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

SAMANTHA M. TINOCO,

Plaintiff,

-against-

DECISION AND ORDER
Index No.: 906540-16
RJI No.: 01-17-124167

ALBANY MEDICAL CENTER HOSPITAL
and DAVID KIMBLE, M.D.,

Defendants.

APPEARANCES:

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Attorneys for Defendants Albany Medical Center and David Kimble, M.D.
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David A. Weinstein, J.:

Plaintiff Samantha Tinoco brought this medical malpractice action seeking to recover for injuries she allegedly suffered following a March 16, 2016 laparoscopic left ovarian cystectomy performed by defendant David Kimble, M.D., while she was a patient in the care of defendant Albany Medical Center Hospital ("AMC") (Mitchell Aff, Ex A). In her complaint, plaintiff asserts three causes of action: (1) negligence; (2) medical malpractice; and (3) lack of informed consent (*id.*). Specifically, the complaint alleges that defendants were negligent in failing to act

in a reasonably safe manner when treating and caring for plaintiff; defendants engaged in malpractice by deviating from the accepted standards of medical care in performing the cystectomy; and defendants failed to secure her consent to treatment and failed to advise, disclose, inform and/or notify her of the risks, benefits and/or alternatives to the prescribed treatment (*id.*).

Defendants now move for summary judgment dismissing all claims. Plaintiffs have submitted papers in opposition, including an expert affidavit.

The parties' submissions reveal no factual dispute as to the general contours of the medical treatment that plaintiff received from defendants on March 16, 2016 and subsequent thereto (*compare* Kimble Aff ¶¶ 5-11 *and* Plaintiff's Expert Affidavit ["Pl Ex Aff"] ¶¶ 7-14; *see also* Mitchell Aff ¶¶ 13-18 *and* DeGasperis Aff ¶¶ 4-12). The background set forth in those submissions is as follows:

On March 10, 2016, plaintiff was admitted to AMC complaining of abdominal pain and distention, frequent urination, painful menstrual periods, and alternating constipation and diarrhea (Kimble Aff ¶ 5; Pl Ex Aff ¶ 7). She was 17 years old at the time (DeGasperis Aff ¶ 1).

Initially, plaintiff was seen by a gastroenterologist (Kimball Aff ¶ 5; Pl Ex Aff ¶ 7). She underwent an ultra sound and computed tomography ("CT-scan") of the abdomen, which revealed a large cystic mass originating in the pelvis, as well as a smaller daughter cyst within the cyst with a small solid component (Kimble Aff ¶ 6; Pl Ex Aff ¶ 8). The cyst extended from the pelvis to the mid-abdomen and exerted pressure on the right kidney and ureter causing hydronephrosis (kidney swelling due to a build up of urine) and hydroureternephrosis (dilation of the ureter and part of the kidney) (Kimble Aff ¶ 6; Pl Ex Aff ¶ 8).

Based on the imaging results, plaintiff was admitted to AMC, and consulted with Dr. Kimble on March 11, 2016. Following this consultation, a decision was made to remove the cyst through laparoscopic surgery (Kimble Aff ¶ 8).

On March 16, 2016, plaintiff was readmitted to AMC for the laparoscopic left ovarian cystectomy (Pl Ex Aff ¶ 10; Kimble Aff ¶ 10). Dr. Kimble performed this surgery with assistance from then fourth-year resident, Dr. Tara A. (Renna) Lynch (Pl Ex Aff ¶ 10; Kimble Aff ¶ 10). Plaintiff was discharged from AMC the same day following the surgery, only to be readmitted again to AMC three days later with a suspected bladder perforation. Following examination, a stent was placed in her right ureter (Kimble Aff ¶ 11). On March 20, 2018,

plaintiff underwent a laparoscopic robotic repair of her bladder, which was performed by an AMC urologist, Dr. Badar Munier Mian, M.D. (Pl Ex Aff ¶ 14; Kimble Aff ¶ 11).

Plaintiff contends that the March 16, 2016 laparoscopic left ovarian cystectomy caused her to suffer injury to her ureter and a punctured bladder, as a result of negligence and medical malpractice on the part of defendants AMC and Dr. Kimble (DeGasperis Aff ¶¶ 2,17; Pl Ex Aff ¶ 21; *see also* Mitchell Aff, Exs D-E).

In support of defendants' summary judgment motion, they submit the affirmation of counsel; the affidavit of David Kimble, M.D. seeking to offer an expert opinion; the deposition transcript of Dr. Kimble ("Kimble Tr"); the deposition transcript of plaintiff ("plaintiff Tr"); the deposition transcript of non-party Valeria Tinoco, plaintiff's mother ("V. Tinoco Tr"); the deposition transcript of non-party Tara A. (Renna) Lynch, M.D. ("Lynch Tr"); the Affidavit of Dr. Badar Munir Mian; the AMC records of plaintiff's March 16, 2016 admission, as well as her AMC Ob/Gyn records; and portions of plaintiff's medical records from November 3, 2016, November 21, 2016 and March 27, 2017 (*see* Mitchell Aff, Exs F-Q).

These submissions indicate that on March 10, 2016, the date of plaintiff's first examination, her mother signed a "Consent for Procedure Form" (Mitchell Aff, Ex M at 19). Although Valeria Tinoco testified at her deposition that this form covered a disimpaction procedure performed that day (V. Tinoco Tr 17-18), the form itself states that it authorizes, *inter alia*, a "laparoscopic cystectomy" and "possible exploratory laparotomy." (*id.*).

Dr. Kimble's affidavit states that he is a New York licensed physician, board certified by the American Board of Obstetrics and Gynecology and employed by AMC (Kimble Aff ¶ 2). He evaluated plaintiff on March 11, 2016 and determined that she should undergo surgery to drain and remove the cyst (*id.* ¶ 8). He avers that he presented plaintiff and her mother with two options for the surgery, a laparotomy (an open procedure) which would leave a substantial scar and require longer recovery time, or a minimally invasive laparoscopic surgery (*id.*).

Dr. Kimble avers that he informed plaintiff of the risks for both procedures, which would include "bleeding, infection, injury to surrounding organs such as the bladder and ureters, injury to vascular structures, recurrence of the cysts, and in the case of a laparoscopic procedure, the possible need to convert to an open procedure" (*id.*; *see also* Kimble Tr 27-29). He also asserts that he advised plaintiff and her mother that the laparoscopic procedure would have to be

converted to an open procedure if the cyst could not safely be removed laparoscopically or if any malignancy was found (Kimble Aff ¶ 8).

According to Dr. Kimble, there was no evidence that the cyst was malignant and he recommended the laparoscopic procedure (Kimble Tr 26). He states that he spent approximately 45 to 60 minutes with plaintiff and her mother discussing the two procedures, and they eventually agreed with his recommended approach (Kimble Aff ¶ 8). In Dr. Kimble's opinion, he provided plaintiff and her mother with ample information regarding risks, benefits and alternatives to the laparoscopic procedure so they could make a knowing and informed decision on how to proceed with the removal of the cyst (Kimble Aff ¶ 8; Kimble Tr 24).

Dr. Kimble avers that on March 16, 2016, the morning of the surgery, he met with plaintiff and her mother to again discuss the surgery and address any further questions and concerns they might have (Kimble Aff ¶ 9). He asserts that both plaintiff and her mother again agreed with the planned laparoscopic procedure (*id.*). Plaintiff's mother then signed a second consent form authorizing the surgery (Mitchell Aff, Ex. M at 148).

At their depositions, neither plaintiff nor her mother recalled what they discussed with Dr. Kimble or the other physicians that they met with prior to the surgery as to the specific risks involved with a laparoscopic procedure (Plaintiff Tr 29-37; V. Tinoco Tr 15-23). Plaintiff testified that her surgical preference was for the laparoscopic surgery because she understood that it would result in the smallest incision (Plaintiff Tr 35).

The surgery lasted approximately three hours, with Dr. Kimble being assisted by Dr. Lynch (Kimble Aff ¶ 10). During the procedure, a catheter was inserted to drain plaintiff's bladder (*id.*). Following the administration of general anesthesia, Dr. Kimble performed a hands-on physical examination of plaintiffs abdomen. He felt the cyst extending out to the bottom of plaintiff's rib and estimated it to be about 40 centimeters in size (Kimble Tr 48-51). A spinal needle was then inserted into the abdomen and a syringe was used to drain fluid from the cyst and cause it to decompress (*id.*; Kimble Aff ¶ 10). During the insertion of the needle, Dr. Kimble was not able to see into the abdomen and no laparoscopic cameras or ports were being utilized at that time (Kimble Tr 51-52). After two liters of fluid had been drained from the cyst, it had decompressed enough to perform the laparoscopic portion of the surgery (Kimble Aff ¶ 10; Kimble Tr 53). Once the camera and tools were inserted into the abdomen, further drainage

occurred, and then Dr. Kimble and Dr. Lynch were able to remove the cyst and preserve plaintiff's ovary[1] (Kimble Aff ¶ 10).

According to Dr. Kimble, before the laparoscopy was completed he surveyed the contents of the pelvis and abdomen and did not see any sign of damage or injury to either of the ureters or the bladder (*id.*). He asserts that, during the laparoscopic procedure, none of the equipment came into contact with the bladder (Kimble Tr 81).

The AMC medical records submitted in support of defendant's motion contain an Operative Report from Dr. Mian, in which he describes the procedure he performed on plaintiff on March 19, 2016 (Mitchell Aff, Ex M at 333-335). The Report stated in relevant part:

> "a retrograde pyelogram was obtained, which did show a transition point in the right ureter and there may have been extravasation;[2] however this was unclear. However, it was clear that the ureter was more dilated above this transition with mild hydronephrosis" (*id.* 334).

The report also explains that the surgical team performed "a systemic inspection of the bladder . . . and were able to see a 1-1.5 cm circumferential defect in the posterior wall bladder with necrotic edges. Similar sized defect was seen in the anterior wall of the bladder" (*id*). In Dr. Mian's opinion, "it appeared that as if this was a port type versus robotic instrument versus Veress needle that went through-and-through the bladder. It appeared that an anterior hole was extraperitoneal and the posterior hole was definitely intraperitoneal" (*id.*). Dr. Mian repaired the bladder the next day on March 20, 2016 (*id.*; *see also* Mitchell Aff, Ex M at 330-332).

Dr. Kimble explains that his review of plaintiff's medical records revealed that, following the laparoscopic surgery, she had "a small defect in the base of the bladder and a very small one at the very top of the bladder" (*id.* 83). He denies, however, that it could definitively be established that these defects were perforations, although he acknowledged that Dr. Mian's post-operative note expressed an opinion that a defect was found in the anterior wall of the bladder that appeared as if it was caused by a port or robotic instrument or needle (*id.* at 83-85).

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[1] Following plaintiff's March 16, 2016 procedure, and subsequent bladder and ureter repair surgery, on November 21, 2016 she underwent what Dr. Kimble understood to be a second laparoscopic operation with Dr. Elliott Birnbaum to remove another ovarian cyst, which may have been a recurrence of the cyst that had been removed by Dr. Kimble or a new cyst that had developed (Kimble Aff ¶ 12). On March 27, 2017, plaintiff had to undergo a third ovarian cystectomy, which was an open procedure (laparotomy) with Dr. Birnbaum (*id.*).

[2] Extravasion is defined by the Collins English dictionary as "the escape of blood or lymph from their proper vessels into surrounding tissues" (*see* https://www.collinsdictionary.com/us/dictionary/english/extravasation).

Dr. Kimble opines that neither his ports nor needles were anywhere near the bladder, which is just below the pelvic bone (*id.* at 85, 92-93). He states that he does "[not] know how in the world [plaintiff] sustained a small one centimeter defect in the posterior wall of the bladder" (*id.* 82).

With regard to the March 16, 2016 laparoscopic procedure, Dr. Kimble denies that there was any identifiable injury to the plaintiff's bladder at the time of the surgery, as his inspection revealed "absolutely no evidence of any damage or injury to the bladder at that time" (Kimble Aff ¶ 13). Even assuming that his surgical procedure may have injured the bladder, Dr. Kimble contends that such an injury is not indicative of a departure from the accepted standards of care (*id.*). According to Dr. Kimble, who states that he is fully familiar with the standard of care for a board certified gynecologist performing ovarian mucinous cyst removal surgery, "it is well recognized in the field of gynecology that there can be injuries to adjacent organs such as the bladder and that such injuries can and do occur in the absence of any negligence or wrongdoing" (*id.*).

Dr. Kimble is also of the opinion that plaintiff did not suffer a right uretal injury from his surgical procedures because, he claims, there is no evidence of this injury (Kimble Aff ¶ 14). He explains that the need for a stent in the ureter was due to a benign condition that existed prior to the March 16, 2016 surgery, and points to the March 10, 2016 imaging that revealed hydronephrosis and dilation of the ureter as evidence of the pre-existing condition (*id.*). It is Dr. Kimble's position that Dr. Mian's post-operative note stating that the presence of an extravasation in the right ureter was "unclear" demonstrates that one cannot, to any degree of medical certainty, state that such an injury occurred during the surgery (*id.*). In the event there were proof of harm to plaintiff's right ureter, Dr. Kimble opines that such an injury is not indicative of any departure from accepted medical standards of care (*id.*).

While plaintiff claims that the March 16, 2016 laparoscopic surgery was contraindicated and that the standard of care required a laparotomy to be performed, Dr. Kimble contests the accuracy of these assertions, arguing that the laparoscopic procedure was consistent with the standard of care and its use was a reasonable exercise of medical judgment (Kimble Aff ¶ 21). Specifically, he expresses the view that the cyst did not present a malignancy concern, nor was it is so large as to require an open surgical procedure to reduce the risk of surgical complications (*id.* ¶¶ 28-29).

In response to plaintiff's claim that there was not adequate visualization of the large ovarian cyst and that the "blind" drainage of the cyst was improper, Dr. Kimble contends that he was able to adequately palpate the abdomen to ensure the needles would be placed directly into the cyst (*id.* ¶ 23). He also asserts that this technique "is a common, safe and accepted method for draining a cyst, and in no way represented a departure from the standard of care" (*id.*). He further explains that "the standard of care did not require that the cystic mass be removed in a single piece, and it was entirely appropriate to remove the mass in several pieces" (*id.*).

During her deposition, Dr. Lynch acknowledged that the method used to decompress the plaintiff's cyst could be referred to as a "blind" decompression, meaning it is not done via direct visualization or additional imaging (Lynch Tr 36). Dr. Lynch testified that it is her understanding that plaintiff sustained an injury to her bladder during the March 16, 2016 laparoscopic surgery and that the injury went from the front of the bladder to the back (*id.* at 54-55). Dr. Lynch was unsure what during the surgery caused the bladder injury; however, she agreed that it is possible that one or more pieces of medical equipment, such as a needle, may have been the cause (*id.*). Dr. Lynch further testified that she believes that plaintiff's readmission to AMC following the March 16, 2016 surgery was likely caused by the injuries that plaintiff sustained during the surgery that she and Dr. Kimble performed (*id.* at 56).

In opposition to defendants' motion, plaintiff submits an affirmation of counsel as well as a physician's affirmation seeking to offer expert opinion on plaintiff's behalf.[3]

Plaintiff's expert is licensed in New York and board certified in gynecologic oncology and in obstetrics and gynecology by the American Board of Obstetrics and Gynecology, with full membership in the Society of Gynecologic Oncologists (Pl Ex Aff ¶ 4). He has served as a clinical instructor at New York University School of Medicine, State University of New York's Health Science Center at Brooklyn, and Jefferson Medical College in Philadelphia (*id.* ¶¶ 1-3). The doctor attests that he routinely performs open radical surgical procedures for a range of gynecology malignancies as well as advanced laparoscopic and robotic surgeries including cancer staging and radical hysterectomy (*id.* ¶ 5).

As noted, plaintiff's expert states, based on his review of the AMC medical, that his professional opinion is that Dr. Kimble deviated from good and accepted standards of care in three ways, all of which were cited in plaintiff's bill of particulars (Mitchell Aff, Exs D-E).

[3] The name of the affiant has been redacted.

The first such deviation was in Dr. Kimball's "[1] . . . performing a "blind" percutaneous aspiration of Plaintiff's left ovarian cyst without adequate visualization . . ." (Pl Ex Aff ¶ 15). Plaintiff's expert contends that the "blind" aspiration of the cyst made it impossible for the surgeon "to know whether the adjacent anatomy was safely out of harm's way" (*id.* ¶ 16). Dr. Kimble's palpation of the abdomen, according to this view, would have provided only a limited sense of the tumor's position within the abdominal cavity and its overall size, shape and dimension (*id.*).

Second, the expert opines that Dr. Kimble deviated from the standard of care by "removing the tumor, which by all objective standards was extraordinarily large, via a laparoscopic procedure instead of a laparotomy . . ." (*id.* ¶ 15). According to plaintiff's physician, due to the large size of the cyst – at a preoperative measurement of 40 centimeters – a treating doctor's ability to determine what is sitting behind or adjacent the targeted mass is significantly obscured and the best approach would be a laparotomy – removing the cyst intact, not in pieces (*id.*). By choosing to perform the operation laparoscopically, plaintiff's expert states that Dr. Kimball caused plaintiff to sustain injuries to her bladder and right ureter during the "blind" drainage of the cyst (*id.* ¶ 21).

Third, the expert states that Dr. Kimball committed malpractice by "not removing the tumor intact" due to the chance of malignancy, even though the risk may have been low (*id.* ¶¶ 15, 18). Thus, Dr. Kimble deviated from the standard of care when he elected to drain the tumor. To the extent that the drainage was an acceptable risk, plaintiff's expert witness opines that it should have been performed under direct visualization, such as during a mini-laparotomy, or via image guided drainage (*id.* ¶ 15). The "blind" technique utilized, in plaintiff's doctor's opinion, increased the likelihood of inadvertent injury to the adjacent anatomy, including the bowel, bladder and other vascular structures (*id.* ¶ 19).

In a reply affirmation of counsel, plaintiff argues, *inter alia*, that plaintiff failed to demonstrate that any actions of defendants caused her injury; plaintiff's expert opinion regarding Dr. Kimball's lack of visualization was based on a "misunderstanding" of the fact that the camera provided direct visualization for "other aspects of the surgery" except drainage of the cyst; and the expert's calculation of the procedure's risks was based on his "concern about malignancy" notwithstanding that the mass at issue was not malignant (*see* Reply Aff ¶¶ 24-25).

Discussion

To obtain summary judgment, a movant must establish its position "sufficiently to warrant the court as a matter of law in directing judgment" in its favor (*Friends of Animals, Inc. v Associated Fur Mfrs.*, 46 NY2d 1065, 1067 [1979], quoting CPLR 3212[b]). The proponent of a summary judgment motion must initially make a prima facie showing of entitlement to judgment as a matter of law, by tendering sufficient evidence to eliminate any genuine material issues of fact from the case (*see Alvarez v Prospect Hosp.*, 68 NY2d 320, 324 [1986]). The failure to make such a showing mandates denial of the motion, regardless of the sufficiency of the opposing papers (*see Winegrad v New York Univ. Med. Ctr.*, 64 NY2d 851, 853 [1985]). If a prima facie showing is made, the burden shifts to the party opposing the motion for summary judgment to come forward with evidentiary proof in admissible form to establish the existence of material issues of fact which require a trial (*see Zuckerman v City of New York*, 49 NY2d 557, 562 [1980]).

As the proponents of a motion for summary judgment in a medical malpractice action, defendants bear the initial burden of establishing that the medical treatment rendered was within acceptable standards of care or that their actions did not injure plaintiff (*see Doucett v Strominger*, 112 AD3d 1030, 1031 [3d Dept 2013] [citation omitted]). Dr. Kimble and AMC may satisfy this burden "through a physician's affidavit or affirmation describing the facts in specific detail and opining that the care provided did not deviate from the applicable standard of care" or that any such deviation did not cause plaintiff's injury (*Randall v Kingston Hosp.*, 135 AD3d 1100, 1101 [3d Dept 2016] [internal quotation marks and citations omitted]). A defendant physician's own affidavit may also "'be sufficient to establish a prima facie entitlement to summary judgment where the affidavit is detailed, specific and factual in nature and does not assert in simple conclusory form that the physician acted within the accepted standards of medical care'" (*Suib v Keller*, 6 AD3d 805, 806 [3d Dept 2004], *quoting Toomey v Adirondack Surgical Assoc.*, 280 AD2d 754, 755 [3d Dept 2001]). If defendants meet their burden, plaintiff must rebut that showing on these elements to defeat summary judgment (*see Fridovich v David*, 188 AD2d 984, 985 [3d Dept 1992] [burden on plaintiff opposing summary judgment in medical malpractice action is "to establish not only a deviation or departure from accepted practice but also the requisite nexus between the malpractice allegedly committed by defendant . . . and the injury"] [citations, brackets and internal quotation marks omitted]).

Deviation from the standard of care, and proximate cause may only be proven by the testimony of a competent expert, unless the issue is "one which is within the experience of and observation" of a lay factfinder (*see Lyons v McCauley*, 252 AD2d 516, 517 [2d Dept 1998], *lv denied* 92 NY2d 814 [1998]). Moreover, "[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 [the] . . . summary judgment motion" (*Alvarez v Prospect Hosp.*, 68 NY2d at 325; *see also Snyder v Simon*, 49 AD3d 954, 956 [3d Dept 2008] [plaintiff failed to rebut defendant's prima facie case when its expert affidavits did "not identify or define the applicable standard of care, and fail[ed] to adequately set forth both the manner in which [defendant] deviated from the standard of care in treating plaintiff and the requisite nexus between that alleged malpractice and the injuries to plaintiff"]). However, in the case of medical malpractice, where causation is almost always a difficult issue, "plaintiff need do no more than offer sufficient evidence from which a reasonable person might conclude that it was more probable than not that the injury was caused by the defendant" (*Johnson v Jacobowitz*, 65 AD3d 610, 613 [2d Dept 2009], *lv denied* 14 NY3d 710 [2010] [citation omitted]).

With these standards in mind, I proceed to address the motion before me.

The crux of plaintiff's first and second causes of action against defendants is that Dr. Kimble was negligent in performing a laparoscopic procedure instead of a laparotomy, because the large size of the cyst displaced the plaintiff's internal anatomy to such an extent that the only safe way to remove it was through an open surgery. Furthermore, plaintiff contends that, in electing to drain the cyst with a needle without being able to visualize the displaced anatomy, Dr. Kimble further deviated from the acceptable standard of care due to the increased risk of an inadvertent injury to the adjacent anatomy.

Upon a review of defendants' submissions, I find that they have met their initial burden of establishing entitlement to summary judgment. Dr. Kimble is appropriately qualified as an expert in obstetrics and gynecological medicine and surgery, and he opines to a reasonable degree of medical certainty, based upon his review of the relevant medical records and pleadings, that the treatment he rendered comported with good and acceptable medical practice and did not cause plaintiff's injuries. He further explains that plaintiff's injuries, to the extent they may have been caused by his laparoscopic procedure, are a known and accepted risk and the occurrence of such is not evidence of a departure from the accepted standard of care (Kimble Aff

¶¶ 13-14). Moreover, Dr. Kimble's affidavit is supported by specific record evidence, and is not speculative or conclusory (*see Toomey*, *supra* [treating doctor's own affidavit explaining that patient's injury was a common complication during laparoscopic surgery, even when performed with appropriate surgical care, was sufficient to shift summary judgment burden to plaintiffs]).

The burden therefore passes to plaintiff to rebut defendants' showing. To meet this burden, plaintiff also submits the affidavit of an appropriately qualified expert in the relevant field. Plaintiff's expert offered an opinion, to a reasonable degree of medical certainty, based on his review of the relevant medical records and pleadings, that the large 40-centimeter cyst displaced plaintiff's anatomy to such a degree that laparoscopic surgery was an inappropriate procedure (Pl Ex Aff ¶ 15). The expert further opines that Dr. Kimble deviated from the accepted standard of medical care in failing to perform a laparotomy, which would have enabled him to visualize the location of plaintiff's bladder and ureter, thus avoiding the injuries that occurred during the "blind" drainage of the cyst (Pl Ex Aff ¶¶ 18-21). This affidavit sufficiently creates triable issues of material fact which must be resolved by a jury[4] (*see Toomey*, *supra* [finding that expert's medical affidavit opining that defendant physician deviated from the accepted standards of care when performing laparoscopic surgery that resulted in plaintiff's injuries was sufficient to deny summary judgment]).

On the issue of causation, plaintiff's expert affidavit alone is sufficient to raise a triable issue of fact, as it states with specificity that the decision to proceed laparoscopically created a "significant increase in the likelihood of inadvertent injury," and did in fact result in injury to plaintiff's bladder and right ureter (Pl Ex Aff ¶¶ 19, 21). In addition, Dr. Lynch testified that she believes that plaintiff's bladder injury occurred during the operation that she and Dr. Kimble performed on plaintiff (Lynch Tr 54-55). This testimony is in direct conflict with that of Dr. Kimble, who is of the opinion that plaintiff did not suffer any injury during the procedures he performed (Kimble Tr 81-85, 92-93; Kimble Aff ¶ 13). Such contradictory testimony between the two physicians who performed the surgery in question, as well as between the parties' experts, raises a factual question as to the causes of action for negligence and medical malpractice.

[4] Given that plaintiff has sufficiently rebutted defendant's prima facie case on the above bases, I need not address plaintiff's theory that Dr. Kimble also erred in not removing the tumor because there was a risk of malignancy.

In regard to the cause of action for lack of informed consent, plaintiff must ultimately prove three things: (1) that the person providing the professional treatment failed to disclose alternatives thereto and did not inform the patient of reasonably foreseeable risks associated with the treatment, and the alternatives, that a reasonable medical practitioner would have disclosed in the same circumstances, (2) that a reasonably prudent patient in the same position would not have undergone the treatment if she had been fully informed, and (3) that the lack of informed consent was a proximate cause of the injury (*see Foote v. Rajadhyax*, 268 AD2d 745, 745 [3d Dept 2000]; *see also* Pub Health Law § 2805-d [3] [for a cause of action to be established for lack of informed consent, it "must also be established that a reasonably prudent person in the patient's position would not have undergone the treatment or diagnosis if he had been fully informed and that the lack of informed consent is a proximate cause of the injury or condition for which recovery is sought"]).

Defendants support their motion on this cause of action through Dr. Kimble's affidavit and deposition testimony indicating that he properly informed plaintiff and her mother about the proposed laparoscopic procedure, as well as the availability of a laparotomy, along with the foreseeable risks and benefits of each (Kimble Tr 26-29; Kimble Aff ¶¶ 8-9). Further, defendants show that plaintiff's mother signed two separate consent forms for the laparoscopic surgery (Mitchell Aff, Ex. M at 19 and 148). This evidence establishes defendant's prima facie entitlement to judgment as a matter of law dismissing this cause of action (*see Zapata v Buitriago*, 107 AD3d 977, 979-80 [2d Dept 2013] [defendant made prima facie showing of entitlement to summary judgment on informed consent claim by submitting evidence demonstrating that he properly informed plaintiff about the procedure, the alternatives thereto, and the reasonably foreseeable risks and benefits]).

Plaintiff's submissions fail to contradict any of these assertions. Indeed, both plaintiff and her mother, in deposition testimony submitted by defendants, indicated that they did not recall the specific discussions they had with Dr. Kimble and the other AMC physicians and staff concerning the risks of the medical options offered to them (Plaintiff Tr 29-37; V. Tinoco Tr 15-23). Further, neither the affidavit of plaintiff's expert nor the affirmation of plaintiff's counsel's address this aspect of defendant's motion. As a result, plaintiff has failed to raise a triable issue of fact on her cause of action based on lack of informed consent (*see Rivera v Anilesh*, 32 AD3d 202, 204-205 [1st Dept 2006] [affirming grant of summary judgment on informed consent claim,

in part, based on plaintiff's failure to address issue in opposition papers]). Therefore, I will grant defendants summary judgment on this cause of action.

Accordingly, it is hereby **ORDERED** that defendants' motion for summary judgment on plaintiff's first and second cause of action for negligence and medical malpractice is denied; and it is further

ORDERED that defendants' motion for summary judgment on plaintiff's third cause of action for lack of informed consent is granted.

This constitutes the Decision & Order of the Court. This Decision & Order is being transmitted to the County Clerk for filing. The signing of this Decision and Order shall not constitute entry or filing under CPLR Rule 2220, and counsel is not relieved from the applicable provisions of that Rule respecting filing, entry and Notice of Entry.

ENTER.

Dated: October 16, 2018
Albany, New York

David A. Weinstein
Acting Supreme Court Justice

10/18/18 AB

Papers Considered:

1. Notice of Motion, dated June 15, 2018; Affirmation of Lia B. Mitchell, Esq. in Support of Summary Judgment Motion, dated June 15, 2018, with annexed exhibits; and Memorandum of Law, dated June 15, 2018;

2. Affidavit of David Kimble, M.D., sworn to on June 13, 2018;

3. Affirmation of John A. DeGasperis, Esq. in Opposition to Summary Judgment Motion, dated August 3, 2018; and Physician's Affirmation, dated August 3, 2018; and

4. Reply Affirmation of Lia B. Mitchell, Esq., dated August 16, 2018.