and were soft, without ischemia, and that the only long-term residual problem was purely cosmetic.

As Dr. Shapiro framed the issue, the plaintiff's only allegation of medical malpractice against the NYPH defendants is that they allegedly failed to diagnose and treat an infection of one of his gluteal implants, and that this resulted in the necessity of removing the implant. He first opined that removal of a gluteal implant is a known and accepted risk of that procedure because the body sometimes rejects foreign bodies, which is even more likely when five foreign bodies are placed at once, as was done in the plaintiff's case. He thereafter concluded that, contrary to the plaintiff's contention, the standard of care never required a workup, diagnosis, or

treatment for infection beyond what the NYPH defendants undertook and administered. In this respect, he asserted that the signs and symptoms of surgical-site infection are fever, unstable vital signs, especially tachycardia, purulent drainage and pus in the surgical site, a foul smell from the surgical site, chills, and night sweats, none of which the plaintiff manifested during his admission to NYPH. In connection with the plaintiff's contention that the NYPH defendants "failed to appreciate that Plaintiff's rising white blood cell count and his complaints of excruciating pain in the area of his buttocks/gluteal implant incision, and the abnormal appearance of the gluteal implant incision wound, were signs of a growing severe infection in and around the gluteal implant," Dr. Shapiro concluded that the plaintiff was mischaracterizing what the NYPH defendants actually did over the course of admission. More specifically, Dr. Shapiro opined that the standard of care did not require the NYPH defendants to diagnose or work up the plaintiff for an infection, and that it was completely appropriate to discharge the plaintiff on December 29, 2021, with instructions to follow up as an outpatient with his privately retained plastic surgeon. In this respect, Dr. Shapiro averred that there are many risks and morbidities associated with prolonged hospital admissions, including other infections and death.

In any event, Dr. Shapiro asserted that each of the signs and symptoms that the plaintiff identified as having been not appropriately appreciated by the NYPH defendants were consistent with the expected conditions of a patient, such as the plaintiff, who was hospitalized one through eight days after a surgical procedure that had created over 15 surgical sites and added 5 implants, and during which he had suffered an acute intraoperative event that triggered multiple organ failure. Dr. Shapiro asserted that it would be expected that the plaintiff would experience severe pain in the weeks after his operation, even if he suffered no complications and that, more particularly, the healing process from bilateral gluteal augmentation and implants "is understood to be especially painful" because the gluteal surgical site is agitated more than other sites due to pressure upon it while a patient is lying down or sitting. Dr. Shapiro further noted that a patient's reports of pain levels are inherently subjective, and that the plaintiff

nonetheless reported a slight abatement of pain over the course of his seven days at NYPH, even as the administration of pain medications was being decreased. In this respect, Dr. Shapiro noted that the plaintiff testified that the pain was abating until a few days prior to the plaintiff's appointments in Texas.

Dr. Shapiro further expressly rejected the plaintiff's contentions that the "abnormal appearance" of the gluteal implant incision was a missed sign of infection, and that the NYPH defendants "failed to reexamine the patient's gluteal implant wound in the 72 hours before discharge." He explained that buttocks that recently had undergone gluteal augmentation and placement of implants would not appear "normal" for weeks after the surgery, and will invariably manifest swelling, edema, discoloration, and redness during the natural healing process. As he framed the issue, {a]ccording to the countless examinations of his gluteal implants conducted by NYPH providers detailed above, that is precisely how BROGAN's gluteal implants appeared during his admission." He additionally opined that the NYPH SICU team was very proactive and exceeded the standard of care since they assigned plastic surgeons personally to examine the plaintiff's surgical sites on at least four days during the plaintiff's seven-day admission, and that, upon each examination, the plastic surgeons noted that he was healing appropriately, with Penrose drains draining serosanguinous drainage without purulent drainage, pus, or foul smells that would have been suggestive of infection. Dr. Shapiro explicitly rejected, as untrue and unsupported by the medical records, the plaintiff's allegation that the gluteal wounds were not examined by NYPH personnel for 72 hours prior to discharge since the chart expressly reported that NYPH plastic surgeons and other staff examined the wounds several times each day between December 26, 2021 and the December 29, 2021 discharge, with four examinations having been conducted on December 29, 2021 alone. He further adverted to Steinbrech's testimony to the effect that Steinbrech had examined the plaintiff's wounds during the seven-day admission, and never saw any signs of infection.

Dr. Shapiro characterized as "misleading" the plaintiff's allegation that the defendants should not have discharged the plaintiff until they had ascertained the cause of his rising WBC count and until his WBC count had started to trend downwards. He described a WBC count as a "non-specific" marker, meaning that the count could be elevated due to multiple conditions, including infection, autoimmune disorders, inflammation, a recent surgery, a reaction to medication, cancer, an issue with the immune system, stress on the body, cardiac stress, and/or the presence of an implant or foreign body. Due to its "non-specific" nature, Dr. Shapiro opined that an elevated WBC count alone would not trigger a workup for infection, and that the standard of care applicable to a determination of whether a post-surgical patient should be diagnosed with infection at a surgical site is to consider the patient's entire clinical picture to determine if the sum total of the signs, symptoms, complaints, and laboratory results are indicative of infection. He explained that, beginning on December 22, 2021, the plaintiff had experienced many of the conditions that can cause an elevated WBC count, including recent extensive surgery, inflammation, stress on the body from an intraoperative event, and subsequent multiorgan failure, cardiac stress, new medications, and five new implants/foreign bodies, all of which could have caused his "mild" WBC elevations and the slightly upward trend of the WBC count during the last few days of his admission. In this respect, Dr. Shapiro asserted that the plaintiff's highest WBC count was recorded immediately upon his admission to NYPH, and that it decreased over the next several days, only increasing slightly during the last three days of the admission. According to Dr. Shapiro, these values were "completely within the expected range for patient who suffered the stresses BROGAN's body did on December 22nd." In the absence of other signs of infection, such as fever, tachycardia, and purulent drainage, Dr. Shapiro concluded that the WBC count was completely consistent with the plaintiff's surgical history, and did not require a workup for infection. For this same reason, he rejected the plaintiff's contention that the NYPH defendants should have performed a blood culture to ascertain the presence of infection before discharging the plaintiff, and noted that the antibiotics

prescribed by Steinbrech and administered by NYPH personnel over the last two days of the plaintiff's admission were recognized prophylactic antibiotics, not antibiotics intended to treat a suspected or confirmed infection.

Dr. Camins, in effect, reiterated the description of the course of the plaintiff's treatment at NYPH that Dr. Shapiro had provided. He concurred with Dr. Shapiro that the NYPH defendants did not depart from the standard of care in treating and discharging the plaintiff, and that nothing that they did or did not do caused or contributed to the plaintiff's claimed injuries, including the need for removal of the gluteal implants.

Dr. Camins explained that infections can occur any time that a foreign body, such as a cosmetic implant, is placed into a patient, and that the risk of infection with gluteal implants is higher than that which is expected with most other implants because of their location, since it is located near the buttocks and anus, which are easily contaminated. He asserted that there is always a gap of time between the introduction of infectious bacteria into a surgical site and when the infection grows enough to become symptomatic and diagnostic, a gap that is larger when implants are involved. Dr. Camins averred that this occurs because implants can become infected with a much smaller amount of bacteria than surgical-site infections where no implants are involved, and that bacteria can develop a "biofilm," which occurs when bacteria adhere together into a glue-like substance onto the surface of the implant. According to Dr. Camins, since biofilm essentially binds all of the bacterial microorganisms together in the form of a coat upon the implant, the infection will remain asymptotic and "subclinical" for a period of time longer than a typical surgical-site infection. Dr. Camins explained that the reason that Dr. Basu likely recommended removal of the implant as early as January 2022 was because the biofilm also protects the bacteria from antibiotics and the working of a person's immune system.

Dr. Camins consequently opined that, while the plaintiff's right gluteal implant became "seeded" with an infectious bacteria during the December 22, 2021 plastic surgery, it was too early to be detected either during the surgery or during the plaintiff's seven-day admission to

NYPH, and that there were no signs or symptoms of infection during that stay. In this respect, he explained that, even in the absence of implants, it is rare to be able to diagnose surgical-site infections within seven days, and that it would be even more infrequent for a physician to diagnose a surgical-site infection where an implant was involved. He stated that this expectation matched "perfectly" with the plaintiff's contemporaneous January 4, 2022 report to Dr. Basu of the post-discharge onset of severe pain and drainage from the surgical site. Dr. Camins thus explicitly disagreed with the plaintiff's allegations that the NYPH defendants were negligent in failing to diagnose an infection, and agreed with Dr. Shapiro's opinion that the standard of care did not require further workup, diagnosis, or treatment for infection.

Dr. Camins essentially reiterated Dr. Shapiro's analysis of when a clinician should suspect an infection and when a clinician should test for infection, noting that the plaintiff manifested none of the signs or symptoms for infection during the hospital stay. He repeated, almost verbatim, Dr. Shapiro's conclusions concerning the non-specific nature of the plaintiff's slightly elevated WBC counts, the reasons why those counts were elevated, the significance of the plaintiff's complaints of pain, and the allegedly "abnormal" appearance of the gluteal surgical site over the course of the hospital admission, as well as Dr. Shapiro's explanations concerning the plaintiff's overall clinical picture, including the absence of fever, tachycardia, purulent discharges, pus, and foul smells, and the insults to the plaintiff's body caused by the surgery itself that likely caused the elevated WBC counts, the pain, and the appearance of the surgical site. Specifically, he concluded that the standard of care did not require the retention of the plaintiff at NYPH, a diagnosis of infection, or a further workup, including blood cultures, to determine the presence of an infection. Moreover, he opined that the NYPH defendants' administration of antibiotics, even prophylactically, would have resolved any infection that the plaintiff might have contracted during his hospital stay.

Dr. Camins asserted that a January 8, 2022 culture generated in Texas from the plaintiff's right gluteal incision fluid was positive for Escherichia coli (E. coli), but the deeper

culture from the March 28, 2022 implant removal surgery grew the bacteria Enterobacter cloacae (E. Cloacae). He opined that E. coli was merely a "contaminant," while the bacteria that actually caused the gluteal implant infection was always E. Cloacae. Dr. Camins explained that, when an implant is infected, antibiotics alone, whether administered intravenously or orally, will not resolve the infection because biofilm will form on the implants, and the infection will never resolve without removal of the implant. Thus, even had an infection been diagnosed while the plaintiff was an inpatient at NYPH, and conservative treatment in the form of intravenous antibiotics had been commenced promptly, the plaintiff would still have been required to undergo the removal of the implant. As he framed the issue

> "[t]his is not a case where an alleged delay changed the course of treatment or outcome for the patient. In fact, the vast majority of infected implants, no matter where in the body they are placed, will need to be removed once they become infected to achieve a cure. Therefore, any alleged failure to place the patient on IV antibiotics did not change the outcome here."

In support of this conclusion, Dr. Camins noted that, after the plaintiff returned to Texas, and did, in fact, begin a four-week regimen of intravenous antibiotic therapy on January 12, 2022, and an additional, multiple, four-week course of the oral antibiotic amoxicillin between February 2, 2022 and March 3, 2022, the infection did not resolve. Since the infection could not be resolved by those treatments, Dr. Camins concluded that the plaintiff was experiencing "a deep-rooted infection that was never going to resolve without removal of the implant." Hence, he opined that, even had intravenous antibiotic therapy been started at NYPH, it would not have made a difference in the course of the plaintiff's treatment, and the plaintiff ultimately would still have required the removal of the right gluteal implant to completely resolve the infection.

In opposition to Garland's motion, the plaintiff relied on many of the same documents as Garland had submitted, and also submitted a counterstatement of material facts, an attorney's affirmation, and the expert affirmation of anesthesiologist Alexander Weingarten, M.D. In opposition to the NYPH defendants' motion, the plaintiff relied on many of the same documents as they had submitted, and also submitted a counterstatement of material facts, an attorney's

affirmation, and the expert affirmations of a board-certified internist and pulmonologist (hereinafter the internist) and a board-certified infectious disease specialist.

Dr. Weingarten asserted that he disagreed with Dr. Jaspan's opinion that it was not a departure from the standard of care for Garland to have declined to insert a Foley catheter into the plaintiff's penis prior to the subject surgery, since good practice required the placement of a Foley catheter where surgery is anticipated to last longer than four hours, while the subject surgery was anticipated to last at least seven hours. He asserted that it was not a defense to attribute this determination to Steinbrech, since, "[a]s the anesthesiologist, it was Dr. Garland's obligation to ensure that the fluids going in and out of Mr. Brogan were balanced and there is no accurate way to do this over the course of a seven hour plus surgery without a [F]oley catheter." According to Dr. Weingarten, if Steinbrech insisted on proceeding without a Foley, the standard of care required Garland "to refuse to proceed with anesthesia as there was no way to safely ensure that a patient's fluids remain balanced over a seven hour surgery without a [F]oley catheter." Noting that Garland did not attempt to insert a Foley catheter until approximately 7:00 p.m. on December 22, 2021, and that the insertion was undertaken solely because Garland detected an abnormality in the plaintiff's breathing, Dr. Weingarten explained that, by this point the surgery with anesthesia had been proceeding for approximately nine hours, which he characterized as a clear departure from the standard of care, "exacerbated by the fact that Dr. Garland had administered approximately six and a half liters of fluids to Mr. Brogan and Dr. Steinbrech had administered an additional two and a half liters of fluid."

Dr. Weingarten expressly rejected Dr. Jaspan's opinion that it was acceptable for Garland to administer the plaintiff 6.5 liters of fluid in the absence of a Foley catheter, inasmuch as, between blood loss, water evaporation, and general daily water requirements, the plaintiff required 6.7 liters of fluid during the course of his surgery, which, according to Dr. Weingarten, was premised on the assumption that the plaintiff was urinating on a periodic basis, which the plaintiff was not doing during the surgery. Hence, he concluded that Dr. Jaspan's calculations

were entirely "off base," and also did not account for the fact that Steinbrech administered an additional 2.5 liters of fluid.

Dr. Weingarten rejected Dr. Jaspan's opinion that the surgery caused the plaintiff's muscles rapidly to break down, leading to rhabdomyolysis, which, in turn, led to a host of further complications. He faulted Dr. Jaspan for failing to explain how the performance of plastic surgery would cause the plaintiff's muscles to break down. As he phrased it, "[t]housands of people undergo plastic surgery every day, often involving multiple procedures[,] and they do not end up on a ventilator." Rather, Dr. Weingarten expressly opined that fluid overload caused the plaintiff to go into organ failure. He asserted that Dr. Jaspan's contrary conclusions were directly contradicted by the NYPH chart, which he noted was "replete with references to Mr. Brogan suffering from fluid overload." In this respect, he referred to an entry for December 23, 2021, one day after the surgery, which reported that the plaintiff's fluid output exceeded his input over the previous 24-hour period by 2.3 liters, and explained that such input and output should be approximately equal over such a 24-hour period. Dr. Weingarten further adverted to a December 25, 2021 entry referable to the NYPH chest x-ray, which reported that the plaintiff had "significant fluid overload, consistent with recent event," as well to a December 26, 2021 chart entry, which reported that fluid input and output measurements and the chest x-ray result were "suggestive of significant fluid overload" that required the plaintiff to be placed on medication to excrete the excess fluid from his body. He also noted a December 27, 2021 chart entry in which an NYPH attending physician wrote that the plaintiff was experiencing edema secondary to fluid overload.

In light of the foregoing, Dr. Weingarten concluded that the plaintiff was necessarily transported to the SICU at NYPH because of organ failure, secondary to fluid overload, which he attributed to Garland's negligent failure to insert a Foley catheter during the course of a nine-hour-long surgery. He further concluded that, due to the fluid overload and concomitant organ failure, the plaintiff could not be extubated and weaned off of the surgical ventilator.

Dr. Weingarten did not address the allegations in the plaintiff's bill of particulars that Garland committed malpractice by placing the plaintiff under anesthesia for 11 hours despite the November 22, 2021 preoperative laboratory results that were positive for moderate kidney failure/disease, and did so despite failing to obtain medical clearance. Nor did he render an opinion as to whether Garland departed from good anesthesia practice by administering excessive amounts of lidocaine, neo-synephrine, and epinephrine to the plaintiff, failing properly to monitor the plaintiff's blood pressure, pulse rate, creatinine and potassium levels, venous pH, and pCO2 levels during the subject surgery, failing obtain a full and complete medical history, administering anesthesia even after the plaintiff's blood pressure was not detectable, and allowing the plaintiff to be moved an excessive number of times while under anesthesia.

The plaintiff's retained internist asserted that the NYPH defendants departed from the standard of care by discharging the plaintiff from NYPH on December 29, 2021. The internist did not dispute Dr. Shapiro's description of the plaintiff's stabilized WBC count and decreasing CK levels during the first few days of the plaintiff's admission, but asserted that, beginning on December 26, 2021, the plaintiff's condition began to deteriorate, so that, by December 29, 2021, "there was a clear trend showing a significant worsening of the patient's condition, with numerous signs pointing to an infection of his gluteal implants." In this respect, the internist noted that the plaintiff's WBC count rose from a reading within normal limits to above the reference range by December 26, 2021, and continued to increase on December 27, 2021, December 28, 2021, and December 29, 2021, despite the fact that he had received two doses of Cephalexin 6 and 10 hours earlier on that last date. Similarly, the internist noted that the plaintiff's creatinine levels rose each day from a reading within normal limit on December 25, 2021 to greater than the reference range on December 28, 2021. The plaintiff's internist, in referring to the NYPH nurse's note reporting "abnormal hardening" of the surgical site, rejected the notion that this observation reflected normal postoperative edema, and challenged Dr. Shapiro's contention that the subsequent examination was conducted by a plastic surgeon,

explaining that the consultation and examination was performed by Dr. Li, who was only five months into a general surgery residency. As the internist explained it, regardless of the presence of postoperative edema, incision wounds should not be "abnormally hardened." The internist further referred to the "severe" pain that the plaintiff reported in his buttocks, despite being administered oxycodone on a regular basis, and to the fact that, on December 28, 2021, for the first time, the plaintiff's gluteal incision wound began to seep. Although the internist conceded that, individually, none of these signs and symptoms necessarily pointed to an infection, or would have been sufficient to prevent the plaintiff's discharge on December 29, 2021, in combination, the plaintiff's clinical picture was highly suggestive of an infected gluteal implant wound that rendered his discharge on that date contraindicated.

The plaintiff's internist opined that the NYPH defendants should have realized that the plaintiff was at extremely high risk of developing an infection in the area of the gluteal implant incision, inasmuch as such implants have a high infection rate to begin with, and, in the plaintiff's case, the risk was significantly increased because the plaintiff had been unable to "offload" the wound at all for the first 72 to 96 hours following the surgery, and was barely able to offload the wound throughout his time at NYPH. The internist further asserted that the trauma that the plaintiff experienced both during the surgery and postoperatively "would have significantly weakened" the plaintiff's immune system. Hence, the internist concluded that the NYPH defendants should have been on high alert for signs of infection in the gluteal implant wound, and that the NYPH defendants departed from accepted practice by discharging the plaintiff on December 29, 2021, without further examining the plaintiff's gluteal incision wound site, and by failing to perform two additional CBC panel tests on that date, while continuing to administer oral antibiotics to the plaintiff. The internist concluded that, in light of the course that the plaintiff's infection actually took, had a physician performed an additional examination of the gluteal incision wound site on December 29, 2021, and performed the additional CBC testing,

that physician would have seen clear signs of infection, and test results indicative of a worsening infection, thus triggering a consultation with an infectious disease specialist.

Moreover, as the internist interpreted the NYPH chart, there was no indication that Steinbrech examined the plaintiff between December 26, 2021 and December 29, 2021, which the internist asserted was important, since the plaintiff is not claiming that there were signs of infection prior December 26, 2021. In addition, the internist noted that, although Dr. Shapiro relied upon the plaintiff's deposition testimony to the effect that the plaintiff was experiencing pain all over his body, the chart reflected that, as of December 26, 2021, the plaintiff was only complaining about pain in the buttocks. The plaintiff's internist further disagreed that the absence of fever and tachycardia during that interval necessarily was dispositive of the presence or absence of infection, since any fever would been abated by the 975-mg doses of Tylenol that the plaintiff had been taking several times each day. In addition, the internist averred that an infection "is diagnosable long before it is so advanced that it causes fever and tachycardia." As the internist also explained it, the fact that the plaintiff's intravenous pain medication had been discontinued on December 26, 2021 did not contradict the fact that the pain in his buttocks actually *increased* as of December 26, 2021, while the pain from all of the other surgical sites decreased significantly.

The plaintiff's retained internist stated that, just because the plaintiff's infection was not yet advanced enough to generate pus and a foul smell at the incision site did "not mean that an examination of the incision cite would not have revealed other signs of infections that appear before pus and a foul smell," such as an redness, swelling, warmth, and fluid drainage, which the internist noted had indeed been observed on December 28, 2021. The internist further faulted Dr. Shapiro for the latter's "misplaced" reliance on a purported December 29, 2021 examination at 1:00 a.m., which was memorialized in what the internist characterized as a "perfunctory note" that directly contradicted a more specific note written 15 hours earlier that had described the incision wound as red, with drainage coming from the wound. With respect to

notes purportedly memorializing examinations at 9:00 a.m. and 11:22 a.m. on December 29, 2021, the internist pointed out that Dr. Shapiro did not provide a page citation for either of these notes, and that an 11:22 a.m. note that had in fact been entered by Nurse Practitioner Ugbogbo did not mention anything about an examination of the gluteal implant incision wound. The internist ultimately concluded that the plaintiff's gluteal implant incision wound should have been examined by an infectious disease specialist or a surgeon on December 29, 2021, but was not.

With respect to the plaintiff's abnormal WBC counts and CK levels between December 26, 2021 and December 29, 2021, although the internist conceded that postoperative patients may indeed manifest such readings, it would be abnormal for a postoperative patient to have WBC and CK results initially return to normal levels in the first few days after surgery, only to increase above normal levels four days after surgery, and persist for four consecutive days thereafter. The internist expressed the same opinion with respect to the initial diminution and later increase in surgical site pain.

The plaintiff's infectious disease specialist agreed with many of the internist's opinions and descriptions of the plaintiff's testing, treatment, and care at NYPH, and accepted Dr. Camins's explanation of how biofilm develops during plastic surgery, as well as Dr. Camins's conclusion that the plaintiff became infected with E. cloacae. The infectious disease specialist reiterated several of the other opinions that the internist had rendered, including the conclusion that the NYPH defendants should not have discharged the plaintiff on December 29, 2021, that the plaintiff's gluteal incision wound likely was infected as of that date, that the NYPH defendants should have been on alert that infection was likely, that the plaintiff should have been examined by an infectious disease specialist or surgeon on December 29, 2021, that additional CBC tests should have been performed on that date, and that, had the NYPH defendants taken those steps, as required by the standard of care, they likely would have diagnosed a bacterial infection and commenced intravenous antibiotic therapy with Vancomycin and Cesepime. In addition, the infectious disease specialist opined that these findings and

results should have triggered an order for a pelvic CT, which likely would have visualized a fluid collection, possibly with gas bubbles, within the subcutaneous tissue, along with signs of fat stranding, involvement of the gluteus major muscle, and/or abscess characterized by rim-enhancing fluid collection. This specialist further concluded that such testing should have triggered an infectious disease consultation, and that "such consult should have noted that the window of opportunity to effectively treat an infected implant before it forms a mature biofilm is a short window." The specialist also explained that it was "entirely plausible that by the morning of December 30th, the biofilm around Mr. Brogan's implants had not yet matured," and that, had the NYPH defendants commenced the recommended course of intravenous antibiotic therapy by the morning of December 30, 2021, it "may have been in time to penetrate an immature biofilm and effectively treat Mr. Brogan's infection." Hence, the expert concluded that, by discharging the plaintiff on December 29, 2021, the NYPH defendants deprived the plaintiff of a chance of saving his implant.

The infectious disease specialist agreed with the plaintiff's internist that there was no indication that Steinbrech examined the plaintiff between December 26, 2021 and December 29, 2021, and that the absence of fever or tachycardia during that period of time was insufficient to rule out infection, particularly in light of the increased WBC count, CK levels, and localized pain, as well as other observable signs of infection such as redness, warmth, and fluid drainage. The infectious disease specialist noted, as did the internist, that the plaintiff complained of increased gluteal pain at the same time as the plaintiff reported reduced pain over the other surgical sites, despite taking a high dose of Tynenol and taking regular doses of oxycodone.

The plaintiff's retained infectious disease specialist expressly disagreed with Dr. Camins's conclusion that the gluteal implant was "seeded" with the infection during Steinbrech's procedures. As this expert explained it, a "significant majority of Enterobacter cloacae infections are contracted in hospital settings, and particularly in ICU settings. As such, it is more probable than not" that the plaintiff was seeded with this infection while in the NYPD SICU at some point

between December 22, 2021 and December 24, 2021. The expert further asserted that, while E. cloacae infections of gluteal implants can lay latent for several weeks, they can also be symptomatic within days of when the infection is seeded, especially in situations such as the plaintiff's, where the patient's immune system has been weakened. The infectious disease specialist further disagreed with Dr. Camins's opinion that, once an implant is infected, it cannot be treated and will always have to be removed. In this respect, the expert concluded that Dr. Camins contradicted himself in the same paragraph of his expert affirmation by asserting that the "vast majority" of infected implants have to be removed, since that implied that Dr. Camins conceded that, "in some cases, they do not need to be removed." While the expert agreed that, in a majority of the cases, infected implants do have to be removed, that was because, in those cases, the patient is not in a hospital at the time when the symptoms begin manifesting and, thus, the infection is only discovered after the biofilm has already formed, by which time it is too late. In the plaintiff's case, however, the plaintiff's expert opined that it was more probable than not that, as of December 30, 2021, the biofilm had not yet fully formed, and the plaintiff could still have been successfully treated with antibiotics. Since, according to the expert, the plaintiff was, in fact, still hospitalized when the signs of infection began to manifest themselves, the expert explained that the NYPH defendants should have realized that the plaintiff presented an atypical case in which an infected implant could be successfully treated without removal.

Ultimately, the infectious disease specialist concluded that the NYPH defendants departed from the standard of care by discharging the plaintiff from NYPH on December 29, 2021, and that is was more probable than not that, had those defendants commenced the plaintiff on a course of intravenous antibiotics on or about December 29, 2021 or December 30, 2021, the plaintiff "may not have needed to have his gluteal implants removed; and he would not need to have three months of antibiotic treatment, and he would not have suffered tissue loss in his glutes."

In reply, both Garland and the NYPH defendants submitted attorneys' affirmations, in which counsel contended that the opinions rendered by the plaintiffs' experts were conclusory, speculative, and not supported by the medical records. Counsel for Garland also argued that Dr. Weingarten did not refute most of Dr. Jaspan's opinions, and simply reiterated the latter's conclusions that were contrary to those of Dr. Weingarten, for example, that fluid overload did not cause the need for the plaintiff's hospitalization, and that Garland was not responsible for any injuries that the plaintiff may have developed as a result of his one-week hospitalization. Counsel for the NYPH defendants argued that some or all of the plaintiff's expert opinions were raised for the first time in opposition to their summary judgment motion.

The court concludes that, although Garland established his prima facie entitlement to judgment as a matter of law with his submissions, including Dr. Jaspan's affirmation, the plaintiff raised triable issues of fact as to whether Garland departed from good and accepted practice by failing to insert, or insist on the insertion of, a Foley catheter to regulate fluid buildup during the subject surgery, administering 6.5 liters of fluid to the plaintiff during the surgery in addition to a separate 2.5 liters that had been administered by the Steinbrech, despite the absence of a Foley catheter, and as to whether those departures caused or contributed to organ failure that required the plaintiff to be admitted to NYPH for more than seven days to address such fluid overload and organ failure. Garland's summary judgment motion must be denied as to those claims. Since Dr. Weingarten did not address any of the other departures that the plaintiff alleged in his complaint and bill of particulars, summary judgment must be awarded to Garland dismissing those claims. Similarly, the NYPH defendants established their prima facie entitlement to judgment as a matter of law with their submissions, including the expert affirmations of Drs. Shapiro and Camins. Nonetheless, the plaintiff raised triable issues of fact as to both malpractice and proximate case with his submissions, including the affirmations of his expert internist and infectious disease specialist opining that those defendants departed from the applicable standard of care and that those departures caused his infection to spread, made

his condition worse, deprived him of an opportunity for a better outcome, and necessitated the removal of his gluteal implants.

The court concludes that, contrary to the defendants' contention, 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 the purported departures that those experts addressed, and whether those departures proximately caused the plaintiff's injuries. 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).

Moreover, although generally, where a plaintiff fails to allege a theory of negligence in his or her bill of particulars, that new theory may not be raised for the first time in response to a defendant's motion for summary judgment (*see Rosado v New York City Hous. Auth.,* 194 AD3d 586, 587 [1st Dept 2021]; *Monmasterio v New York City Hous. Auth.*, 39 AD3d 354, 355 [1st Dept 2007])." Thus, while the court recognizes that "a plaintiff cannot raise a new or materially different theory of recovery against a party from those pleaded in the complaint and the bill of particulars for the first time in opposition to a motion for summary judgment" (*Fasce v Catskill Reg. Med. Ctr.*, 209 AD3d 1138, 1139-1140 [3d Dept 2022] [citations and internal quotation marks omitted]; *see Anonymous v Gleason*, 175 AD3d 614, 617 [2d Dept 2019]; *Palka v Village of Ossining*, 120 AD3d 641, 643 [2d Dept 2014]*; Scanlon v Stuyvesant Plaza*, 195 AD2d 854, 855-856 [3d Dept 1993]), a bill of particulars in a medical malpractice action need only "'provide a general statement of the acts or omissions constituting the alleged negligence'" (*Contreras v Adeyemi*, 102 AD3d 720, 722 [2d Dept 2013], quoting *Toth v Bloshinsky*, 39 AD3d 848, 849 [2d Dept 2007]; *see* CPLR 3043[a][3]). The court disagrees with the NYPH defendants' contention that any of the departures addressed by the plaintiff's internist and infectious disease specialist were not raised in the bill of particulars. Rather, the plaintiff's succinct bill of particulars as to

those defendants expressly identified, as departures, those defendants' allegedly premature discharge of the plaintiff, their failure to have an appropriate physician perform adequate or additional physical examinations of the surgical site, their failure to appreciate a rising WBC count after that count already had decreased, the plaintiff's increased complaints of localized pain, and the abnormal appearance of the gluteal surgical site, their failure to suspect, test for, or diagnose an infection, and their failure to administer broad-spectrum intravenous antibiotics.

Accordingly, it is,

ORDERED that the motion of the defendant Marshall Garland, M.D., for summary judgment dismissing the complaint insofar as asserted against him (MOT SEQ 001) is granted only to the extent that he is awarded summary judgment dismissing so much of the medical malpractice cause of action insofar as asserted against him as was premised upon his placement the plaintiff under anesthesia for a 9-to-11-hour surgery despite preoperative laboratory results from November 22, 2021 indicating that the plaintiff had been experiencing moderate kidney failure/disease, his failure to obtain medical clearance, his alleged administration of excessive amounts of lidocaine, neo-synephrine, and epinephrine to the plaintiff intraoperatively, his alleged failure properly to monitor the plaintiff's blood pressure, pulse rate, creatinine and potassium levels, venous pH, and pCO2 levels intraoperatively, his alleged failure obtain a full and complete medical history, his administration of anesthesia during surgery even after the plaintiff's blood pressure was not detectable, and his repositioning, or acquiescence in the repositioning of the plaintiff an excessive number of times while under anesthesia, those claims are dismissed, and his motion is otherwise denied; and it is further,

ORDERED that the motion of the defendants Nima Maghami, M.D., and The New York and Presbyterian Hospital, doing business as New York-Presbyterian Hospital/Weill Cornell Medical Center, for summary judgment dismissing the complaint insofar as asserted against them (MOT SEQ 002) is 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 April 29, 2026, at 2:45 p.m., at which time they shall be prepared to discuss resolution of the action, the scheduling of a future two-hour, mediation-style settlement conference, and the scheduling of a firm date for the commencement of jury selection.

This constitutes the Decision and Order of the court.

4/8/2026
DATE

JOHN J. KELLEY, J.S.C.

MOTION 001:		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
MOTION 002:		CASE DISPOSED			X	NON-FINAL DISPOSITION		
		GRANTED	X	DENIED		GRANTED IN PART		OTHER
APPLICATION:		SETTLE ORDER				SUBMIT ORDER		
CHECK IF APPROPRIATE:		INCLUDES TRANSFER/REASSIGN				FIDUCIARY APPOINTMENT		REFERENCE