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

PRESENT: COBLS Justice PART 6

ANONYMOUS

-v-

ANITA PANNES LATSACA

INDEX NO. 112933/07

MOTION DATE 9/27/11

MOTION SEQ. NO. 004

MOTION CAL. NO.

The following papers, numbered 1 to ____ were read on this motion to/for Summary judgment

	PAPERS NUMBERED
Notice of Motion/ Order to Show Cause — Affidavits — Exhibits ...	1-23
Answering Affidavits — Exhibits x mot.	24-27
Replying Affidavits	28

Cross-Motion: ☑ Yes ☐ No

Upon the foregoing papers, it is ordered that this motion

FILED

DEC 19 2011

NEW YORK
COUNTY CLERK'S OFFICE

THIS MOTION IS DECIDED IN ACCORDANCE WITH THE ACCOMPANYING MEMORANDUM DECISION

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

Dated: 12/15/11

JOAN B. LOBIS J.S.C.

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

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ANONYMOUS #1 and ANONYMOUS #2,

Plaintiffs,

Index No. 112933/07

-against-

Decision and Order

ANITA PARNES LaSALA, PAULO A. PACHECO, PAULO A. PACHECO, M.D., P.C., BRIAN A. GOLDWEBER, M.D., BRIAN A. GOLDWEBER, M.D., LLP, ABBE J. CARNI, ABBE CARNI, M.D., P.C., and PROFESSIONAL ANESTHESIA, P.A.,

Defendants.

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Joan B. Lobis, J.S.C.:

Motion sequence numbers 004 and 005 are consolidated for disposition.

Abbe Carni, M.D. ("Carni") and Abbe Carni, M.D., P.C. ("Carni, P.C.") (collectively the "Carni defendants") move, pursuant to C.P.L.R. § 3212, for an order granting them summary judgment dismissing plaintiffs Anonymous #1 and Anonymous #2's complaint (motion sequence 004). Plaintiffs cross-move, pursuant to C.P.L.R. § 3212, for an order granting them summary judgment finding that named defendant, Brian Goldweber ("Goldweber"), was negligent, that he was the Carni defendants' employee, and that the Carni defendants are vicariously liable for Goldweber's negligence.

Paulo Pacheco, M.D. ("Pacheco") and Paulo Pacheco, M.D., P.C. ("Pacheco, P.C.") (collectively the "Pacheco defendants") move, pursuant to C.P.L.R. § 3212, for an order granting them summary judgment dismissing the complaint (motion 005).

Background

This is a case in which it is claimed that Anonymous #1, then a surgical resident, acquired hepatitis C during a colonoscopy performed on June 3, 2005 by gastroenterologist Pacheco, as a result of the administration of the anesthetic propofol by Goldweber, who was alleged to be an employee of Brian A. Goldweber, M.D., LLC[1] ("Goldweber, LLC").[2] Pacheco had previously administered certain anesthetic agents to patients undergoing procedures in his office, but decided, several weeks before Anonymous #1's colonoscopy, to have anesthesiologists administer the anesthetic agents, because that was becoming the standard in outpatient care. Pacheco had never administered propofol with which he was unfamiliar. He was also unfamiliar with the FDA instructions as to its use. Pacheco contacted Carni, P.C. to obtain the services of anesthesiologists. Carni, a board certified anesthesiologist, was its president, sole shareholder, and the only person running its business.

Carni, P.C. had at one time only provided the services of Carni himself to colorectal/gastroenterology practices, but Carni decided that Carni, P.C. should retain other anesthesiologists and concentrate on the business of providing anesthesiologists to practices which performed ambulatory procedures in their offices. Carni began focusing his attention more on the administration of that business.

[1] It appears that the entity was actually an LLC, but the caption lists it as an LLP.

[2] Goldweber and Goldweber, LLC have not appeared in this action and have been discharged in bankruptcy.

Carni, P.C. retained about five other anesthesiologists, including Goldweber, through Goldweber, LLC, as alleged independent contractors. Carni looked for anesthesiologists with at least seven to eight years of post-residency experience. Carni found Goldweber on a website of anesthesiologists seeking work. Carni interviewed him and obtained his resume, which indicated that he had worked as an attending anesthesiologist for almost 20 years, through April 2001, at Rochester General Hospital and from November 2001 through July 1, 2003 at Lakeside Memorial Hospital. Goldweber provided four highly favorable letters of recommendation from surgeons who had worked with him at Rochester General Hospital and a letter of recommendation from an anesthesiologist who had known him as a co-member of Rochester General Hospital's anesthesiology department. That anesthesiologist had subsequently become the chief of the anesthesiology department at Lakeside Memorial Hospital, and offered Goldweber a position after he left Rochester General Hospital. Carni did no further background check. He did, however, ascertain that Goldweber was licensed and had malpractice insurance and the requisite infection control certification.

Carni then brought Goldweber to the office of Somerset Surgical Associates ("Somerset"), one of the groups which utilized Carni, P.C.'s services, discussed with Goldweber his anesthesiological technique, and had Goldweber administer anesthesia, including propofol from multi-dose vials provided by Carni, P.C., to six to eight of Somerset's patients to assess Goldweber's ability. Carni determined that Goldweber's performance was excellent. Neither at that time nor thereafter did Carni ever see Goldweber reuse a syringe to re-dose a patient from a vial of propofol. Goldweber, LLC and Carni, P.C. then entered into an alleged oral independent contractor agreement

for Goldweber, LLC to provide anesthesia services. In 2006, they entered into a written version, which was allegedly identical to the oral version, but contained a non-compete provision.

Carni, P.C. paid rent to the offices where anesthesiology services were provided in exchange for use of office space, a computer, a telephone, and a place to store its medications and equipment. Pacheco's office gave Carni the sole key to the cabinet where Carni, P.C.'s anesthetics were kept. Carni, P.C., rather than its "independent contractors," determined the patients' fees and had them billed directly or through their insurance companies for the anesthesiology services rendered, using information obtained by the offices where the procedures were performed. The bills did not reflect that the services had been performed by the anesthesiologists who actually rendered the services.

Goldweber worked five days a week providing anesthesia services for the approximately ten medical practices to which he was sent by Carni. Goldweber's LLC was paid a flat fee regardless of the number of procedures he performed and the hours he worked. Also, Goldweber was paid during vacations. Additionally he received numerous bonuses from Carni, P.C., based on how well Carni, P.C. was doing, not based on the work Goldweber performed. Carni, P.C. furnished Goldweber with the forms and anesthesia charts he used during the procedures, and paid for all equipment and medication which Goldweber used.

According to Goldweber, he had free rein as to the medications and supplies he ordered, and Carni did not control his administration of medications or the techniques he used. Carni

testified that the routine was to use multi-use vials on more than one patient. His practice did not use single-use (20 ml) vials of propofol. Goldweber continued the practice of using multi-dose vials. Carni also instructed the anesthesiologists to lay out money for holiday parties at the offices where services were rendered, which Carni reimbursed. It does not appear that Goldweber worked anywhere but where Carni sent him. Goldweber's hours and where he worked were determined by Carni. Goldweber was required to obtain his own malpractice insurance, pay his own taxes, received no health insurance from Carni, P.C., and received 1099 forms from Carni, P.C.

When Pacheco approached Carni about providing anesthesiology services for his office, he was advised by Carni that Carni, P.C. would ensure that the anesthesiologists provided would be licensed and had the requisite training. Pacheco did not ask that they be board certified or that they carry liability insurance, but assumed that they would. Pacheco did not independently investigate Goldweber's qualifications and, instead, relied on Carni to do so.

Anonymous #1, who had performed colonoscopies as part of her medical training and had undergone a colonoscopy previously, with anesthesia provided by a nurse on the staff of the physician performing the colonoscopy, first presented to Pacheco in late May 2005. On June 3 Pacheco performed a colonoscopy on Anonymous #1 after she signed a form in which she consented to Pacheco performing the procedure with conscious sedation. That form indicated that the risks, benefits, and alternatives to the treatment, including the anesthesia, had been explained by Pacheco. According to Anonymous #1's deposition testimony, Pacheco did not discuss with her that an anesthesiologist was available to administer anesthesia or who would be administering the

anesthesia. Anonymous #1 was under the impression that the anesthesia would be administered by Pacheco, evidently meaning him or his staff. Anonymous #1 further testified that she did not receive a bill for anesthesia services from Carni and first learned of Carni several years after the fact.

Goldweber testified that he would, as a practice, identify himself as the anesthesiologist, without revealing his affiliation. Pacheco testified that his practice was to inform patients on the day of the procedure that they could opt for no anesthesia, anesthesia provided by him, or anesthesia provided by an anesthesiologist, and if they opted for the latter, they would be informed that they would get a separate bill. Pacheco then testified that he informed Anonymous #1, at the time she scheduled her procedure, that anesthesia could be administered by an independent anesthesiologist from Carni's group.

The colonoscopy was performed without taking a biopsy, and, therefore, without biopsy equipment. Anonymous #1, who had previously tested negative for hepatitis C in November 2003, after having been stuck with a patient's needle, underwent, in connection with routine screening as part of her surgical residency program, another hepatitis C test ten days after the colonoscopy in issue. The results were again negative for hepatitis C, which has an incubation period of two weeks to six months, with a mean of six to nine weeks. About seven months after the colonoscopy, Anonymous #1, who was pregnant, was screened for hepatitis C as part of her prenatal testing. She tested positive, but was never informed of the results.[3]

[3] Because she miscarried, her obstetrician never followed up on the test results, leading her to be named as a defendant in this action. The action was eventually settled as to the obstetrician.

On August 14, 2006, another gastroenterologist's patient had a procedure done with anesthesia administered by Goldweber. That patient, who had tested negative for hepatitis C about a week before his procedure, fell ill in October 2006, and was diagnosed with hepatitis C. That patient, suspecting that he had contracted it at his gastroenterologist's office, contacted the New York City Department of Health ("NYCDOH") in March 2007, which commenced an investigation that month.

NYCDOH's investigation initially focused on those who had undergone procedures in the other gastroenterologist's office around the time of that other patient's procedure. A cluster of patients with hepatitis C and B were discovered. Four of those occurred in patients who had, on August 14, 2006, consecutively undergone procedures following a colonoscopy on a patient (the source patient) known to have had hepatitis C of the 1b genotype. Of those four and the source patient, two had undergone colonoscopies, and three had undergone endoscopies, so that those patients did not all have their procedures performed by the gastroenterologist using the same equipment. The last three of the four cases were determined to be outbreak-associated because of the genetic relatedness of the hepatitis C strains to the source patient's, all had been administered propofol by Goldweber, and because, in the case of two patients, there were no other known risk factors. The first of the four cases after the source patient's was considered a probable outbreak-associated case. Two other cases of hepatitis C of the 1a genotype were found to have been probable outbreak-associated cases stemming from procedures performed on August 15, 2006 after a procedure was performed that day on a patient known to have hepatitis C of that genotype. In addition, a patient who was known to have hepatitis B had a procedure performed on August 14.

Six patients over the course of the remainder of that day and on the next developed hepatitis B which was considered to be probable outbreak-associated because none of those patients had major risk factors for the disease, and because all of the patients received propofol from Goldweber in the same office and within a day of the other outbreak-associated cases.

The investigation expanded to other patients who had received anesthesia from Goldweber, after it seemed that the only common link in the discovered hepatitis cases was his administration of propofol. The goal of the investigation was to determine, among other things, whether hepatitis C occurred in connection with the administration of anesthesia and/or the endoscopic procedures, identify the source of transmission, if transmission was confirmed to have occurred, and to make recommendations to prevent the further spread of infections.

As is relevant, Anonymous #1 was contacted and advised that she should be tested for hepatitis B and C and HIV. After that testing, she learned, in June 2007, that she had hepatitis C. NYCDOH concluded that Anonymous #1's hepatitis C was outbreak associated. In particular, at about 9:00 a.m. on the procedure day, a patient, known to be positive for hepatitis C underwent a colonoscopy by Pacheco with propofol administered by Goldweber. That patient received 150 mg of propofol (i.e. more than the 10 cc's of propofol which a syringe could hold), and, therefore, was necessarily redosed with propofol during the procedure. At about 9:30 a.m., the next patient to undergo a colonoscopy was Anonymous #1. NS5B genetic testing of the strains of hepatitis C carried by the prior patient and Anonymous #1 was conducted at the laboratory within the Office of Public Health at the New York State Department of Health. That testing showed that their viruses

were about 98% identical.[4] Confirmatory NS5B testing, as well as HVR-1 region testing,[5] was then performed at the Center for Disease Control and Prevention's ("CDC") laboratory. Based on that testing, NYCDOH found that there was a high degree of relatedness between Anonymous #1 and the prior patient's viruses, which NYCDOH found was consistent with the transmission of the virus from the prior patient to Anonymous #1. NYCDOH's report further indicated that its investigation's findings "strongly suggest[ed]" that hepatitis C was transmitted from the prior patient to Anonymous #1. NYCDOH report, at 37. Since no biopsy was taken from Anonymous #1, and since Pacheco's office had a practice of rotating endoscopy scopes between patients, NYCDOH found it quite unlikely that the infection was caused by the scope used by Pacheco. NYCDOH also found that, since Anonymous #1 tested negative for hepatitis C ten days after the colonoscopy (i.e., a period shorter than the incubation period), she was hepatitis negative at the time of the colonoscopy. In addition, NYCDOH determined that Anonymous #1 had no major risk factors for hepatitis C.

NYCDOH's report noted that, during an interview, Goldweber had reported possible syringe re-use when re-dosing patients with medications such as propofol. NYCDOH concluded that the outbreaks of hepatitis B and C were caused by Goldweber's misuse of syringes when single-patient use, 100 ml multi-dose vials of propofol were used to administer that medication to multiple patients. In particular, NYCDOH concluded that during source patients' procedures, Goldweber

[4] A finding of 90-95% would mean that the viruses were not particularly related, but one of 99% would not be expected in two randomly selected individuals. With a result of about 95%, HVR-1 testing can be useful to determine the level of virus relatedness.

[5] According to NYCDOH's report (at p. 11) because of the instability of the HVR-1 region, a high degree of relatedness in that region between patients "is very strong evidence that the viruses are related and came from a common source."

withdrew propofol from vials with syringes previously used to introduce propofol into source patients' intravenous ("IV") tubing, thereby contaminating the vials, and thereafter withdrew the contaminated propofol from the vials and administered it to other patients. NYCDOH, in the conclusion portion of its report, ruled out other possible transmission routes because not all patients had biopsies, because patients had different procedures using different equipment, and because the confirmed hepatitis C outbreak-associated cases involving highly genetically related hepatitis C viruses occurred in two different gastroenterologists' offices.

NYCDOH, noting that propofol is labeled as a single-patient use product and that a vial should not be used on more than one patient, recommended that Goldweber should discard propofol remaining in a vial, rather than using it on another patient. NYCDOH also found that open bottles of propofol, which had a six-hour life, had been stored overnight, and recommended that all expired anesthetic agents be discarded. Further, to prevent inadvertent contamination, it was recommended that single-use medication vials be used, and that multi-dose anesthetic agents be labeled with the opening day and discarded according to the manufacturers' recommendations or within 28 days, whichever was earlier. NYCDOH's report also indicated that, if use of multi-dose vials was required, a sterile syringe be used for each dose given to a patient. NYCDOH's report recited that, as a consequence of its investigation, it was going to urge the FDA to consider limiting the availability of multi-dose vials of anesthetic agents, including propofol, to diminish the possibility of patient-to-patient infection transmittal.

NYCDOH's report further revealed that its committee had reviewed the New York

State Office of Professional Misconduct ("OPMC") website during its investigation and found that Goldweber's license had previously been suspended for negligence on more than one occasion, but that none of the acts of negligence alleged involved infection control, and that the suspension had been stayed "with monitoring terms and medical competency evaluation and training." A review of the documents pertaining to that proceeding reveals that in 1999, Goldweber had signed a consent agreement and order in which he admitted guilt to the third specification of charges leveled against him by OPMC and agreed to the terms of the stayed three-year suspension, which ended on November 1, 2002. The third specification charged him with negligence on more than one occasion[6] in giving a patient a 3 cc bolus of medication, which had a concentration of .5%, instead of .25%, and/or in failing to adequately monitor that patient after administering that medication, and/or in administering a medication to a patient with a history of adverse reaction to that medication and a family history of close to lethal reaction to that medication, and/or in administering a muscle relaxant to a patient without a secured airway, and/or in failing to remain with a patient until it was clear that the patient was medically stable. Although not mentioned in NYCDOH's report, in March 2002, OPMC again disciplined Goldweber by censuring, reprimanding, and fining him for responding "no" on a July 2001 hospital application to the question of whether his license had ever been suspended or limited. Neither Carni nor Pacheco were previously aware of any disciplinary proceedings against Goldweber.

During the course of NYCDOH's investigation of the hepatitis outbreak, it reported

[6] Evidently, none of Goldweber's patients was injured as a result of the alleged negligence.

the situation to OPMC. OPMC then began an independent investigation of Goldweber in May 2007, who agreed to discontinue his medical practice pending that investigation. Meanwhile, at about that time, Carni, who had not annually checked whether Goldweber's credentialing and malpractice insurance were up-to-date, learned from Goldweber that his malpractice carrier had dropped his coverage in the spring of 2004.[7] Carni, P.C. immediately severed its relationship with Goldweber.

In October 2008, OPMC charged Goldweber with gross incompetence, gross negligence, negligence and incompetence on more than one occasion, and with failing to comply with provisions governing the practice of medicine, in that he violated infection control practices, inappropriately used propofol, and let his infection control certification lapse in 2006. All of the charges were sustained by a determination and order of March 20, 2009, and his medical license was revoked.

OPMC essentially confirmed NYCDOH's findings, concluding that Goldweber regularly used multi-dose vials of anesthetic, i.e., 100 ml vials of propofol, and 50 cc vials of lidocaine and pentothal. OPMC noted that the American Society of Anesthesiologists ("ASA") guidelines did not prohibit using multi-dose vials and that multi-dose vials were permitted by the FDA. However, OPMC indicated that NYCDOH, the New York State Department of Health, and the Center for Disease Control had been urging the FDA to bar the use of multi-dose vials of medication, since they provided the opportunity to transmit infections. OPMC then noted that ASA

[7] Goldweber testified that the coverage was dropped because he failed to pay the premiums and that he never attempted to obtain coverage from another carrier. Carni testified that Goldweber had informed him that he could not afford his premiums.

guidelines recited that propofol was for single-patient use because it did not have adequate preservatives. OPMC also concluded that Goldweber had inappropriately used propofol by using a product which was indicated for single-patient use on multiple patients, notwithstanding that it was sold in multi-dose form. OPMC, observing that propofol does not contain adequate preservatives, found that Goldweber improperly failed to discard propofol vials after six hours in accordance with its label, and acted improperly in storing open vials overnight and then using those vials the next day. Additionally, OPMC concluded that Goldweber must have, on occasion, re-dosed a patient with the same syringe, thereby creating a risk of contaminating the vials. OPMC opined that, since syringes were labeled as single-use items, reusing them was a violation of infection control standards. OPMC then observed that Goldweber had expressed surprise that blood and viruses could flow back into a syringe from a patient's IV tubing, and thereby contaminate a vial when the used syringe was reintroduced into the vial.

As to Anonymous #1, OPMC heard testimony from the head of the laboratory within the Office of Public Health at the NYDOH regarding its and the CDC's testing, which showed the viral strains from Anonymous #1 and the prior patient to be "very, very highly related, which suggest[ed] that they ha[d] a common source of infection or, that one transmitted the infection to the other." OPMC order, ¶ 80. OPMC, evidently rejecting Goldweber's hearing testimony that he would only re-dose a patient with the same syringe in an emergency, concluded that hepatitis C was transmitted from the prior patient to Anonymous #1 by Goldweber's administration of propofol from a multi-dose vial. At his deposition, Goldweber conceded that he told OPMC that he reused syringes to redose patients, but claimed that he only did that occasionally, and only to empty a bottle.

Meanwhile, in September 2007, before either NYCDOH or OPMC issued their findings, Anonymous #1 and her husband, Anonymous #2, suing derivatively, commenced this action against the moving defendants, her obstetrician, and a non-appearing entity, Professional Anesthesia, P.A. The complaint asserts causes of action for negligence/medical malpractice,[8] lack of informed consent, negligent hiring/retention & supervision, and for Anonymous #2's loss of services. The complaint alleges, as is relevant, that Goldweber was an agent and/or employee of Goldweber, LLC, Carni, Carni, P.C., Pacheco, and Pacheco, P.C. The complaint further alleges that Pacheco was an agent and/or employee of Pacheco, P.C.

The Instant Applications

The Carni defendants and the Pacheco defendants move for an order granting them summary judgment dismissing the complaint. Anonymous #1 and her husband oppose the motions, in part, and cross-move for an order granting them summary judgment finding that Goldweber was negligent, that he was employed by Carni and Carni, P.C., and that the Carni defendants are vicariously liable for Goldweber's negligence.

The law is well settled that the movant on a summary judgment application bears the initial burden of prima facie establishing that party's entitlement to the requested relief, by eliminating all material allegations raised by the pleadings. Alvarez v. Prospect Hosp., 68 N.Y.2d

[8] This cause of action, which contains allegations of departures from accepted standards of medical practice was denominated "negligence."

320 (1986); Winegrad v. New York Univ. Med. Ctr., 64 N.Y.2d 851 (1985); Kuri v. Bhattacharya, 44 A.D.3d 718 (2d Dep't 2007). The failure to do so mandates the denial of the application, "regardless of the sufficiency of the opposing papers." Winegrad, 64 N.Y.2d at 853. Where a moving party makes its required showing, the burden shifts to the other side to demonstrate the existence of a material fact. Ferluckaj v. Goldman Sachs & Co., 12 N.Y.3d 316, 320 (2009).

The branches of the Carni defendants' and the Pacheco defendants' motions which seek an order granting them summary judgment dismissing the lack of informed cause of action are granted, and that cause of action is dismissed as to these defendants. The plaintiffs' bills of particulars indicate that the basis for this cause of action is the alleged failure to advise Anonymous #1 of the risk of contracting hepatitis C. The Carni defendants' motion is supported by their expert's opinion that hepatitis C is not a reasonably foreseeable risk of the procedure, and, therefore, was not required to have been disclosed. Pacheco similarly testified at his deposition. The plaintiffs do not offer any specific opposition to these branches of defendants' motions. Moreover, a physician is not required to inform a patient of the risks the patient might encounter if subjected to departures from accepted standards of medical care, and plaintiffs do not refute defendants' prima facie showing that hepatitis is not a foreseeable risk of a colonoscopy. Thus, the lack of informed consent cause of action is dismissed as to Carni, Carni, P.C., Pacheco, and Pacheco, P.C.

The branch of the Pacheco defendants' motion which seeks an order granting them summary judgment dismissing the negligence/malpractice cause of action is denied. Initially, it should be noted that Pacheco and Pacheco, P.C. did not seek to distinguish between themselves on

their motion. Also, Pacheco was not asked at his deposition about Pacheco, P.C. or his relationship to it. Thus, they will be considered together in their motion.

The Pacheco defendants assert that this branch of the motion must be granted because plaintiffs will be unable to establish that Pacheco departed from accepted standards of medical malpractice, since NYCDOH attributed Anonymous #1's hepatitis C infection to Goldweber, not to Pacheco. The motion is also supported by Pacheco's deposition testimony, including that his office, which had several scopes, did not reuse scopes on consecutive patients, except where there was a lengthy interval between procedures, so that there was sufficient time for a scope to have been cleaned, disinfected, and reused. The section of the Pacheco defendants' motion requesting dismissal of the negligence/malpractice cause of action did not seek relief on the ground that these defendants would not be vicariously liable for Goldweber's acts and omissions. In the section in which these movants sought dismissal of the negligent hiring, supervision, and retention claims, it was asserted that Carni, rather than Pacheco or Pacheco, P.C., employed or retained Goldweber as an independent contractor. However, the issue of agency was not addressed.

In response, plaintiffs, who take the position that Anonymous #1 acquired hepatitis C as a result of the anesthesia administered by Goldweber, do not dispute that Pacheco himself did not commit malpractice. Nevertheless, plaintiffs observe that the Pacheco defendants did not seek dismissal of this cause of action on the ground that Goldweber was not Pacheco and Pacheco, P.C.'s ostensible or apparent agent. Thus, plaintiffs maintain that this branch of the Pacheco defendants' motion must be denied.

The pleadings, when fairly read, raised the issue that Goldweber and Goldweber, LLC were these defendants' agents, and therefore required the Pacheco defendants to prima facie eliminate the issue of apparent agency. Since they did not, this branch of the motion is denied. Even if this were an issue, there is enough conflicting evidence contained in Anonymous #1, Pacheco, and Goldweber's deposition transcripts and in Anonymous #1's opposing affidavit to raises an issue of fact as to whether Anonymous #1 was led to believe that the anesthesiology services were being provided by the Pacheco's practice. See Hill v. St. Clare's Hosp., 67 N.Y.2d 72, 79– 2 (1986); Schacherbauer v. University Assoc. in Obstetrics & Gynecology, P.C., 56 A.D.3d 751, 752 (2d Dep't 2008).

I now turn to the branches of plaintiffs' cross motion seeking an order finding that Carni and Carni, P.C. employed Goldweber and that Carni and Carni, P.C. are vicariously liable for Goldweber's acts and omissions. I also turn to that branch of Carni and Carni, P.C.'s motion seeking an order dismissing the negligence/malpractice cause of action on the ground that they cannot be held vicariously liable for Goldweber's alleged acts and omissions. The Carni defendants, who observe that plaintiffs do not urge here that Carni himself departed from accepted standards of medical practice, claim that they cannot be vicariously liable for Goldweber since he, through Goldweber, LLC, was Carni, P.C.'s independent contractor, rather than its employee, and since it was Carni, P.C., rather than Carni personally, which retained Goldweber, through Goldweber, LLC, as an independent contractor. The Carni defendants add that there is no evidence that Anonymous #1 believed that Goldweber was acting on behalf of Carni or Carni, P.C. so as to render Goldweber

their apparent agent. Plaintiffs concede that the theories of apparent or ostensible agency are irrelevant, but maintain that the facts establish, as a matter of law, that Carni and Carni, P.C. employed Goldweber, and are therefore vicariously liable for his acts and omissions. The Pacheco defendants, in their reply papers, support the branches of plaintiffs' cross motion which seek an order finding that the Carni defendants were Goldweber's employers and are, therefore, vicariously liable for his acts and omissions.

The evidence, including Carni's deposition transcript' the checks issued by Carni, P.C. to Goldweber, LLC; the written 2006 independent contractor agreement between Goldweber, LLC and Carni, P.C.; and Carni, P.C.'s tax returns, establishes that it was Carni, P.C., rather than Carni, which retained Goldweber, through Goldweber, LLC. Therefore, those branches of plaintiffs' cross motion which seek an order finding that Carni employed and is vicariously liable for Goldweber and Goldweber, LLC are denied, and that branch of the Carni defendants' motion which seeks an order dismissing the negligence/malpractice cause of action as to Carni is granted, and that cause of action is dismissed as to him. See Yaniv v. Taub, 256 A.D.2d 273, 274 (1st Dep't 1998) (doctrine of respondeat superior does not impose vicarious liability on supervisor who was the sole shareholder of professional corporation which bore his name, but such individual can be liable for his own negligent supervision of the office staff).

However, the branch of Carni, P.C.'s motion which seeks an order dismissing the negligence/malpractice cause of action as to it is denied. An entity which retains an independent contractor is usually not liable for the contractor's acts and omissions, since that entity "has no right

to control the manner in which the work is to be done." Kleeman v. Rheingold, 81 N.Y.2d 270, 273-274 (1993). "Whether a person is an 'employee' or an 'independent contractor' is an ultimate fact to be determined from the evidence itself. It may be called a conclusion to be drawn from the contract itself, the attitude of the parties toward each other, the nature of the work *and all relevant circumstances*." Felice v. St. Agnes Hosp., 65 A.D.2d 388, 396 (2d Dep't 1988); Araneo v. Town Bd. for Town of Clarkstown, 55 A.D.3d 516, 518 (2d Dep't 2008). Generally, whether an employment relationship exists is based on whether the retaining party exercises control over the means utilized to produce the results or over those results. Chuchuca v. Chuchuca, 67 A.D.3d 948, 950 (2d Dep't 2009). However, at least in the context of Unemployment Insurance Appeals Board ("Board") proceedings involving professionals whose work does not lend itself to such control, control over other significant aspects of the work can be considered, and overall control can establish an employment relationship. In re Salamanca Nursing Home (Roberts), 68 N.Y.2d 901, 903 (1986); In re Concourse Ophthalmology Assoc. (Roberts), 60 N.Y.2d 734, 736 (1983). In this regard, the Appellate Division, Third Department, has upheld Board determinations which found an employment relationship where an entity screens or solicits professionals' services, establishes their pay, and provides their services to clients. See, e.g., In re Wells (Madison Consulting, Inc.–Commissioner of Labor), 77 A.D.3d 993 (3d Dep't 2010); In re Kimberg (Hudacs), 188 A.D.2d 781 (3d Dep't 1992); In re Polinsky (Hartnett), 163 A.D.2d 684 (3d Dep't 1990); In re Stat Servs. (Hartnett), 148 A.D.2d 903 (3d Dep't 1989). The issue of whether one is an employee or an independent contractor is usually for the trier of fact. Carrion v. Orbit Messenger, 82 N.Y.2d 742, 744 (1992). Some factors relevant in determining control are whether the person could engage in other work, paid their own taxes, was on a fixed schedule, could set their own hours, was given

fringe benefits, furnished the materials they needed for their work, paid their own expenses, was free to compete with the retaining entity, and was on the retaining entity's payroll. See, e.g., In re O'Brien v. Spitzer, 7 N.Y.3d 239, 243 (2006); Barak v. Chen, 87 A.D.3d 955, 957 (2d Dep't 2011). That a contract recites that one is an independent contractor, is a factor "to be considered, but is not dispositive." Araneo v. Town Bd. for Town of Clarkstown, 55 A.D.3d at 518.

In the instant case, some factors suggest that Goldweber was an independent contractor. These include the alleged oral independent contractor agreement; Goldweber and Carni's testimony that Goldweber was an independent contractor; Goldweber's testimony that Carni did not control the medicines used or his technique; Goldweber's receipt of 1099s and his payment of his taxes; the lack of a non-compete agreement at the time in issue; and the fact that Carni, P.C. did not give Goldweber health insurance and required him to obtain his own liability insurance. Other factors point to an employment relationship, including that Goldweber appears to have worked full-time and only for Carni, P.C.; did not control the billing or where and when he worked; was not paid per case; received paid vacation and generous bonuses, which were not based on his performance; was not required to pay for his supplies; was required to use charts and anesthesia records provided by Carni, P.C.; and was instructed to hold holiday parties in the offices where he worked. In addition, Carni required Goldweber to provide, in his presence, anesthesia to numerous patients before he retained Goldweber, which suggests that Carni wanted to observe whether Goldweber's methodology was to his liking. If it was not, Carni would not necessarily have declined to retain Goldweber, but instead could have dictated how he wanted the work performed.

In light of the foregoing conflicting evidence, Carni, P.C.'s application to dismiss the negligence/malpractice cause of action as to it must be and is denied. Although plaintiffs claim that the unemployment insurance cases demonstrate that they are entitled to a determination that Goldweber was Carni, P.C.'s employee as a matter of law, it is evident that those cases merely found that substantial evidence supported the Board's determinations. Indeed, in many of the cases upon which plaintiffs rely, the Appellate Division specifically noted that the fact that there may have been evidence supporting the opposite conclusion was not determinative of whether there was substantial evidence for the Board's determination. See, e.g., In re Wells, 77 A.D.3d at 995– 96; In re Singh (Thomas A. Sirianni, Inc.– Commissioner of Labor), 43 A.D.3d 498 (3d Dep't 2007); In re Kimberg, 188 A.D.2d at 781; In re Polinsky, 163 AD2d at 685. Further, the Appellate Division, Third Department, has held that the issue of whether an individual is an employee or an independent contractor "is a mixed question of fact and law for the Board to resolve." In re Stat Servs., 148 A.D.2d at 904; In re Mark Slovin, D.D.S, P.C. (Hartnett), 158 A.D.2d 824, 825 (3d Dep't 1990). Therefore, in those proceedings the Board was sitting as the trier of fact. In the instant case, the issue should also be resolved by the trier of fact. Accordingly, the branch of plaintiffs' cross motion, which seeks an order granting them summary judgment finding that Carni and Carni, P.C. were Goldweber's employers and are vicariously liable for any of his acts and omissions, is denied.

Carni and Carni, P.C. urge that the negligent hiring/retention causes of action, which include negligent supervision, must be dismissed because Carni could not reasonably have known that Goldweber had a propensity to break sterile technique. Initially, it should be observed that negligent hiring, retention, and supervision claims can be asserted against one who retains an

independent contractor (see Chuchuca v. Chuchuca, 67 A.D.3d at 950), and these movants do not claim otherwise. That Goldweber lacked board certification does not give rise to a claim of improper hiring, since there is no requirement that an anesthesiologist be board certified. Thomas v. Solon, 121 A.D.2d 165, 166 (1st Dep't 1986). In addition, there is no requirement that a physician carry malpractice insurance. Further, that Carni did not check Goldweber's references, investigate the gap between his employment at Rochester General Hospital and at Lakeside Memorial Hospital, or seek to learn whether he had ever been sanctioned is unavailing, since Carni would not have learned that Goldweber had a propensity for breaking sterile technique and infecting patients. Coffey v. City of New York, 49 A.D.3d 449, 450 (1st Dep't 2008); Rochlin v. Alamo, 209 A.D.2d 499, 500 (2d Dep't 1994) (negligent hiring/retention claim requires showing of notice of the wrongdoer's particular tortious leanings). I also note that Goldweber testified that, prior to his involvement with Carni, he had never been sued for malpractice. Further, despite having been previously sanctioned, Goldweber, by the time he was involved in Anonymous #1's care, had no restrictions on his license, thereby indicating that OPMC was of the opinion that Goldweber was capable and free to provide anesthesia services to other practitioners' patients.

As to the negligent supervision, hiring and retention claims, Carni and Carni, P.C. have also prima facie demonstrated, through Carni's testimony and his expert's detailed affirmation, that it was appropriate to use a multi-dose vial of propofol on more than one patient, as long as a sterile technique was maintained, and that Carni had no knowledge, from observing Goldweber's technique, when he initially observed him at Somerset's premises or during the times he would periodically see him at the offices where Goldweber was providing services, of Goldweber having

broken sterile technique. Carni never saw Goldweber re-dose a patient with the same syringe or store an open vial of propofol overnight. Further, that package labeling or the Physicians' Desk Reference (PDR) provides that propofol is for single-patient use is hearsay and does not, standing alone, establish the standard of care. Spensieri v. Lasky, 94 N.Y.2d 231, 236, 237, n.1, 239 (1999); see also Saccone v. Gross, 84 A.D.3d 1208, 1209 (2d Dep't 2011); Carni ebt (permissible to use propofol vial on more than one patient, irrespective of the PDR). ASA guidelines, stating that propofol vials are for single-patient use, also do not establish the standard of care absent proof that "they reflected a generally-accepted standard or practice." Cf. Scarito v. St. Joseph Hill Academy, 62 A.D.3d 773, 775 (2d Dep't 2009).

Plaintiffs' expert, who opines that Goldweber departed from accepted standards of medical practice by misusing syringes and contaminating the source patient's anesthetic vial, does not rebut the Carni defendants' prima facie showing of entitlement to dismissal of the negligent hiring/retention/supervision claims by his bald statement that Carni should have paid closer attention, caught Goldweber breaking sterile technique, and instructed him accordingly. In addition, plaintiffs' expert failed to address, with any factual analysis, the defense expert's opinion that the use of a multi-dose vial of propofol on more than one patient would be appropriate, as long as proper sterile technique was maintained. Abalola v. Flower Hosp., 44 A.D.3d 522 (1st Dep't 2007); Rebozo v. Wilen, 41 A.D.3d 457, 459 (2d Dep't 2007). Nor does it avail plaintiffs' expert to assert that Carni should have instructed Goldweber how to safely use propofol under sterile technique, here where: Carni watched Goldweber performing excellently at Somerset and where Goldweber was fully licensed; had been administering propofol for about 10 years; had worked as an

anesthesiologist for more than 20 years; had an up-to-date infection control certification; and, after the trial run at Somerset, was not being supervised by Carni in his administration of anesthesia. Accordingly, the branch of the Carni defendants' motion seeking an order granting them summary judgment dismissing the negligent hiring/retention causes of action is granted and such causes of action are dismissed as to Carni and Carni, P.C.

Pacheco and Pacheco, P.C. also seek an order granting them summary judgment dismissing the negligent hiring and retention causes of action asserted against them on the grounds that it was Carni and Carni, P.C. which were involved in Goldweber's hiring and retention, whether as Carni, P.C.'s employee or its independent contractor, and because Pacheco had no knowledge of any problem with Goldweber's qualifications or of any propensity on his part to transmit infectious diseases. Plaintiffs do not dispute that Pacheco lacked knowledge of any problems with Goldweber's qualifications or of any inappropriate actions on Goldweber's part during the course of the procedures performed on Pacheco, P.C.'s premises. Plaintiffs maintain that the Pacheco defendants were negligent because they were required to conduct an inquiry into Goldweber's qualifications and insurance coverage before permitting him to provide services to their patients.

This branch of Pacheco and Pacheco, P.C.'s motion is granted, and the negligent hiring/retention causes of action, which include claims of negligent supervision, are dismissed as to them since, again, there were no requirements that Goldweber be board certified or insured, and a reasonable inquiry would not have shown that Goldweber had the propensity to break sterile

technique. Moreover, Pacheco, and Pacheco, P.C. were entitled to delegate the hiring services to Carni, P.C., which acted through Carni. Cf. Sandra M. v. St. Luke's Roosevelt Hosp. Ctr., 33 A.D.3d 875, 880 (2d Dep't 2006) (service of supplying staff to hospital is not so integral to hospital's main job of providing health care that hospital is barred from delegating that ancillary service, as well as the liability for doing so negligently, to an independent contractor).

This leaves the issue of whether plaintiffs are entitled to a finding that Goldweber was negligent. It is evident from a review of the cross-moving papers that plaintiffs are not merely seeking a finding that Goldweber was negligent, but are also seeking a finding that his negligence caused Anonymous #1's hepatitis C infection. This branch of plaintiffs' cross motion is supported by the affirmation of Sheldon H. Deluty, M.D. ("Deluty"), plaintiffs' expert anesthesiologist, who relies on OPMC's and NYCDOH's findings and conclusions. Deluty asserts that it "is clear and indisputable" from NYCDOH's report and OPMC's order, that Goldweber was negligent and that such negligence caused Anonymous #1's hepatitis C infection. Deluty aff., ¶ 6. Deluty maintains that NYCDOH concluded, based on genetic testing, that the virus had been transmitted from the infected prior patient to Anonymous #1, and that the results of the testing were consistent with the transmission of the virus from one to the other. Deluty further observes that NYCDOH and OPMC concluded that the hepatitis cases resulted from the misuse of syringes when single-patient-use propofol vials were used to administer propofol to more than one patient. Based on NYCDOH and OPMC's findings and conclusions, Deluty opines that Goldweber departed from standards of accepted practice by misusing syringes and contaminating the anesthetic vial that was used on the prior patient, and then using the contaminated drug on Anonymous #1, thereby causing her to

contract hepatitis C.

The Carni defendants reply papers do not contain any opposition to this branch of the cross motion, (see Zeitler reply aff.,¶ 3), and while the Pacheco defendants' reply papers indicate that they only support the part of plaintiffs' cross motion seeking a finding that Carni was Goldweber's employer, and is liable for his acts and omissions, they do not specifically oppose or otherwise address that part of plaintiffs' cross motion which seeks a finding that Goldweber was negligent and that his negligence caused Anonymous #1's hepatitis C infection. None of the moving defendants urges here that Deluty was not entitled to rely on the relevant portions of NYCDOH's report or OPMC's order. In fact, the Pacheco defendants' motion offered the substance of NYCDOH's report as a basis for a finding that the negligence/malpractice cause of action had to be dismissed as to them, since that report found that Anonymous #1 was infected by Goldweber. The Carni defendants' expert also relied on that report's findings to show that Carni was not negligent. In light of the lack of any opposition by Carni, P.C. and the defendants' reliance on NYCDOH's findings to support their summary judgment applications, there is no dispute on these applications that Anonymous #1's hepatitis C was caused by Goldweber having misused a syringe to re-dose the prior patient, thereby contaminating the propofol vial, and then administering the contaminated propofol to Anonymous #1, who was hepatitis negative at the time of her colonoscopy, but positive fewer than seven months later. Further, none of the defendants rebutted Deluty's showing that Goldweber departed from standards of good and accepted practice in misusing the syringes. Accordingly, the branch of plaintiffs' motion seeking an order granting them summary judgment finding that Goldweber was negligent and that his negligence caused

Anonymous #1's hepatitis C infection is granted to the extent of finding that Goldweber negligently misused a syringe, during the prior patient's procedure, thereby contaminating the propofol vial, with hepatitis C, which contaminated propofol he then administered from the same vial to Anonymous #1, thereby proximately causing her to contract hepatitis C. In conclusion, it is

ORDERED that Abbe J. Carni and Abbe J. Carni, M.D., P.C.'s motion (sequence number 004), which seeks an order granting them summary judgment dismissing the complaint is granted solely to the extent that the complaint is dismissed and is severed as to Abbe J. Carni, and the lack of informed consent (second cause of action) and the negligent hiring/retention (sixth cause of action) causes of action are dismissed and are severed as to Abbe J. Carni, M.D., P.C., but the motion is otherwise denied; and it is further

ORDERED that Paulo A. Pacheco and Paulo Pacheco, M.D., P.C.'s motion (sequence number 005), which seeks an order granting them summary judgment dismissing the complaint is granted solely to the extent that the lack of informed consent cause of action (second cause of action) and the negligent hiring/retention causes of action (third and fourth causes of action) are dismissed and are severed as to Paulo A. Pacheco and Paulo Pacheco, M.D., P.C., but the motion is otherwise denied; and it is further

ORDERED that the branch of Anonymous #1 and Anonymous #2's cross motion, which seeks an order granting them summary judgment finding that Abbe J. Carni and Abbe J. Carni, M.D., P.C. were Brian A. Goldweber's employers and that Abbe J. Carni and Abbe J. Carni,

M.D., P.C. are vicariously liable for Brian A. Goldweber's acts and omissions is denied; and it is further

ORDERED that the branch of Anonymous #1 and Anonymous #2's cross motion which seeks an order granting them summary judgment finding that Brian A. Goldweber was negligent and that such negligence was a proximate cause of Anonymous #1's contracting hepatitis C is granted to the extent of finding that Brian A. Goldweber negligently misused a syringe during the prior patient's procedure, thereby contaminating the propofol vial with hepatitis C, which contaminated propofol he then administered from the same vial to Anonymous #1, thereby proximately causing Anonymous #1 to contract hepatitis C.

Dated: Dec. 15, 2011

ENTER:

JOAN B. LOBIS, J.S.C.