[* 1]
SCANNED ON 5/1/2012

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

PRESENT: LOBIS Justice PART 6

CUCINDA MOREDO
-v-
PATRICIA FARRELLY, M.D.

INDEX NO. 104824/08
MOTION DATE 2/14/12
MOTION SEQ. NO. 1
MOTION CAL. NO.

The following papers, numbered 1 to 29 were read on this motion to/for dismiss

	PAPERS NUMBERED
Notice of Motion/ Order to Show Cause — Affidavits — Exhibits ...	1→14
Answering Affidavits — Exhibits	15→25
Replying Affidavits	26→29

Cross-Motion: ☐ Yes ☒ No

Upon the foregoing papers, it is ordered that this motion

THIS MOTION IS DECIDED IN ACCORDANCE
WITH THE ACCOMPANYING MEMORANDUM DECISION

FILED
MAY 01 2012
NEW YORK
COUNTY CLERK'S OFFICE

Dated: 4/27/12

JOAN B. LOBIS J.S.C.

MOTION/CASE IS RESPECTFULLY REFERRED TO JUSTICE FOR THE FOLLOWING REASON(S):

Check one: ☐ FINAL DISPOSITION ☒ NON-FINAL DISPOSITION

Check if appropriate: ☐ DO NOT POST ☐ REFERENCE

☐ SUBMIT ORDER/ JUDG. ☐ SETTLE ORDER/ JUDG.

SUPREME COURT OF THE STATE OF NEW YORK
NEW YORK COUNTY: IAS PART 6

----------X

LUCINDA NATERA MERCEDES and RAMON MERCEDES,

Plaintiffs,

-against-

PATRICIA A. FARRELLY, M.D., PATRICIA A. FARRELLY, M.D., P.C., DAVID CANGELLO, M.D., and LENOX HILL HOSPITAL,

Defendants.

----------X

Index No. 104824/08

Decision and Order

JOAN B. LOBIS, J.S.C.:

Motion Sequence Numbers 001 and 002 are hereby consolidated for disposition. In Motion Sequence Number 001, defendant David Cangello, M.D., and Lenox Hill Hospital ("LHH") move, by order to show cause, for an order pursuant to C.P.L.R. Rule 3212, granting them summary judgment and dismissing the complaint and the action against them, with prejudice. In Motion Sequence Number 002, defendants Patricia A. Farrelly, M.D., and Patricia A. Farrelly, M.D., P.C. ("Farrelly P.C."), also move, by order to show cause, for an order pursuant to C.P.L.R. Rule 3212, granting them summary judgment and dismissing the complaint and any cross-claims against them. Additionally, Farrelly P.C. seeks an order pursuant to C.P.L.R. Rule 3211, dismissing the action against it for lack of personal jurisdiction. Plaintiffs Lucinda Natera Mercedes ("Ms. Natera")[1] and Ramon Mercedes oppose the motions.

This action involves defendants' treatment of Ms. Natera's abdominal hernia in 2007. In 2006, Ms. Natera was referred to Dr. Farrelly by her primary care physician, Jose Ortiz, M.D., for

---

[1] During her deposition, Lucinda Natera Mercedes testified that she is known as Lucinda Natera.

complaints of nausea, vomiting, and acid reflux; Dr. Ortiz suspected that a ventral hernia had reoccurred. Ms. Natera first saw Dr. Farrelly on December 13, 2006. Dr. Farrelly's notes reflect that Ms. Natera was a 67-year old female who only spoke Spanish; the visit was interpreted through Dr. Farrelly's office manager. Dr. Farrelly documented that in 1995, Ms. Natera had emergent surgery with a colostomy for what sounded like perforated diverticulitis. The colostomy was closed six months later and required a repair of the ventral hernia, though no apparent mesh was used in the repair. The notes reflect that Ms. Natera had noticed a lump in her upper abdomen in the past several months and what felt like "acid" in the area, though she was tolerating her diet, had normal bowel movements, and had no nausea, vomiting, or weight change. Dr. Farrelly's notes reflect that she observed scars on Ms. Natera's body from the prior colostomy and a palpable incisional hernia; she recalled, during her deposition, that the hernia was approximately 8 centimeters long vertically. Dr. Farrelly believed Ms. Natera had a recurrent incisional hernia, she recommended a computed tomography ("CT") scan for further evaluation, and she noted that Ms. Natera would need elective repair of the hernia with mesh and drain.

Ms. Natera went for a CT scan on December 28, 2006. The report of the CT scan indicated that there were three ventral hernias with a prolapse of bowel into the hernias. Dr. Farrelly's notes reflect that on January 3, 2007, Dr. Farrelly—through her office manager—discussed the results of the CT scan with Ms. Natera. According to Dr. Farrelly's notes, the results of the CT scan, together with Ms. Natera's reports of increasing symptoms of pain, made surgery necessary. Her notes reflect that it was unclear to what extent the bowel would need to be manipulated during the surgery, but that Ms. Natera was made aware of the possible risk of resection, and that Ms. Natera's questions about the alternatives, risks, and benefits of the procedure were answered via the

interpreter. Dr. Farrelly testified at her deposition that it is customary for her to discuss the alternative of no surgery and the risks of a bowel obstruction needing urgent surgery; risks related to anesthesia; risks of bleeding and infection; risks associated with using mesh; risk of a necessary intestinal resection and repair; and risks of recurrent hernias and additional surgeries. Ms. Natera testified at her deposition that prior to the surgery, Dr. Farelly did not discuss with her the possible complications of the procedure, the possibility of infection, the possibility of bleeding after the procedure, the possibility that the hernia repair would be unsuccessful, or the possibility that her bowel might have to be resected.

On January 23, 2007, Ms. Natera was admitted to LHH under the care of Dr. Farrelly. She signed a consent form prior to the surgery. The operation to repair the multiple ventral hernias was performed by Dr. Farrelly with assistance from Dr. Cangello, a resident at LHH. Dr. Cangello assisted by holding the bowel at Dr. Farrelly's direction. The operative record indicates that during the operation, adherent loops of small bowel within multiple hernia sacs in both the midline and left lower quadrant were identified. Extensive adhesions to the anterior abdominal wall and the hernia sacs were encountered, which were dissected to free the bowel. An area of small bowel was inadvertently entered in two separate areas; Dr. Farrelly testified that the enterotomy between the jejunum and the ileum was repaired with resection and an end-to-end anastomosis, which was stapled and secured with sutures, and that the other enterotomy was repaired with sutures. The hernia was repaired with a "10 x 8 Composix mesh." In her testimony at her deposition, Dr. Farrelly described Ms. Natera abdomen as "very hostile," meaning that there was extensive scar tissue from prior surgery and that a lot of intestine needed to be manipulated in order to fix the hernia. She further testified that the portion of bowel that she resected did not look healthy.

After the surgery, Ms. Natera experienced nausea, vomiting, intermittent fever and pain. Ms. Natera was discharged from LHH on January 28, 2007. Ms. Natera testified at her deposition that as early as the day she was released from the hospital, she started running a fever, she felt stitches popping out from her incision, and she had a foul-smelling yellow discharge from the incision. On February 3, 2007, (a Saturday) Dr. Farrelly returned a telephone call from Mr. Mercedes; her office notes reflect that he reported that his wife was vomiting, that her pain was controlled, and that she had a bowel movement, though Mr. Mercedes testified at his deposition that he did not report that information. Dr. Farrelly instructed Mr. Mercedes that his wife should drink liquids and, if there were no improvement, to go to the emergency room. Dr. Farrelly testified that she offered to see Ms. Natera in her office but the offer was declined. Ms. Natera had a scheduled postoperative examination on February 5, 2007. Dr. Farrelly's office records reflect that on February 5, Mr. Mercedes called to cancel the appointment because it was too cold outside and his wife was too tired to get out of bed, though Mr. Mercedes testified at his deposition that he did not make such phone call. Later on February 5, Dr. Farrelly's office called plaintiffs to follow-up with Ms. Natera. Dr. Farrelly's office notes reflect that Mr. Mercedes reported that Ms. Natera was feeling better but had discomfort, although Mr. Mercedes testified at his deposition that he never reported that Ms. Natera was feeling better. On February 7, 2007, Ms. Natera was seen in Dr. Farrelly's office; plaintiff's daughter, Elizabeth, accompanied her to the doctor's office and translated the conversation. Dr. Farrelly's notes reflect that she reviewed the operative findings and the need for the resection with Ms. Natera. Dr. Farrelly's notes reflect that Ms. Natera was moaning but that she stated that she felt a little better. Dr. Farrelly noted: "Since yesterday foul smelling drainage from wound." Ms. Natera reported positive bowel movements, no further vomiting, and no fevers, but some nausea and pain in her shoulders and chest from coughing. Dr. Farrelly's notes reflect that

upon examination, the abdomen incisions appeared clean, there was no erythema, there was a small amount of discharge near the umbilicus, and there was no swelling or tenderness. Dr. Farrelly prescribed antibiotics and instructed Ms. Natera to follow-up in one week or sooner if her symptoms worsened.

On February 8, 2007, Dr. Farrelly's office notes indicate that her office contacted plaintiffs but received no answer and left a message; the message was returned by a telephone call from Ms. Natera's daughter, Roseann, who wanted to discuss the outcome of the surgery. The office notes reflect that Roseann reported that her mother had been vomiting the previous night but seemed better that day. Dr. Farrelly instructed Roseann to contact her if anything changed. Mr. Mercedes testified that he contacted Dr. Farrelly's office a number of times over the days that Ms. Natera was home. He testified that he spoke to Dr. Farrelly's secretary, Wanda, and reported that there was seepage from Ms. Natera's wound. He further testified that he was repeatedly informed that this was normal.

On February 10, 2007, Ms. Natera presented to the emergency room ("ER") at LHH. She reported discharge from the wound, fever, chills, sweats, abdominal pain, and vomiting. She reported that her symptoms had worsened over the past week. The notes from the ER reflect that she had copious yellow/brown thick discharge from her incision. A resident from the ER telephoned Dr. Farrelly. Ms. Natera was admitted and Dr. Farrelly saw her on both February 10 and the next morning on February 11, when she observed enteric (small bowel) contents on the wound dressings. Dr. Farrelly concluded that surgical intervention was required and advised the family of the risks of a bowel resection and osteotomy. She performed an exploratory laparotomy, observed dense

adhesions, and suspected that a fistula was forming in the small bowel. Dr. Farrelly testified that when she inspected the mesh, it was soiled with infection. During the operation, she called for a consultation by Michael Weinstein, M.D., an LHH surgeon, who agreed that the mesh should be replaced and that the wound should be left open and packed. Dr. Farrelly did so, accepting that a fistula would eventually develop.

Ms. Natera remained at LHH until June 4, 2007. A peripherally-inserted central catheter ("PICC") was inserted to provide total parenteral nutrition directly to Ms. Natera's vascular system while her bowel healed. She was put on a wound vacuum to help the wound close. On June 4, 2007, Ms. Natera was discharged from LHH with an open wound to Hudson Pointe at Riverdale Center for Nursing and Rehabilitation ("HPRC"). On July 11, 2007, Ms. Natera underwent small bowel resection and fistula repair by Maurizio Miglietta, M.D., at New York Presbyterian Hospital. Presently, she reports abdominal pain, reduction of mobility and activity, abdominal scarring, loss of consortium, and gastrointestinal issues including nausea.

This action was commenced on or about April 3, 2008, by the filing of a summons and complaint. The complaint raises causes of action sounding in medical malpractice and lack of informed consent against all defendants, and negligent hiring and/or retention against LHH. The complaint also asserts a cause of action for loss of services on behalf of Mr. Mercedes. Dr. Farrelly, Dr. Cangello, and LHH served their answers between April and May 2008. It is not disputed that Farrelly P.C. was never served with the complaint, that Farrelly P.C. never appeared in the action, and that plaintiffs never moved for a default judgment against Farrelly P.C.; accordingly, the action shall be dismissed against Farrelly P.C.

Shortly after defendants answered, plaintiffs served them with bills of particulars ("First BPs"). In July 20011, after most of the discovery had been completed and the parties and two of plaintiffs' daughters were deposed, plaintiffs served defendants with supplemental verified bills of particulars ("Second BPs") and filed their note of issue three days later. The First and Second BPs allege a number of departures from the standard of care. Against Dr. Farrelly, plaintiffs essentially allege that she negligently caused Ms. Natera's bowel to be injured during the January 23, 2007 hernia repair surgery; that Dr. Farrelly did not properly repair the injury or injuries to Ms. Natera's bowel during the hernia repair; that after the hernia repair, Dr. Farrelly failed to recognize signs and symptoms that the bowel was injured and failed to appropriately treat such injury or injuries; that Dr. Farrelly's subsequent repair of the bowel on February 11, 2007, was negligently performed; and that the postoperative care after February 11, 2007, was negligently administered. The essential allegations against Dr. Cangello and LHH are similar to those against Dr. Farrelly, plus there are a number of alleged departures against LHH related to the quality of the staff it provided and its rules and regulations pertaining to bowel injury. Plaintiffs allege that these departures caused Ms. Natera to incur injury to her bowel and enterocutaneous fistulae, and complications resulting therefrom; unnecessary subsequent surgeries; infection and scarring; prolonged hospitalization and rehabilitation; emotional distress; risk of future surgeries; and incontinence.

Defendants now seek summary judgment. Summary judgment is a drastic remedy, "which should not be granted where there is any doubt as to the existence of a triable issue or where the issue is even arguable, since it serves to deprive a party of his day in court." Gibson v. American Export Isbrandsten Lines, Inc., 125 A.D.2d 65, 74 (1st Dep't 1987) (internal citations omitted). As established by the Court of Appeals in Alvarez v. Prospect Hosp., 68 N.Y.2d 320, 324 (1986) and

Winegrad v. New York Univ. Med. Ctr., 64 N.Y.2d 851, 853 (1985), and as has recently been reiterated by the First Department, it is "a cornerstone of New York jurisprudence that the proponent of a motion for summary judgment must demonstrate that there are no material issues of fact in dispute, and that [he or she] is entitled to judgment as a matter of law." Ostrov v. Rozbruch, 91 A.D.3d 147, 152 (1st Dep't 2012), citing Winegrad, 64 N.Y.2d at 853. In a malpractice case, to establish entitlement to summary judgment, a physician must demonstrate that he did not depart from accepted standards of practice or that, even if he did, he did not proximately cause injury to the patient. Lowhar v. Eva Stern 500, LLC, 70 A.D.3d 654, 654-55 (2d Dep't 2010). The failure to meet this burden mandates the denial of the application, "regardless of the sufficiency of the opposing papers." Winegrad, N.Y.2d at 853. However, once a movant meets this burden, it is incumbent upon the opposing party to proffer evidence sufficient to establish the existence of a material issue of fact requiring a trial. Ostrov, 91 A.D.3d at 152, citing Alvarez, 68 N.Y.2d at 324. In medical malpractice actions, expert medical testimony is the sine qua non for demonstrating either the absence or presence of material issues of fact pertaining to departure from accepted medical practice or proximate cause.

Dr. Cangello maintains that he is entitled to summary judgment. Citing prevailing case law, he argues that he cannot be held liable for any alleged malpractice as he was a resident acting under the direction and control of Ms. Natera's private physician. Dr. Farrelly testified that Dr. Cangello did not perform any of the surgery; rather, he assisted her and held things that she asked him to. Dr. Cangello also points out that after January 23, 2007, he provided no treatment to Ms. Natera other than entering routine postoperative orders. Dr. Cangello further avers that he did not deviate from that direction or from the standard of care. In support of his arguments, Dr. Cangello

submits an affirmation from a physician, Thomas H. Dailey, M.D., duly licensed to practice medicine in New York and board certified in general surgery and colorectal surgery. Dr. Dailey opines that Dr. Cangello did not depart from the standard of care in treating Ms. Natera and that his care was not a proximate cause of her injuries.

Plaintiffs maintain that Dr. Cangello's motion is insufficient for summary judgment in his favor because he testified at his deposition that he was responsible for holding Ms. Natera's bowel during the January 23, 2007 surgery and for checking her bowel to make sure there were no perforations. They maintain that he failed in both undertakings. They fail to address Dr. Cangello's primary argument that he cannot be held liable for malpractice as a resident acting at the direction and behest of a private attending surgeon.

In general, a hospital staff member who is following the orders of a private attending physician and is not acting independently is not liable for malpractice attributable to the private physician. See Toth v. Comm. Hosp. at Glen Cove, 22 N.Y.2d 255, 265 (1968). Accord Costello v. Kirmani, 54 A.D.3d 656, 657 (2d Dep't 2008); Walter v. Betancourt, 283 A.D.2d 223, 224 (1st Dep't 2001). An exception to the rule applies where "the hospital staff knows that the doctor's orders are so clearly contraindicated by normal practice that ordinary prudence requires inquiry into the correctness of the orders." Toth, 22 N.Y.2d at 265 n.3. Accord Soto v. Andaz, 8 A.D.3d 470, 471 (2d Dep't 2004). Plaintiffs do not dispute that Dr. Cangello was a resident acting under the supervision and direction of Dr. Farrelly at all times or that he did not exercise any independent medical judgment, and there is no evidence proffered that any of Dr. Farrelly's orders to Dr.

Cangello were clearly contraindicated by normal practice. Accordingly, Dr. Cangello is entitled to summary judgment on the cause of action asserted against him sounding in medical malpractice.

LHH also argues that it is entitled to summary judgment. LHH maintains that although LHH staff monitored Ms. Natera throughout her hospitalization, Dr. Farrelly dictated her treatment. LHH argues that it cannot be held vicariously liable for Dr. Farrelly because she was Ms. Natera's private physician and was neither an employee nor an agent of LHH. LHH further argues that it is not directly liable for any alleged malpractice because its staff followed Dr. Farrelly's orders and provided appropriate care. LHH maintains that there is no medical testimony or documentary evidence to suggest that the care provided by LHH staff was inadequate in any way. In support of this argument, LHH offers Dr. Dailey's affirmation. Dr. Dailey sets forth that LHH cannot be held directly liable for malpractice allegedly attributable to its staff because Dr. Farrelly was responsible for the patient and neither LHH nor its staff were charged with the responsibility of making decisions regarding Ms. Natera's care. He points out that plaintiffs have not alleged that any LHH employees, such as nurses or assistants, were involved with, or negligent during, the January 23, 2007 surgery. He opines that at no point did LHH staff depart from the standard of care or that any alleged action or inaction by LHH or its staff proximately caused any of Ms. Natera's injuries. Dr. Dailey maintains that his review of the records shows no indication that any of Ms. Merceces' postoperative complaints were not promptly and adequately addressed; that the voluminous records show that Ms. Natera was continuously monitored and treated by Dr. Farrelly and LHH staff at all times; that the records show that her bandages and wound vacuum were routinely changed and that her drainage output was consistently monitored; and that even when complications arose regarding the wound vacuum, these issues were appropriately recognized and addressed.

In opposition, plaintiffs do not dispute that LHH is not vicariously liable for malpractice allegedly attributable to Dr. Farrelly, a private attending physician. Plaintiffs do argue that LHH is liable for its employees' independent negligence related to Ms. Natera's postoperative care. Plaintiffs offer an expert affidavit from a physician (name redacted) admitted to practice medicine in Connecticut. Their expert opines that after the January 23, 2007 surgery, LHH failed to appreciate that Ms. Natera's fever, increased white blood cell count, low red blood cell count, low hemoglobin, low hematocrit, and nausea—as reflected in LHH's record—indicated that she had an infection or an internal injury. The expert opines that LHH employees were still responsible for providing appropriate and necessary medical care and treatment, despite that Ms. Natera was Dr. Farrelly's private patient. The expert states that LHH should have called for an infectious disease or surgical consultation, or ordered imaging testing, to rule out or diagnose infection or unrepaired bowel perforation. The expert opines that the staff's failure to do so here was a departure from good and accepted medical practices and was a substantial factor in Ms. Natera's bowel perforations not being timely or properly repaired. The expert further opines that LHH's failure to diagnose Ms. Natera's infection and small bowel perforation on February 10, 2007, resulted in unnecessary delay and contributed to her ongoing injuries and pain and suffering.

With plaintiffs having significantly narrowed down the alleged independent acts of negligence against LHH in their opposition, in reply, LHH points out that plaintiffs do not dispute that Ms. Natera was admitted to LHH as Dr. Farrelly's private patient both on January 23, 2007 and February 10, 2007, and that the care rendered to Ms. Natera was at all times under Dr. Farrelly's direction. LHH argues that plaintiffs' expert's affidavit is conclusory and offers no explanation or medical basis for the stated opinions, and is thus insufficient to defeat their summary judgment

motion. Nevertheless, LHH submits a second affirmation from Dr. Dailey addressing plaintiffs' newly limited claims as set forth above. Dr. Dailey points out that plaintiffs' expert fails to explain how LHH's alleged failure to timely treat the bowel perforation or infection caused two fistulae and fails to explain the significance of various lab results, vital sign recordings, or temperature readings, or how they imply any liability on behalf of LHH. He further contends that plaintiffs' expert's conclusions as to fever causing infection, and infection causing fistulae, were erroneous and unsupportable, because fevers are often present in the postoperative period from a number of possible sources and do not necessarily indicate surgical pathology. Additionally, Dr. Dailey opines that all of Ms. Natera's blood test results were within expected postoperative limits and did not evidence infection. Dr. Dailey opines that her white blood count was not elevated with the exception of a slightly elevated level of 12.2 on January 25, 2007 (normal range is 4.5 to 11.5); regardless, she was appropriately treated with antibiotics. He opines that her hematocrit, hemoglobin, and red blood count were within expected postoperative levels, and to the extent that there was any decrease in these values postoperatively, it was expected and not significant with regard to the presence or absence of infection or perforation. He points out that Ms. Natera had been afebrile for twenty-four hours prior to her discharge, and though she had a brief temperature of 99.8 degrees Fahrenheit at 8:25 a.m. on January 28, 2007, she had a temperature of 98 degrees Fahrenheit at the time she was discharged. Moreover, she was improving consistently over the five days, she denied pain, she was out of bed and ambulating, and she was tolerating a regular diet. Thus, Dr. Dailey opines that Ms. Natera was not exhibiting any signs or symptoms of infection or perforation at the time she was discharged. For this reason, Dr. Dailey opines that there is no support for plaintiffs' claims that infectious disease consults, surgical consults, or imaging studies should have been ordered. As to plaintiffs' claims that LHH failed to diagnose infection and small bowel

perforation on February 10, 2007, Dr. Dailey points out that plaintiffs' expert fails to specify which steps LHH allegedly failed to take. Moreover, Ms. Natera's private attending physician was at LHH on February 10, 2007.

As to the allegations against LHH sounding in vicarious liability for malpractice allegedly attributable to Dr. Farrelly, it is well established in New York that

> [a] hospital may hot be held concurrently liable for injuries suffered by a patient who is under the care of a private attending physician chosen by the patient where the resident physicians and nurses employed by the hospital merely carry out the orders of the private attending physician, unless the hospital staff commits 'independent acts of negligence or the attending physician's orders are contraindicated by normal practice.'

Suits v. Wykoff Heights Med. Ctr., 84 A.D.3d 487, 488 (1st Dep't 2011), quoting Cerny v. Williams, 32 A.D.3d 881, 883 (2d Dep't 2006). In a plaintiff's bills of particulars, s/he must specify any independent acts of negligence by a hospital's staff. Suits, 84 A.D.3d at 489. It is undisputed that Ms. Natera was admitted to LHH both times as Dr. Farrelly's private patient. Plaintiffs cite no evidence or even argue that LHH should be held vicariously liable for Dr. Farrelly. Accordingly, LHH is entitled to summary judgment on the cause of action asserted against it sounding in vicarious liability for the acts or omissions of Dr. Farrelly. As to whether LHH is directly liable for any alleged malpractice, a review of plaintiffs' bills of particulars against Dr. Farrelly and LHH shows that plaintiffs have never identified any member of LHH's staff (aside from Dr. Cangello) as having been negligent. Amongst the numerous departures alleged against LHH, there only four that are distinct from those alleged against Dr. Farrelly. The distinct departures alleged against LHH are failing to have a qualified staff treat the plaintiff; failing to have a qualified surgical staff treat the plaintiff; failing to have a qualified resident to assist the attending during the January 23, 2007

operation; and failing to timely promulgate rules and regulations to ensure the bowel was properly inspected prior to the closing on the January 2007 operation. The first three departures fall under plaintiffs' claim for negligent hiring or retention, and the fourth has not been expounded on in any way by either LHH or plaintiffs in this motion practice. Plaintiffs have not, in essence, asserted any direct claims against LHH's staff. Importantly, plaintiffs have not disputed defendants' assertion that Ms. Natera's care from January 23 through January 28 was undertaken by LHH entirely at the direction and behest of Dr. Farrelly. Further, the claims raised by plaintiffs' experts related to the care that Ms. Natera received in the few hours in the emergency room on February 10, 2007, are vague, unspecified, and without reference to any course of action that should have been undertaken by LHH staff but was not; indeed, the records reflect that Ms. Natera arrived at the emergency room around 9:30 a.m. and was seen by Dr. Farrelly before 1:30 p.m. Quite simply, plaintiffs never asserted any truly independent causes of action pertaining to medical malpractice against LHH prior to this motion practice. Plaintiffs have failed to show the existence of a true issue of fact requiring a trial. Accordingly, LHH is entitled to summary judgment on the cause of action asserted against it sounding in medical malpractice.

Dr. Cangello and LHH both assert that plaintiffs' lack of informed consent claim against them must be dismissed because it is the private attending physician's responsibility to procure the patient's informed consent; their expert, Dr. Dailey, supports this position in his affirmation. As to the cause of action asserted in the complaint sounding in negligent hiring or retention, LHH maintains that plaintiffs have never specified such claims in their bills of particulars and have, in no way, elaborated upon this vague allegation or provided any support for such a claim. LHH contends that the allegation for negligent hiring or retention has no factual or legal merit and

is unsubstantiated, and on this basis, asks the court to dismiss the claim. As plaintiffs have neither addressed nor provided expert testimony relative to the claims for lack of informed consent or negligent hiring or retention as asserted against either Dr. Cangello or LHH, it appears that they have abandoned these two claims as against these defendants, and as such, the claims for lack of informed consent and negligent hiring or retention are hereby dismissed as against Dr. Cangello and LHH. Additionally, as none of Ms. Natera's personal claims against these two defendants are remaining, Dr. Cangello and LHH are entitled to dismissal of Mr. Mercedes' derivative loss of services claim as a matter of law.

Dr. Farrelly also seeks summary judgment. She maintains that her treatment was within the standard of care and that her care did not proximately cause Ms. Natera's injuries. In support of her motion for summary judgment, Dr. Farrelly submits an affirmation from Dan Reiner, M.D., who states that he is a general surgeon licensed to practice in New York. Dr. Reiner states that he has reviewed the pleadings, the deposition transcripts, and the relevant medical records. He first goes through Ms. Natera's extensive past medical history regarding a number of surgeries on her abdomen, including for hernia repair. He then addresses Dr. Farrelly's surgical technique during the hernia repair procedure on January 23, 2007. As stated by Dr. Reiner, Dr. Farrelly documented an abdominal anatomy complicated by adhesions from prior surgeries; she successfully dissected the bowel away from the adhesions; she observed multiple sutures in the bowel from a prior surgery; and she encountered two separate enterotomies, one of which she repaired using silk sutures, and the other of which was in an area of deserosalization (the outer layers of bowel were stripped) such that Dr. Farrelly decided to resect and close that portion of the bowel using staples. Dr. Reiner states that after the resection, Dr. Farrelly "ran the bowel" (explored it from end to end) and noted no other

enterotomies; reapproximated the hernias and placed a mesh to reinforce the hernia closure; irrigated the surgical wound; reapproximated the fascia; closed the patient using sutures; and inserted a drain in the subcutaneous tissue to draw normal postoperative serous fluid away from the surgical site. Dr. Reiner opines that the hernia repair performed in January 2007 was indicated and properly performed. He states that Ms. Natera's prior abdominal procedures made it more likely that there would be many adhesions requiring lysis, but that there was no way for Dr. Farrelly to confirm this prior to starting the hernia repair. Dr. Reiner contends that contrary to plaintiffs' allegations, there is no way to "map" the anatomy of the abdomen or otherwise know what kind of anatomical difficulties a surgeon will encounter prior to the surgery actually being performed. Further, Dr. Reiner opines that even if Dr. Farrelly could have known what she would encounter in Ms. Natera's abdomen, it would not have affected how the surgery was performed. He opines that the surgical technique was in complete accordance with the standard of care. He states that the fact that two enterotomies were encountered was not malpractice and that enterotomies frequently occur in hernia repair operations where the abdominal anatomy is complicated by adhesions. Dr. Reiner states that there was a lot of scar tissue to dissect and bowel to manipulate, which meant that there was a significant likelihood that enterotomies could develop leading to resection, the risk of which was disclosed and consented to. Dr. Reiner further opines that the absorbable mesh used was appropriate because it keeps the bowel from adhering to it and it is durable, and thus preferable, when a patient has had a number of hernias. He states that there were no contraindications to the placement of the mesh because Ms. Natera's bowel was not contaminated with enteric contents and the mesh was not in contact with the anastomosis that Dr. Farrelly created.

Dr. Reiner opines that the remainder of Ms. Natera's admission to LHH through January 28, 2007, was uncomplicated. He sets forth that her vomiting and complaints of nausea were not concerning; that she was being observed for anticipated postoperative bowel ileus (obstruction); that she remained afebrile with a normal white blood cell count one day prior to her discharge; that, by January 26, she was refusing pain mediation, ambulating independently, and assisting with activities of daily living; that flatus and bowel sounds were present; and that by her discharge, she was tolerating a normal diet and had a normal temperature. He opines that she was appropriately managed with Cefoxitan antibiotic. He contends that Ms. Natera's postoperative course did not portend the complications that followed.

Dr. Reiner opines that the treatment rendered between January 28, 2007 and February 10, 2007 met the standard of care. He sets forth that the telephone discussions between Dr. Farrelly's staff and plaintiffs did not reveal ominous signs or symptoms, and that complaints of nausea and vomiting are not unexpected in a patient who underwent bowel surgery. Dr. Reiner opines that nothing during the February 7 visit would have led to an earlier hospitalization, because Dr. Farrelly's notes indicate that she did not observe foul-smelling discharge and she did not observe that the patient appeared toxic. Dr. Reiner believes that if enteric contents were discharging from the wound on February 7, Dr. Farrelly would have admitted Ms. Natera to the hospital. He states that the symptoms that Ms. Natera was experiencing on February 10, 2007, were never communicated to Dr. Farrelly prior to that date.

Dr. Reiner then goes through the second procedure that Dr. Farrelly performed on February 11, 2007. During the exploratory laparotomy, Dr. Farrelly observed dense adhesions of

the entire bowel. A fistula appeared to be forming. Dr. Reiner states that Dr. Farrelly concluded that further mobilization of the bowel was unwarranted because the risks outweighed the benefits. Dr. Farrelly called for a consultation by a senior surgeon, who agreed that she should not further mobilize the bowel and advised her to place mesh where there was no leakage and pack the wound. Dr. Reiner opines that Dr. Farrelly's approach to allow the wound to heal by natural means, rather than surgically closing the skin, met the standard of care because it would have been more dangerous to attempt a fistula takedown and repair at that point. Without evidence of an abscess, Dr. Reiner opines, it is proper to have the patient live with the fistula, stabilize over time, and attempt to avoid complications such as more adhesions.

Dr. Reiner then describes Ms. Natera's course of treatment at LHH from February 11 through June 4, 2007. He states that the care was focused on treating her for a definitive bowel repair and wound closure once she was medically optimized—thus, the PICC line insertion for total parenteral nutrition; the wound vacuum; and a consultation by a wound specialist. He opines that the wound was difficult to manage but that the approach to treating it was indicated. Dr. Reiner states that despite defendants' best efforts, however, an enterocutaneous fistula developed and was confirmed by a small bowel series performed on April 16, 2007. He then points out that Ms. Natera's chart from February 11, 2007, onward shows that she became more stable and her body became more conducive to tolerating the surgery that was eventually performed in July 2007. Dr. Reiner opines that had there been malpractice in the treatment of the wound, there likely would have been further complications such as necrosis of the bowel, further enterotomies, or infection, which Dr. Reiner states did not occur. Dr. Reiner points out that by the time Ms. Natera's course of care ended in August 2007, her surgical wound was healing and she was independent with all activities

of daily living. He states that thereafter, plaintiff saw her primary care physician Dr. Ortiz several times in 2007 and 2008, with no complaints of abdominal pain or gastrointestinal related signs or symptoms.

Dr. Reiner further opines that there is no merit to plaintiffs' claim for lack of informed consent. He opines that no reasonable person would have refused to undergo the hernia repair; that Ms. Natera was made adequately aware of the risks of doing nothing and those associated with undergoing the repair; and that she was aware of the risks associated with hernia repair as she had undergone prior extensive bowel surgeries including two hernia repairs. As to the February 2007 admission, Dr. Reiner opines that by that point, Ms. Natera's condition was emergent, but regardless, the hospital chart shows that the surgical risks and benefits of the exploratory laparotomy were explained to her, and he opines that no reasonable person would have refused to undergo surgery designed to find out the source of the complications that he or she was experiencing.

Plaintiffs maintain that factual conflicts between Dr. Reiner's opinion and the medical records and testimony exist such that Dr. Farrelly did not meet her prima facie burden on summary judgment. They also argue that even if she had met the burden, their expert's opinion raises issues of fact precluding summary judgment. Plaintiffs submit an affidavit from a physician (name redacted) who sets forth that s/he is a board-certified general surgeon admitted to practice medicine in Connecticut. Plaintiffs' expert points to what s/he believes are inconsistencies amongst the records, the deposition testimony, and Dr. Reiner's affirmation. The expert highlights notes in the medical records that indicate to him/her that Dr. Farrelly encountered more than two enterotomies in the bowel during the January 23, 2007 hernia repair procedure, but that she only addressed two

of them. The expert also points out that Dr. Farrelly testified that on January 23, 2007, she resected a portion of Ms. Natera's small bowel because it had an enterotomy, areas of deserolization, and sutures from a prior procedure, but according to the pathology report for the specimen of bowel, there were no findings of either an enterotomy or sutures in the specimen. Plaintiffs' expert states that Dr. Farrelly's notes lead him/her to believe that there were at least three improper perforations of Ms. Natera's small bowel on January 23, 2007. The expert opines that Dr. Farrelly departed from good and accepted medical practice by improperly perforating Ms. Natera's bowel in three places. S/he opines that good practice dictates that Dr. Farrelly work carefully so that a perforation does not occur. The expert sets forth that causing three separate injuries to the small bowel was a violation of good practice. According to plaintiffs' expert, Dr. Farrelly was not careful because Ms. Natera's bowel was perforated three times. S/he contends that Dr. Farrelly did not properly visualize and protect the bowel; rather, she blindly cut and handled the bowel in such a way that three perforations occurred. Plaintiffs' expert maintains that these perforations resulted in a host of injuries.

Plaintiffs' expert asserts that although Dr. Farrelly's operative report states that she copiously irrigated the abdomen and fully explored the bowel after the procedure on January 23, there is nothing in the operative report indicating that an anti-bacterial solution was administered to prevent infection and/or peritonitis. The expert contends that due to risk of infection, proper medical and surgical technique requires a washout of the peritoneal cavity with antibacterial solution intraoperatively and an administration of prophylactic antibiotics starting the day of the procedure. Plaintiffs' expert, in reviewing the medical records, states that these measures were not undertaken, nor were drains put in intraoperatively to remove pus, blood, or fluids from Ms. Natera's abdomen

or perforation. The expert maintains that the fact that these measures were not undertaken were departures from good and accepted medical practice which exposed Ms. Natera to infection.

Plaintiffs' expert sets forth that the standard of care required Dr. Farrelly to recognize, diagnose, and repair bowel perforations prior to closing Ms. Natera's surgical incision. The expert opines that at least one of the perforations went unrepaired, based on the fact that Ms. Natera was running a fever and leaking enteric contents from the surgical incision after the procedure. The expert states that an unrepaired bowel perforation can cause infection, severe pain, and other complications, which occurred in this case. The expert opines that Dr. Farrelly's failure to timely treat the bowel perforations caused the injuries that Ms. Natera suffered through February 11, 2007, and thereafter.

The expert states that Ms. Natera's fever and other signs and symptoms indicated that she had an infection, which is caused when enteric contents spill into the abdomen. The expert sets forth that prior to her discharge, Ms. Natera exhibited signs and symptoms of infection, such as fever, which the expert opines was caused by peritonitis from the enteric contents spilling into the abdomen. The expert sets forth that perforation of a bowel is a well-known cause of infection because bacteria-ridden enteric contents enter the abdomen, and that in patients who have just had abdominal surgery, bowel perforation should be at the top of the differential diagnosis. The symptoms that Ms. Natera exhibited which indicated a bowel perforation were fever, increased white blood cell count, low red blood cell count, low hemoglobin, low hematocrit, and nausea. Plaintiffs' expert states that the standard of care requires investigation into the etiology of these symptoms by way of an infectious disease or surgical consultation, or imaging studies to confirm or rule out

infection or bowel perforation. The expert sets forth that these measures were not undertaken here. The expert opines that Dr. Farrelly failed to appreciate that Ms. Natera's complaints, test results, and medical conditions after January 23, 2007, indicated a bowel perforation; that this failure was a departure from the standard of care; and that the departure was a substantial factor in Ms. Natera's bowel perforations not being timely repaired.

Plaintiffs' expert maintains that from his review of the records and testimony, there are inconsistencies between Dr. Farrelly's description of Ms. Natera's symptoms between January 28 and February 10, 2007, and her family's description of her symptoms. For instance, on February 3, 2007, Dr. Farrelly's office notes indicate that over the telephone, Mr. Mercedes told Dr. Farrelly that Ms. Natera was vomiting, that her pain was controlled, and that she had a bowel movement. The expert maintains that this note contradicts the testimony of Ms. Natera's family members, and that if Dr. Farrelly had been informed of Ms. Natera's symptoms as her family members so testified, then she departed from the standard of care by failing to send Ms. Natera immediately to the hospital. Plaintiffs' expert also sets forth that Dr. Farrelly's note from February 7—that Ms. Natera had a foul smelling drainage "since yesterday"—conflicts with Dr. Reiner's claim that Ms. Natera had no discharge on that day. Plaintiffs' expert believes that Dr. Farrelly failed to appreciate the signs and symptoms of a bowel perforation from January 28 through February 11, 2007, and that this failure caused an unnecessary delay in diagnosing the bowel perforation, thereby contributing to Ms. Natera's ongoing injuries, pain, and suffering through February 11, 2007.

As to informed consent, plaintiffs' expert points out that despite Dr. Farrelly's testimony and office notes, Ms. Natera testified that Dr. Farrelly did not discuss the risks of the

hernia repair with her prior to the procedure, and that based on Ms. Natera's testimony, there was a total failure to obtain her informed consent. Regardless, plaintiffs' expert sets forth that even if Dr. Farrelly provided Ms. Natera with the information that she testified to, it was insufficient because she failed to mention the risk of bowel perforation, which was a necessary disclosure in order to obtain informed consent.

In reply, Dr. Farrelly argues, inter alia, that the court should reject plaintiffs' expert's affidavit as untimely because plaintiffs have yet to respond to Dr. Farrelly's demand for expert witness disclosure pursuant to C.P.L.R. § 3101(d) but they filed their note of issue indicating that all known discovery was complete. There are a number of cases from the Second Department upholding the trial court's discretion to decline to consider expert affidavits from experts who were not identified during pretrial disclosure and who were first introduced in opposition to a post-note of issue summary judgment motion. See, e.g., Dawson v. Cafiero, 292 A.D.2d 488, 489 (2d Dep't), app. denied, 98 N.Y.2d 610 (2002); Ortega v. New York City Tr. Auth., 262 A.D.2d 470 (2d Dep't 1999); Mankowski v. Two Park Co., 225 A.D.2d 673 (2d Dep't 1996). However, the First Department has declined this approach. See Mauro v. Rosedale Enters., 60 A.D.3d 401 (1st Dep't 2009); Downes v. Am. Monument Co., 283 A.D.2d 256 (1st Dep't 2001). Additionally, section 3101(d)(i) does not contain a deadline by which experts must be disclosed. Moreover, the parties' preliminary conference order sets forth that expert witness disclosure pursuant to C.P.L.R. § 3101(d) shall be exchanged by plaintiff no later than sixty (60) days before trial and by defendant no later than forty-five (45) days before trial. Finally, Dr. Farrelly concedes that she has not served her own 3101(d) expert disclosure. Accordingly, plaintiff's expert's affidavit shall not be rejected on the grounds that plaintiffs have yet to respond to Dr. Farrelly's demand for expert witness disclosure.

Dr. Farrelly further objects to plaintiffs' expert on the grounds that s/he did not list enough information about his/her qualifications. The expert stated that s/he is a board-certified general surgeon and familiar with the standards of care in 2007 applicable to surgical and post-surgical care. Generally, once an expert professes the requisite knowledge necessary to render an opinion, "the issue of the expert's qualifications to render such opinion must be left to trial." Limmer v. Rosenfeld, 92 A.D.3d 609 (1st Dep't 2012) (citations omitted). Plaintiffs' expert's statements as to his/her board certification and familiarity with the standard of care are sufficient at this juncture.

Dr. Farrelly made out a prima facie case for summary judgment in her motion, but plaintiffs raised sufficient issues of fact pertaining to treatment from January 23 through February 11, 2007. Dr. Farrelly's expert opines that Dr. Farrelly's technique during the January 23, 2007 hernia repair was within the standard of care and that enterotomies are not indicative of malpractice and are frequent occurrences in hernia repair operations and other bowel procedures where the abdominal anatomy is complicated by adhesions. In opposition, plaintiffs' expert opines that enterotomies are indicative of malpractice and can be prevented if the surgeon proceeds carefully and protects the bowel. Additionally, there are issues of fact regarding whether Ms. Natera's symptoms between January 23, 2007 and February 11, 2007, should have alerted Dr. Farrelly to the presence of a perforation and/or an infection during that period of time. There are also sufficient issues of fact regarding proximate cause. The experts have reviewed the same materials and have reached differing opinions. 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. Frye v. Montefiore Med. Ctr., 70 A.D.3d 15, 25 (1st Dep't 2009); Barnett v. Fashakin, 85 A.D.3d 832 (2d Dep't 2011); Barbuto v. Winthrop Univ. Hosp., 305 A.D.2d 623, 624 (2d Dep't 2003).

However, Dr. Farrelly provided uncontroverted expert testimony that the procedure on February 11 and the care she provided thereafter comported with the standard of care and was not negligent, and plaintiffs have failed to counter or dispute any of Dr. Reiner's opinions regarding any of plaintiffs' alleged departures arising out of the February 11 procedure or the care provided thereafter. Accordingly, Dr. Farrelly is entitled to partial summary judgment in her favor regarding plaintiffs' claims of departures arising out of the February 11 procedure or the care provided thereafter.

As to the claim that Dr. Farrelly failed to obtain Ms. Natera's informed consent, lack of informed consent is

> the failure of the person providing the professional treatment or diagnosis to disclose to the patient such alternatives thereto and the reasonably foreseeable risks and benefits involved as a reasonable medical, dental or podiatric practitioner under similar circumstances would have disclosed, in a manner permitting the patient to make a knowledgeable evaluation.

Pub. Health L. § 2805-d(1). A defendant will be entitled to summary judgment on a lack of informed consent claim if he or she demonstrates that the plaintiff was informed of the alternatives to and the reasonably foreseeable risks and benefits of the treatment, and "that a reasonably prudent patient would not have declined to undergo the [treatment] if he or she had been informed of the potential complications[.]" Koi Hou Chan v. Yeung, 66 A.D.3d 642, 644 (2d Dep't 2009); see also Pub. Health L. § 2805-d(1). Issues of fact exist as to whether the risk of bowel perforation was adequately disclosed to Ms. Natera prior to the January 23 operation for her to make an informed decision to proceed with the hernia repair. Therefore, summary judgment on this claim is denied. Accordingly, it is hereby

ORDERED that Motion Sequence Number 001 is granted in its entirety and the complaint against defendants David Cangello, M.D., and Lenox Hill Hospital is dismissed, and the clerk is directed to enter judgment accordingly; and it is further

ORDERED that Motion Sequence Number 002 is partially granted, to the extent that the complaint against Patricia A. Farrelly, M.D., P.C., is dismissed for lack of jurisdiction, and the complaint against Patricia A. Farrelly, M.D., is dismissed as to all claims for malpractice arising out of events occurring during the procedure on February 11, 2007, and onward; and it is further

ORDERED that the case remains against Dr. Farrelly as to claims of malpractice from January 23, 2007 through February 10, 2007, and as to the cause of action sounding in lack of informed consent; and it is further

ORDERED that the parties shall appear for a pre-trial conference on May 15, 2012, at 9:30 a.m.

Dated: April 27, 2012

ENTER:

JOAN B. LOBIS, J.S.C.