SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NEW YORK: PART 10

----------X

BARBARA RUCHAMES,

Plaintiff,

-against-

THE NEW YORK AND PRESBYTERIAN HOSPITAL, EMPIRE STATE ORTHOPAEDICS, PLLC, SHARYN N. LEWIN, M.D., NICHOLAS J. MORRISSEY, M.D., ANDREW L. ROSEN, M.D., and THOMAS P. SCULCO, M.D.,

Defendants.

----------X

Index 805026/2015
Motion Seq. 003

DECISION & ORDER

GEORGE J. SILVER, J.S.C.:

In this medical malpractice action, defendants THE NEW YORK AND PRESBYTERIAN HOSPITAL ("NYPH"), SHARYN N. LEWIN, M.D. ("Dr. Lewin"), and NICHOLAS J. MORRISSEY, M.D. ("Dr. Morrissey") (collectively, "defendants") move for summary judgment. Plaintiff BARBARA RUCHAMES ("plaintiff") opposes the motion. For the reasons discussed below, the court grants the motion.

On June 25, 2012, plaintiff, then 64 years old, presented to Dr. Lewin, a gynecologic oncologist, at the NYPH due to a recurrence of ovarian cancer. Plaintiff was initially diagnosed with ovarian cancer in July 2007, and had a total abdominal hysterectomy, a bilateral salpingo-oophorectemy, a pelvic lymph node dissection, and six cycles of chemotherapy. Plaintiff also had an artificial hip replacement surgery in 2008. Dr. Lewin and plaintiff discussed various options to treat the new cancerous tumor such as surgery, chemotherapy, and clinical trials. Dr. Lewin documented that she also discussed the risks of chemotherapy with plaintiff, including "sepsis/infection," and that plaintiff "expressed understanding." Plaintiff elected chemotherapy and underwent chemotherapy via intravenous needle sticks at the NYPH Infusion Therapy Center ("Infusion Center") on July 9, 2012, July 16, 2012, and July 17, 2012.

On July 17, 2012[1], plaintiff chose to have a port inserted for delivery of chemotherapy instead of the intravenous needle sticks. Dr. Lewin referred plaintiff to Dr. Morrissey for the port insertion procedure. On July 23, 2012, plaintiff met with Dr. Morrissey, and signed a consent form for the port insertion. On July 27, 2012, plaintiff signed a consent form again, and Dr. Morrissey implanted the port without any intra-operative complications. An operative report by Dr. Morrissey on July 27, 2012 documented that Cefazolin, an antibiotic, was administered to plaintiff prior to her surgery to minimize the risk of infection. Plaintiff was also given written discharge instructions and was told to follow-up with Dr. Lewin.

On July 30, 2012, plaintiff had an elevated white blood cell count, which was thought to be secondary to Neulasta, a bone marrow stimulant given to plaintiff on July 17, 2012 to help her body produce white blood cells since chemotherapy can lower one's white blood cell count. Plaintiff did not complain about the port on this day, and there were no documented indications of any abnormalities or clinical signs of an infection. On August 6, 2012, plaintiff's temperature and white blood cell count were within normal limits, and there were no clinical signs of an infection. On August 7, 2012, plaintiff received Neulasta, and on August 13, 2012, plaintiff reported to her gynecologist, Dr. Raymond Reilley that she was "feeling great."

On August 20, 2012, plaintiff received Neulasta again. Her temperature was normal and her skin was clear, but her white blood cell count was elevated that day. Plaintiff reported that she was "feeling great," and Dr. Lewin noted that plaintiff looked healthy. There were no documented complications or complaints about the port.

On August 27, 2012, plaintiff returned to the Infusion Center for chemotherapy. Her temperature was normal, and she reported mild fatigue and left hip pain. (NYPH records indicate

[1] The exact date that plaintiff decided to have the port implanted is unclear. Defendants' affirmation incorrectly notes that plaintiff chose to have the port inserted on July 19, 2017, but plaintiff identifies the date as July 17, 2012.

that plaintiff fell around this time.) Plaintiff also had rashes on her knees and thighs similar to a rash she had on her forearms and chest on July 19, 2012[2], which plaintiff attributed to a reaction to Gemzar, a chemotherapy agent. Plaintiff was sent to Dr. Lewin that day for further assessment. When plaintiff saw Dr. Lewin on August 27, 2012, her temperature was normal, and she denied having fevers or chills. Plaintiff reported "erythema around port," but upon examining the area, Dr. Lewin did not find any erythema (redness) at the port, except along the suture line. Dr. Lewin prescribed plaintiff with Keflex, an antibiotic, and instructed plaintiff to return in a week for an assessment of the port, but to call immediately if she had a fever. Dr. Lewin also ordered a CT scan to monitor the response of the cancerous tumor to the chemotherapy before plaintiff's fourth chemotherapy cycle.

On August 28, 2012, plaintiff returned to the Infusion Center for Neulasta, and did not report any complaints. On August 31, 2012, Dr. Morrissey performed an examination to check whether plaintiff's port was infected, and documented that there was "no erythema over the port site or the catheter as it travels under the skin, no tenderness, no pus, no skin breakdown." Dr. Morrissey's impression was that there were "no signs clinically of port site infection." Dr. Morrissey also noted that plaintiff did not have a fever or chills, and that plaintiff's white blood cell count went down from 20 to 15. Dr. Morrissey instructed plaintiff to follow up if she developed worsening erythema or drainage.

On September 4, 2012, plaintiff had routine CT scans, which confirmed that the "port was in good position," and a routine blood work, which showed an elevated white blood cell count of 30. Dr. Lewin ordered a port blood culture, but noted that plaintiff had no pain, redness, or swelling at the port site. The port was then flushed. The following day, the blood culture grew out gram

[2] Defendant states July 19, 2017, but this appears to be a typographical error.

positive cocci in clusters, and Dr. Lewin instructed plaintiff to go to the hospital for treatment for a presumed infection.

Plaintiff was admitted to NYPH on September 5, 2012 with an elevated temperature of 100.4 degrees. The Infectious Disease Service was consulted and IV antibiotic, Vancomycin, was started. Plaintiff also complained of left hip pain, which she described as sore, aching, intermittent, and gradual. On September 6, 2012, gynecology resident Dr. Chantae Sullivan-Pike saw plaintiff, who again reported left hip pain and said that she had fallen a week earlier. At around 11:48 p.m., plaintiff's fever spiked to 103.1 degrees, but decreased to 101.8 degrees after she was given Motrin. Dr. Lewin informed plaintiff that the port would likely be removed the following day.

On September 7, 2012, Dr. Lewin planned to remove the port because plaintiff had "recurrent fevers" despite being on antibiotics. At around 9:30 a.m. that morning, the port blood culture identified the bacteria as Methicillin-Susceptible Staphylococcus Aureus ("MSSA"). At around 10:07 a.m., a note entered by fellow Heather Platt stated that the gynecology team was already at plaintiff's bedside and planned to remove the port. She also noted that plaintiff had a greater risk of seeding with prolonged bacteremia, with specific concern for seeding in plaintiff's heart and prosthetic hip. On examination, plaintiff was noted to have mild tenderness, erythema at the port site of entry, erythema induration at the tunneled area superior to the port, and a concern for drainage at the entry site. Dr. Lewin removed the port at around 10:00 a.m. and Oxacillin, the antibiotic of choice for MSSA, was started. The Infectious Disease Service thereafter managed plaintiff's infection.

Plaintiff resumed chemotherapy on September 10, 2012, and was discharged from NYPH on September 14, 2012. She continued chemotherapy at the Infusion Center on September 17, 2012. On September 21, 2012, plaintiff saw Dr. Ellen Morrison ("Dr. Morrison"), an infectious

disease specialist, who reiterated that plaintiff would be on IV Oxacillin for four weeks until October 8, 2012. In April 2013, plaintiff was diagnosed with MSSA infection to her left hip prosthesis and had to undergo two-stage exchange hip replacement surgeries since she had turned septic. On May 8, 2013, plaintiff underwent an explant of left total hip arthroplasty with placement of a left hip antibiotic spacer. On September 11, 2013, plaintiff underwent a removal of left hip antibiotic spacer and a reimplantation of total hip arthroplasty.

ARGUMENTS

Based on the record before the court, defendants argue that summary judgment must be granted, because plaintiff cannot establish that defendants' medical treatment of plaintiff deviated from accepted standards of care or proximately caused plaintiff's alleged injuries.

Defendants argue that plaintiff's subjective complaints about the port are insufficient to raise a question of fact as to whether there were signs of an infection. According to defendants, although plaintiff complained about the port and an infection on three to five occasions, plaintiff as a layperson was unqualified to assess the signs of an infection, and therefore plaintiff's expert cannot establish that plaintiff had signs of a port infection based on plaintiff's own subjective, undocumented complaints. To the contrary, defendants argue that Dr. Lewin, Dr. Morrissey, and NYPH staff at the Infusion Center examined and assessed plaintiff each time she commented about the port area, and did not find clinical signs of an infection.

In support of their motion, defendants annex the affirmations of infectious disease specialist Dr. Bruce Farber ("Dr. Farber") and vascular surgeon Dr. William Suggs ("Dr. Suggs"), both of whom assert that defendants' evaluation and prompt diagnosis of plaintiff's infection met the standard of care. In Dr. Farber and Dr. Suggs' opinion, the medical records establish that

plaintiff did not have any clinical signs or symptoms of infection from the time the port was implanted on July 27, 2012 to September 4, 2012 when plaintiff's white blood cell count rose to 30. According to both experts, plaintiff first manifested signs of infection when she was admitted to NYPH on September 5, 2012, and even if plaintiff had an infection earlier, there is no proof that it was diagnosable. Dr. Farber and Dr. Suggs also assert that even if plaintiff's infection was diagnosed earlier, she would have had the same injury.

Dr. Farber and Dr. Suggs further opine that plaintiff's development of a port infection does not suggest that there was a departure from the standard of care in the insertion of the port. Dr. Suggs notes that it is not within the standard of care to order imaging studies after the port is inserted. Moreover, Dr. Suggs highlights that fluoroscopy images on the day the port was inserted and a CT scan on September 4, 2012 both showed that the port was properly placed and "in good position." Dr. Suggs also remarks that there is no evidence that the port components were infected or that an infection was introduced during the insertion procedure. According to both experts, Dr. Morrissey met the standard of care by administering Cefazolin antibiotic to plaintiff prior to inserting the port, cleansing the area, performing the implantation with sterile port components, and applying a sterile dressing after the procedure. Dr. Suggs adds that the port components come in a sterile pre-packed kit, and that plaintiff was given written discharge instructions, including to follow-up with Dr. Lewin. In that regard, both experts conclude that the standard of care does not require administration of antibiotics after the port is inserted. Moreover, according to Dr. Farber and Dr. Suggs, port infections can occur approximately 4% of the time.

Dr. Farber also asserts that plaintiff did not have any signs or symptoms of an infection before September 4-5, 2012 that would have warranted a blood culture. According to Dr. Farber,

it is not within the standard of care to perform a blood culture unless there is an index of suspicion[3] that an infection is present. However, Dr. Farber points out that Dr. Lewin, Dr. Morrissey, and NYPH staff consistently monitored plaintiff for clinical signs of infection, and found none. Specifically, Dr. Farber notes that plaintiff did not exhibit any local or constitutional evidence of infection, and that plaintiff's temperature on the days leading up to September 5, 2012 was normal. Therefore, Dr. Farber concludes that such a low index of suspicion for a port infection did not warrant a blood culture, and that Dr. Lewin only ordered a port blood culture because plaintiff's routine blood work on September 4, 2012 showed an elevated white blood cell count. Dr. Farber further notes that plaintiff's white blood cell was routinely monitored in July and August of 2012, and her elevated white blood cell count on several occasions did not raise the index of suspicion for an infection because plaintiff's Neulasta medication can cause a high white blood cell count, and plaintiff did not consistently have an elevated white blood cell count. Accordingly, Dr. Farber states that it is not within the standard of care for Dr. Lewin to do a blood culture on those days.

Further, Dr. Suggs avers that Dr. Morrissey's examination, assessment, and conclusion that there was no evidence of a port infection on August 31, 2012 met the standard of care since Dr. Morrissey was aware of plaintiff's history, considered her white blood cell results, examined the port site for any signs of an infection, and noted the absence of fevers, chills, tenderness, erythema, puss, or skin breakdown. At the outset, Dr. Suggs points out that contrary to plaintiff's assertion, NYPH records and Dr. Lewin's chart clearly document plaintiff's medical history. Dr. Suggs also states that Dr. Morrissey was not required to draw blood from the port site for a culture on August

[3] According to Dr. Farber, the index of suspicion that a patient may have an infection in the blood from the port is based on the presence of clinical signs upon physical examination of the patient's presentation and condition (i.e. pain, redness, swelling, fever, chills, sweats, malaise). Once there is a suspicion based on these clinical signs, blood cultures are used to confirm or deny the existence of an infection and to identify the specific bacteria in the blood if there is an infection.

31, 2012, or conduct additional tests other than a physical examination because plaintiff's white blood cell count had decreased from 20 to 15 and there were no clinical signs of an infection. To the contrary, Dr. Suggs clarifies that the rashes on plaintiff's knees and thighs were not suggestive of an infection because she had rashes on her forearms and chest on July 19, 2012, before the port was inserted, and the rashes on her knees and thighs were resolved with Medrol steroid by July 30, 2012. Dr. Farber also explains that because plaintiff had an infection in the blood that originated from the port, which is more difficult to diagnose than a superficial port infection because the local signs of infection may not be present, it was reasonable for Dr. Lewin to prescribe plaintiff with Keflex on August 27, 2012 out of caution for what might have been a superficial infection at most.

Moreover, Dr. Farber opines that it was reasonable to remove the port on September 7, 2012 due to either plaintiff's fevers or MSSA. Dr. Farber explains that while there is no specific timeframe to remove the port, it was reasonable to wait for the final blood culture result before removing the port because the bacteria can take up to five or more days to complete its growth. Dr. Farber also explains that there were no signs, symptoms, or test results that required the port to be removed any earlier. Indeed, the port did not have to be removed until plaintiff spiked fevers and until the organism was identified as MSSA, both of which happened on September 7, 2012. Likewise, Dr. Farber asserts that the infection disease specialists did not need to inform Dr. Lewin to remove the port earlier than September 7, 2012. However, Dr. Farber contends that even if the port had been removed earlier, plaintiff still would have needed four weeks of IV Oxacillin for MSSA and prolonged hospitalization.

In addition, Dr. Farber opines that the Infectious Disease Service's management of plaintiff's infection met the standard of care. Dr. Farber notes that the infection disease specialists did not need to see plaintiff on September 5, 2012 since they can and frequently do consult about

the choice of antibiotics without seeing the patient. Dr. Farber also states that it was appropriate to prescribe plaintiff with Vancomycin after obtaining the preliminary culture results since Vancomycin is good for gram positive cocci in clusters. Dr. Farber similarly agrees with changing plaintiff's antibiotics to Oxacillin on September 7, 2012 once MSSA was identified.

Defendants also argue that there is no basis for plaintiff's lack of informed consent claim. Specifically, defendants contend that plaintiff admitted at her deposition that she knew of the risk of infection from the port, and that based on her "expressed understanding," she knew that chemotherapy carries a risk of "infection/sepsis." Defendants also claim that since plaintiff had received chemotherapy via intravenous needle sticks at the Infusion Center on three occasions prior to the port implantation, she was aware of an alternative way of getting chemotherapy, but chose to have the port instead. Defendants further assert that plaintiff signed a consent form on July 23, 2012 and July 27, 2012 for the port insertion, which states that she "fully understand(s)" the "... nature, purpose, as well as reasonably foreseeable risks and benefits of the procedure." Based on the foregoing, Dr. Suggs opines that defendants met the requisite standard of care by informing plaintiff of the nature and risks of the port.

Finally, defendants argue that plaintiff's negligent hiring claim is without merit. Defendants aver that plaintiff's complaint does not allege that NYPH had knowledge that its employees had a propensity for the sort of behavior that caused plaintiff's injuries. Further, defendants clarify that Dr. Lewin and Dr. Morrissey were not hired or retained by NYPH, but are employees of Columbia University, who are qualified to have privilege at or be affiliated with NYPH. Because plaintiff failed to name Columbia University as a defendant, defendants argue that plaintiff's negligent hiring claim must be dismissed.

In opposition, plaintiff states that she does not oppose Dr. Morrissey's motion for summary judgment, but opposes NYPH and Dr. Lewin's motion. Plaintiff argues NYPH and Dr. Lewin failed to demonstrate that their actions conformed to the requisite standard of care. In support of her opposition, plaintiff annexes the expert affidavit of orthopedic surgeon Andrew S. Holmes, M.D. ("Dr. Holmes"), who asserts that the acts and inactions of Dr. Lewin and NYPH deviated from the appropriate standard of care and proximately caused plaintiff's injuries.

In Dr. Holmes' opinion, plaintiff should have been referred to an orthopedic surgeon once it was confirmed that she had an active infection, and Dr. Lewin's failure to refer plaintiff to an orthopedic surgeon to examine her artificial hip at the time she complained of hip pain when her infection was first diagnosed was a departure from the standard of care. Dr. Holmes explains that since plaintiff had an artificial hip, the risk for seeding of the infection in the artificial prosthetic device was high, and notes that plaintiff's infection did in fact get seeded onto her artificial hip. Dr. Holmes concludes that a referral to an orthopedic specialist would have revealed that plaintiff's hip was infected, and that plaintiff would have had an irrigation and debridement and a possible liner exchange to clear the hip from any infection. Dr. Holmes also remarks that plaintiff should have had intraoperative cultures taken during the irrigation and debridement which would have revealed the infecting bacteria. Furthermore, Dr. Holmes opines that the outcome would have been different if plaintiff's original symptoms had been addressed earlier through a referral, and thus, this delay was the proximate cause of plaintiff's morbidities. Dr. Holmes further concludes that but for Dr. Lewin and NYPH's departures, plaintiff could have avoided turning septic and requiring hip replacement surgeries.

In reply, defendants assert that plaintiff has abandoned her complaints of a port infection, her claims for lack of informed consent and negligent hiring, and all theories of malpractice against

NYPH by failing to allege any departures by NYPH. Defendants also contend that plaintiff's out-of-state expert affidavit is legally inadequate because it was not accompanied by a certificate of conformity. Defendants further state that plaintiff never told Dr. Lewin that she had hip pain, and that Dr. Lewin, a gynecologic oncologist, had no duty to refer plaintiff to an orthopedic surgeon. Moreover, defendants aver that plaintiff saw two orthopedic surgeons, and neither did an incision and debridement, nor recommended a liner exchange or took cultures as plaintiff's expert claimed an orthopedic surgeon would have done. Defendants also point out that neither surgeon found evidence of a hip infection. Finally, defendants argue that plaintiff impermissibly alleges for the first time in her opposition that she should have been referred to an orthopedic surgeon.

DISCUSSION

To prevail on summary judgment in a medical malpractice case, 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 the patient's injury (*Roques v. Noble*, 73 AD3d 204, 206 [1st Dept. 2010]). In claiming treatment did not depart from accepted standards, the movant must provide an expert opinion that is detailed, specific and factual in nature (*see e.g.*, *Joyner-Pack v. Sykes*, 54 AD3d 727, 729 [2d Dept. 2008]). The opinion must be based on facts in the record or personally known to the expert (*Roques*, 73 AD3d at 207). The expert cannot make conclusions by assuming material facts which lack evidentiary support (*id.*). The defense expert's opinion should state "in what way" a patient's treatment was proper and explain the standard of care (*Ocasio-Gary v. Lawrence Hosp.*, 69 AD3d 403, 404 [1st Dept. 2010]). Further, it must "explain 'what defendant did and why'" (*id. quoting Wasserman v. Carella*, 307 AD2d 225, 226 [1st Dept. 2003]).

Once defendant makes a *prima facie* showing, the burden shifts to plaintiff "to produce evidentiary proof in admissible form sufficient to establish the existence of material issues of fact which require a trial of the action" (*Alvarez v. Prospect Hosp.*, 68 NY2d 320, 324 [1986]). To meet that burden, plaintiff must submit an expert affidavit attesting that defendant departed from accepted medical practice and that the departure proximately caused the injuries (*see Roques*, 73 AD3d at 207). "Summary judgment is not appropriate in a medical malpractice action where the parties adduce conflicting medical expert opinions" (*Elmes v. Yelon*, 140 A.D.3d 1009 [2nd Dept 2016] [citations and internal quotation marks omitted]). Instead, the conflicts must be resolved by the factfinder (*id.*).

Here, defendants set forth a *prima facie* case in favor of dismissal, as evidenced by the submission of defendants' medical records, and defendants' expert affidavits, all of which attest to the fact that defendants' treatment of plaintiff was in accordance with accepted standards of care and did not proximately cause plaintiff's alleged injuries. To be sure, defendants' expert affirmations are detailed and predicated upon ample evidence within the record. As defendants have made a *prima facie* showing, the burden shifts to plaintiff.

As an initial matter, plaintiff's opposition to defendants' *prima facie* showing is deficient as plaintiff's expert affidavit is inadmissible. CPLR § 2309(c) requires that an oath taken outside of New York be accompanied by a certificate of conformity. Because plaintiff's orthopedic expert is not licensed in New York, his affidavit fails since it was not accompanied by a certificate of conformity. Accordingly, defendants are entitled to summary judgment, as plaintiff has proffered inadmissible evidence to rebut defendants' *prima facie* showing.

Even if plaintiff's expert affidavit were admissible, plaintiff has failed to raise triable issues of fact. In a medical malpractice action, "expert medical opinion evidence is required to

demonstrate merit" "except as to matters within the ordinary experience and knowledge of laymen" (*Fiore v. Galang*, 64 N.Y.2d 999, 1001 [1985] [granting defendants summary judgment where the "failure to diagnose cancer and the performance of an abdominal operation are not matters within the ordinary experience of laypersons," and plaintiff failed to supply an affidavit of merits from a person competent to attest to the meritorious nature of the claim]). Here, defendants correctly assert that plaintiff, as a layperson is unqualified to assess or diagnose the signs and symptoms of an infection, and therefore cannot establish that she indeed had an infection earlier than September 4-5, 2012 (*id.*). While plaintiff supports her claim with an expert affidavit, plaintiff's expert cannot rely on plaintiff's subjective and undocumented complaints to establish that plaintiff had signs of an infection when there is no medical basis or evidence in plaintiff's records from which he can draw such a conclusion (*Kaplan v. Hamilton Med. Assocs., P.C.*, 262 A.D.2d 609, 610 [2d Dept. 1999] [granting defendants summary judgment where plaintiff's expert affidavit "merely stat[ing] in conclusory terms that [defendants] should have diagnosed and treated his bacterial endocarditis sooner" was insufficient to raise a triable issue of fact]).

To the contrary, plaintiff failed to raise a triable issue of fact to rebut defendants' assertion that there were no clinical signs of an infection prior to September 4-5, 2012. "[G]eneral allegations of medical malpractice, merely conclusory and unsupported by competent evidence tending to establish the essential elements of medical malpractice, are insufficient to defeat [a] defendant physician's summary judgment motion" (*Grzelecki v. Sipperly*, 2 A.D.3d 939, 941 [3d Dept. 2003] [plaintiff failed to raise an issue of fact precluding summary judgment where plaintiff's expert affidavits "are speculative, conclusory and generalized"]; *see also Frye v. Montefiore Med. Ctr.*, 70 A.D.3d 15, 24 [1st Dept. 2009]). Plaintiff's expert fails to point to any documentation in plaintiff's medical records that shows that plaintiff had signs or symptoms of an

infection such as fevers, redness, or swelling prior to September 4-5, 2012, or that any additional tests would have confirmed or denied the existence of an infection (*Grzelecki*, 2 A.D.3d at 941, *supra* [granting defendants summary judgment where plaintiff's expert failed to "identify symptoms upon which a diagnosis of severe depression could have been made and do not provide a causal nexus between the alleged malpractice and decedent's suicide"]; *Graziano v. Cooling*, 79 A.D.3d 803, 805 [2d Dept. 2010] [granting defendants summary judgment where plaintiff's expert did not assert that "plaintiff exhibited key symptoms such as photophobia and neck stiffness, or other "cardinal signs," which would have led to a diagnosis of meningococcal meningitis prior to the afternoon of September 29, 2004." "Plaintiff's expert also did not assert that any further testing was indicated"]). On the other hand, defendants sufficiently established that plaintiff's medical records and Dr. Morrissey's August 31, 2012 examination showed that there were no clinical signs or symptoms of an infection.

Furthermore, plaintiff failed to address or rebut defendants' assertion that defendants properly treated plaintiff in September 2012. Although plaintiff's expert proffers that the port should have been removed before September 7, 2012, he fails to specify when the port should have been removed, the basis for why the port should have been removed earlier, and how removing the port earlier would have changed plaintiff's injury, treatment, or outcome (*Biondi v. Behrman*, 149 A.D.3d 562, 565 [1st Dept. 2017] [granting defendants summary judgment where plaintiff's expert did not explain how pre-surgical testing would have changed the result, and advanced only conclusory opinions that a specific infection was somehow the cause of her injuries]). Plaintiff also fails to rebut defendants' argument that she would have had the same injury even if her infection was diagnosed earlier (*Graziano*, 79 A.D.3d at 805, *supra* [granting defendants summary

judgment where plaintiff's expert affidavit was conclusory, speculative, and failed to address defendants' expert assertion regarding proximate cause]).

Instead, plaintiff's expert submits a two-page opinion, asserting in broad, conclusory terms that plaintiff should have been referred to an orthopedic surgeon. However, this assertion speculates, without any proof, that plaintiff's hip infection existed in September 2012 at the time plaintiff's MSSA port infection was diagnosed, although plaintiff's hip infection was diagnosed seven months after the port infection. Plaintiff's expert also fails to show any scientific or medical evidence for his sweeping claims that but for Dr. Lewin and NYPH's departures, plaintiff could have avoided turning septic and requiring hip replacement surgeries or that additional testing would have revealed that the infection seeded in plaintiff's hip. Dr. Holmes fails to identify what these additional tests are, what their results would reveal, or how they would ultimately change plaintiff's outcome. To the contrary, defendants' reply solidifies their argument in that the two orthopedic surgeons who examined plaintiff's hip after her port infection was diagnosed did not recommend the tests and procedures that plaintiff's expert claims should have been conducted. Furthermore, defendants assert that plaintiff's orthopedic surgeon Dr. Thomas Sculco ("Dr. Sculco") did not believe that plaintiff had an infection in her hip that seeded from the port infection. Because there is "no support for plaintiff's expert's conclusory and speculative statement that [plaintiff's infection] would have been diagnosed sooner" but for [defendants'] alleged deviations from the standard of care, there are no triable issues of fact here sufficient to preclude summary judgment (*id.*).

Moreover, defendants properly contend that plaintiff cannot now assert a new claim based on defendants' alleged failure to refer plaintiff to an orthopedic surgeon. A plaintiff cannot defeat a motion for summary judgment by asserting a new theory of liability (*Sutin v. Manhattan & Bronx*

Surface Transit Operating Auth., 54 A.D.3d 616, 616 [1st Dept. 2008]; *Abalola v. Flower Hosp.* 44 A.D.3d 522, 522 [1st Dept. 2007]). In her opposition papers, plaintiff alleges for the first time that the outcome would have been different if plaintiff's symptoms had been addressed earlier through a referral, and that but for Dr. Lewin and NYPH's departures, plaintiff could have avoided turning septic and requiring hip replacement surgeries. However, plaintiff made no allegations of that nature in her initial pleadings. In plaintiff's verified bill of particulars, for instance, her only reference to a hip infection was that defendants' failure to treat plaintiff's MSSA ultimately transmitted to her prosthetic hip, which resulted in her having to undergo a surgery to remove the infected hip on May 8, 2013. Plaintiff makes no reference to defendants' failure to refer her to an orthopedic surgeon. Because plaintiff raises a claim that was not previously alleged, and because it constitutes a substantive change in plaintiff's theory of liability, it is insufficient to raise a triable issue of fact as a matter of law (*id.*).

Furthermore, defendants are entitled to summary judgment as to plaintiff's negligent hiring claim since plaintiff submitted no opposition to rebut defendants' assertions. Plaintiff failed to demonstrate that NYPH hired or retained Dr. Lewin and Dr. Morrissey, both of whom are employees of Columbia University, and fatally fails to name Columbia University as a defendant in this action. Additionally, defendants have sufficiently established that there is no evidence that NYPH had knowledge that Dr. Lewin and Dr. Morrissey had any propensity for the sort of behavior that caused plaintiff's injuries. Accordingly, summary judgment must be granted in defendants' favor.

Similarly, plaintiff fails to proffer any evidence to rebut defendants' assertion that they obtained her informed consent to insert the port. To the contrary, defendants set forth undisputable evidence that plaintiff consented to having the port through her testimony that she knew of the risk

of an infection, Dr. Lewin's documentation that plaintiff "expressed understanding" that chemotherapy carries a risk of "infection/sepsis," and plaintiff's awareness of alternatively receiving chemotherapy through intravenous needle sticks from her prior treatment at the Infusion Center. Significantly, the *coup de grâce* of plaintiff's claim comes from her execution of a consent form on July 23, 2012 and July 27, 2012, informing her of the "... nature, purpose, as well as reasonably foreseeable risks and benefits of the procedure" (*DeCintio v. Lawrence Hosp.*, 55 A.D.3d 407, 407 [1st Dept. 2008] [granting defendants summary judgment where "plaintiffs' expert's conclusory affidavit . . . failed to raise a triable issue of fact as to whether decedent was treated by defendants without informed consent"]; *Aharonowicz v. Huntington Hosp.*, 22 A.D.3d 615, 615 [2d. Dept. 2005] [granting defendant summary judgment regarding lack of informed consent claim where plaintiff's expert affidavit "contained only conclusory allegations"]). Because plaintiff failed to address or rebut defendant's assertion that she gave her informed consent to having the port inserted, plaintiff's lack of informed consent claim must be dismissed.

Accordingly, based on the foregoing, it is hereby ORDERED that defendants' motion for summary judgment is GRANTED in its entirety; and it is further

ORDERED that the clerk is directed to enter judgment accordingly.

This constitutes the decision and order of the court.

July 3, 2018

HON. GEORGE J. SILVER