Youssef v Fayez Guirguis, M.D.
2019 NY Slip Op 33390(U)
November 1, 2019
Supreme Court, Kings County
Docket Number: 510249/2016
Judge: Bernard J. Graham
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SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF KINGS: Part 36

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BOOSEY YOUSSEF as Parent and Natural Guardian of E.A. an Infant, and BOOSEY YOUSSEF Individually,

Plaintiff,

-against-

FAYEZ GUIRGUIS, M.D., PETER GUIRGUIS, M.D., NEW YORK METHODIST HOSPITAL, THE GUIRGUIS OBSTETRICS & GYNECOLOG GROUP OF BROOKLYN, GUIRGUIS OBSTETRICS & GYNECOLOGY, P.L.L.C., and GUIRGUIS HOLDINGS, L.L.C.,

Defendants.

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Index No.: 510249/2016

DECISION/ORDER

Hon. Bernard J. Graham
Supreme Court Justice

Recitation, as required by CPLR 2219(a), of the papers considered in the review of this Motion:

Papers	**Numbered**
Defendant's Motion for Summary Judgment and Affirmation in Support ...	1-2
Plaintiff's Affirmation in Opposition..	3
Defendant's Reply Affirmation...	4

Upon the foregoing cited papers, the Decision/Order on this application is as follows:

Decision:

Defendant New York Methodist Hospital ("NYMH") submits the instant motion for summary judgment pursuant to §3212 of the CPLR to dismiss the plaintiff's complaint on the grounds that it did not depart from accepted medical practice in the care and treatment rendered to the plaintiff, Boosey Youssef ("Ms. Youssef"), and the infant-plaintiff E.A ("infant E.A."), and that any alleged departure was not the proximate cause of the infant's alleged injuries.

Alternatively, defendant moves for partial summary judgment dismissing plaintiff's claims as to the neonatal care of the infant E.A.

In addition, defendant Peter Guirguis, M.D. submits a motion for summary judgment pursuant to §3212 of the CPLR to dismiss the plaintiff's complaint against him. Dr. Peter Guirguis' motion for summary judgment is unopposed by plaintiff's counsel, and as such, the Court grants his motion and dismisses plaintiff's complaint against Dr. Peter Guirguis.

Plaintiff, Ms. Youssef, by her attorneys, opposes the motion for summary judgment filed on behalf of defendant NYMH, asserting there are triable issues of fact as to whether NYMH departed from accepted medical practice in the care and treatment rendered to Ms. Youssef and E.A., and that those departures were a substantial factor in causing the significant injuries sustained by the infant E.A. Argument was heard in Part 36 of this Court on September 26, 2019 before the undersigned.

Facts:

Plaintiff, a thirty-three-year-old woman, presented to NYMH on December 16, 2013 at 4:22pm by the referral of her private physician, Dr. Fayez Guirguis, to rule out preeclampsia. At the time she was thirty-eight weeks and three days pregnant. Ms. Youssef was evaluated by an obstetrical triage attending physician (Dr. Santo Fianscaro), a resident physician (Dr. Talib), and was then admitted to NYMH under Dr. Fayez Guirguis' care. Ms. Youssef was placed on a fetal heart monitor and was diagnosed with preeclampsia with Category II tracings.[1]

[1] Category II tracings are defined as tracings that are neither Category I (normal) or Category III (abnormal). Category II can include tracings that indicate a variety of circumstances. ACOG guidelines state that Category II tracings are indeterminate and require evaluation and surveillance, considering all clinical circumstances.

At 5:00pm Ms. Youssef was having contractions every two to three minutes, lasting forty to seventy seconds of moderate intensity. The fetal heart monitor showed a baseline heart rate of 140 that was reactive, with moderate variability, including abrupt accelerations and late but variable decelerations. In response, the NYMH staff turned Ms. Youssef on her left side and increased fluids, and as a result the tracings improved. At 5:04pm the NYMH staff started Ms. Youssef on penicillin as a prophylactic measure to prevent early onset Group B Strep positive and continued to monitor both her contractions and the fetal heart rate. The fetal heart rate at 6:00pm was momentarily non-reactive, but the baseline was within the normal range (110-160), with minimal variability, no accelerations, and some late decelerations. At this point the resident, Dr. Talib, noted Ms. Youssef was three centimeters dilated, fifty-percent effaced at -2 station, with a cephalic presentation. The fetal heart tracings, which were still Category II, were addressed by the NYMH staff in the same manner as before—by increasing Ms. Youssef's fluids and repositioning her on her right side—which resulted in improvement of the fetal heart tracings. At 6:30pm the fetal heart rate was non-reactive, there was minimal variability, no accelerations and late decelerations. At 6:33pm she was evaluated by the resident, Dr. Talib, who developed the plan to admit her to labor and delivery, obtain labs, continue monitoring, keep her NPO, start IV fluids, analgesia as needed, and to discuss her progress with her private physician, Dr. Fayez Guirguis, who was monitoring Ms. Youssef remotely from his office.

Ms. Youssef was admitted to labor and delivery at 7:30pm and was monitored by the nursing staff until 11:00pm. At that time, the fetal heart strips reported a baseline in the 140's with moderate variability, accelerations present, but no decelerations. Dr. Fayez Guirguis arrived at NYMH at about 10:30pm and allowed Ms. Youssef to continue with labor until 12:43am, when she was transferred to the operating room for a c-section. Dr. Fayez Guirguis performed

the c-section, with assistance from Dr. Sticco, at 1:11am. Upon delivery, the infant E.A.'s Apgar scores[2] were four, seven, and eight at one, five, and ten minutes respectively. He had non-reassuring fetal tracing and thick meconium. The infant E.A.'s cord blood tests demonstrated a pH of 7.09 (7.14-7.42) with a base excess of -8.8 (7.8-2.6), and a venous cord blood gas pH of 7.2 (7.21-7.46) and base excess of -7.7 (-6.9-1.9). It was noted that Ms. Youssef tolerated the c-section well, however the infant E.A. was non-vigorous at birth and required tracheal suction x2, retrieving meconium below the cords, followed by twenty-two seconds of positive pressure ventilation.

Due to his persistent low oxygen saturation and retraction, as well as tachypnea (rapid breathing), the infant E.A. was admitted to NICU. Upon admission, his diagnosis was transient tachypnea of a newborn with respiratory distress syndrome, hypoglycemia meconium stained amniotic fluid, large for gestational age, and moderate meconium aspiration. The plan was to perform a chest x-ray, test blood gasses, place him on a CPAP, follow-up on CBC differential, take blood cultures, monitor respiratory status, and echo starting on IV fluids. The infant E.A. was also seen by cardiology. On December 18, the infant E.A. was weaned off CPAP, and was receiving antibiotics empirically for sepsis. At this point he was assessed as a full-term infant with resolving respiratory distress, meconium stained amniotic fluid, thrombocytopenia (low platelet count), leukopenia, and neutropenia (low white blood count).

Ms. Youssef was discharged on December 20, 2013, and the infant E.A. remained at NYMH. On December 22, 2013, the infant E.A. had multiple episodes of desaturation. The staff also suspected bradycardia that required stimulation, due to the infant E.A.'s cyanotic color

[2] The Apgar scoring system is a standardized and rapid method of assessing a newborn's clinical status consisting of five components: (1) color; (2) heart rate; (3) reflexes; (4) muscle tone; and (5) respiration. Each component is scored 0-2, at one minute after birth and five minutes after birth, and consecutively every twenty minutes for infants with a score of less than seven.

change and abnormal eye movements. He was transferred to isolation and started on Acyclovir and Cefotazime for suspected sepsis and to rule out HIV infection. That evening, the infant E.A. developed frequent apneic episodes, which the neurologist attributed to a potential central nervous system infection, stroke, or seizure. On December 23, 2013 the neurologist recommended a twenty-four-hour video EEG to rule out seizures and an MRI of the brain to rule out stroke and infections, as well as an ID consult for infectious disease. The pediatric neurologist performed the video epilepsy monitoring on December 24, 2013, which was noted as abnormal due to findings of paucity of active sleep, prolonged run of left temporal spikes, and twenty electrographic seizures lasting from thirty-nine to 111 seconds. Some of these events were accompanied by staring and behavioral arrest or biclonic activity of the left and right arm. Such an abnormal EEG indicates diffuse cerebral dysfunction with epileptic potential, particularly in both central and left temporal regions. The brain MRI showed extensive diffuse restriction involving bilateral periventricular and subcortical white matter, as well as multiple microhemorrhages within the bilateral parietal periventricular white matter and centrum semiovale. The neurologist noted the MRI results revealed diffuse white matter changes, with no significant involvement in grey mater, raising the possibility of leukodystrophies,[3] as well as hypoxic ischemic encephalopathy or congenital infections. The infant E.A. was transferred to Columbia University Medical Center on December 27, where he was evaluated over the course of three days by various specialists. The doctors at Columbia attributed various causes to the infant E.A.'s injuries, including a hypo-perfusion injury, partial hypoxic injury, or neonatal hypoglycemia.

[3] Leukodystrophies are a group of rare, progressive metabolic genetic diseases that affect the brain, spinal cord, and often the peripheral nerves.

Discussion:

A defendant moving for summary judgment in a case sounding in medical malpractice "must make a prima facie showing either that there was no departure from accepted medical practice, or that any departure was not a proximate cause of the plaintiff's injuries." Guctas v Pessolano, 132 AD3d 632, 633 [2d Dept. 2015], quoting Matos v Khan, 119 AD3d 909, 910 [2d Dept. 2014]. Once the movant has made a prima facie showing, the plaintiff must submit evidence in opposition to rebut the movant's prima facie showing. Alvarez v Prospect Hosp., 68 NY2d 320 [1986]; Poter v Adams, 104 AD3d 925 [2d Dept. 2013]; Stukas v Streiter, 83 AD3d 18 [2d Dept. 2011]. The plaintiff must "lay bare her proof and produce evidence, in admissible form, sufficient to raise a triable issue of fact as to the essential elements of a medical malpractice claim, to wit, (1) a deviation or departure from accepted medical practice, [and/or] (2) evidence that such a departure was a proximate cause of injury." Sheridan v Bieniewicz, 7 AD3d 508, 509 [2d Dept. 2004]; Gargiulo v Geiss, 40 AD3d 811-812 [2d Dept. 2007]. In order to prevail on a claim for medical malpractice, "expert testimony is necessary to prove a deviation from accepted standards of medical care and to establish proximate cause." Nicholas v Stammer, 49 AD3d 832-833 [2008].

In addressing the issue of proximate cause, the Court notes that "in a medical malpractice action, where causation is often a difficult issue, a 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 Jamaica Hosp. Med. Ctr., 21 AD3d 881, 883 [2d Dept. 2005], quoting Holton v Sprain Brook Manor Nursing Home, 253 AD2d 852 [2d Dept. 1998]. "A plaintiff's evidence of proximate cause may be found legally sufficient even if his or her expert is unable to quantify the extent to which the defendant's act or omission decreased the

plaintiff's chance of a better outcome or increased the injury, as long as evidence is presented from which the jury may infer that the defendant's conduct diminished the plaintiff's chance of a better outcome or increased the injury." Semel v Guzman, 84 AD3d 1054, 1055-1056 [2d Dept. 2011], quoting Goldberg v Horowitz, 73 AD3d 691, 694 [2d Dept. 2010], quoting Alicea v Liguori, 54 AD3d 784, 786 [2d Dept. 2008].

Here, the court is presented with the issue as to whether the defendant NYMH deviated from or departed from accepted medical practice in the care and treatment rendered to Ms. Youssef and infant E.A., and if so, whether that departure from accepted medical practice was the proximate cause of the injuries that allegedly occurred.

In support of the motion for summary judgment, defendant NYMH, by its attorneys, relies upon the opinions of medical experts Dr. Muscciolo and Dr. Ellington. The defendant argues that NYMH is not vicariously liable for the actions of Dr. Fayez Guirguis, as he was Ms. Youssef's private physician and was not an employee of NYMH. Dr. Muscciolo asserts that Dr. Fayez Guirguis was documented as Ms. Youssef's private attending and was therefore responsible for any and all decisions regarding Ms. Yousef's care. According to Dr. Muscciolo, the management of labor and delivery of a private patient is the responsibility of the private attending, and as such, hospital staff can make recommendations, but the private attending is ultimately responsible for making decisions.

In addition, defendant NYMH asserts that there are no triable issues of fact with respect to the treatment rendered by NYMH staff during Ms. Youssef's labor and delivery. Dr. Muscciolo opines that the hospital appropriately intervened when the tracings on the fetal heart strips showed decelerations, and the decelerations responded to the interventions. According to Dr. Muscciolo, the appropriate interventions for Category II tracings include changing the

position of the patient, increasing IV fluids, and supplemental oxygen, all of which were performed by the NYMH staff. Since the tracings made adequate recovery after the interventions, Dr. Muscciolo claims there was no need for further interventions or emergent delivery. Further, Dr. Muscciolo notes that Ms. Youssef's private physician, Dr. Fayez Guirguis, was satisfied with her progression because he did not call for a c-section upon his arrival at the hospital at 10:30pm. (See Dr. Muscciolo Aff., annexed to defendant's motion for summary judgment, p. 7.)

With respect to the infant E.A., the defendant asserts that there was no departure from the standard of care regarding his delivery and subsequent treatment, and therefore no triable issues of fact. It is Dr. Muscciolo's opinion, which Dr. Ellington concurs with, that the cord gasses and Apgar scores of the infant E.A. point to other causes of the infant's injuries, rather than plaintiff's theory of a hypoxic ischemic event. Despite being monitored and evaluated by various specialists, Dr. Muscciolo asserts the causes of the infant E.A.'s conditions remained unclear. Dr. Ellington asserts that the placental pathology report is abnormal and suggestive of a chronic utero-placental issue, and that the alleged injuries sustained by the infant E.A. most likely occurred prior to Ms. Youssef's arrival at NYMH. In support, Dr. Ellington offers his opinion that the December 24 brain MRI does not represent a typical MRI of an infant who suffered a hypoxic injury. According to Dr. Ellington, a hypoxic injury is something that typically occurs over the span of ten to thirty minutes, evidence of which would be seen throughout the infant's brain. The fact that the infant E.A.'s MRI shows microhemorrhages that are limited to the white matter only indicates, to Dr. Ellington, that this is not a typical hypoxic injury. Dr. Ellington further explains that various abnormal lab results would be expected if the infant E.A. were suffering from a hypoxic birth injury. Dr. Ellington states doctors would typically look to liver

function tests, platelet counts and blood gasses, which would display certain patterns and trends in an infant with HIE. Here, Dr. Ellington asserts, the infant's blood work did not follow that pattern, which suggests a cause other than a birth injury. Further, Dr. Ellington claims that the pathology report shows an extremely abnormal placenta, one that was suggestive of an insult that occurred during the prenatal period rather than during the course of the labor and delivery. It is Dr. Ellington's opinion that this report suggests chronic ischemia is the cause of infant E.A.'s injuries rather than an acute birth injury. (See Dr. Ellington Aff., annexed to defendant's motion for summary judgment, pp. 34.)

As to the meconium present at birth, Dr. Ellington argues this is neither indicative of malpractice or malfeasance, nor the condition of meconium aspiration syndrome. To be diagnosed with meconium aspiration syndrome, according to Dr. Ellington, the infant would need to have other clinical signs of the syndrome, such as sustained labored breathing, retractions, grunting sounds, or airway obstruction. Here, Dr. Ellington claims the chest x-rays did not show meconium in the lungs or any other symptoms of meconium aspiration syndrome. Rather, following the delivery, Dr. Ellington asserts the neonatologist properly aspirated/suctioned the meconium upon delivery, there was no indication for the administration of a Surfacant, and the infant E.A. was not intubated. (See Dr. Ellington Aff., annexed to defendant's motion for summary judgment, pp. 36.)

Dr. Muscciolo maintains the treatment of the infant E.A., as well as his mother Ms. Youssef, for Group B Strep was within the standard of care. The Group B Strep treatment was administered prophylactically, and the blood cultures taken were negative, indicating the infant E.A. did not suffer Group B Strep or any other infection.

Dr. Ellington asserts that there was no indication for brain-cooling treatment[4] for the infant E.A. Based on the infant E.A.'s blood gasses (pH 7.09) and Apgar scores (greater than seven at five minutes), Dr. Ellington maintains there was no evidence of HIE at birth. Further, Dr. Ellington argues that there was no indication to access or correct an acid base balance or administer bicarbonate, because the infant E.A. was not acidotic.[5] According to Dr. Ellington, a base excess of -12 is accepted as a threshold risk for brain injury, and there is a debate as to whether bicarbonate is even an appropriate treatment.

Plaintiff's opposition to defendant's motion to dismiss:

Plaintiff, Ms. Youssef, by her attorneys, opposes the motion for summary judgment, claiming NYMH departed from the accepted standard of medical care when the hospital staff entered inaccurate fetal heart monitor data and failed to administer anticonvulsant medication when the infant E.A.'s seizure activity was first observed. In opposition to the motion, plaintiff asserts there still exists a question of fact as to the cause of the infant E.A.'s injuries.

Plaintiff's medical expert, Dr. Brickner, states the standard of care for recording fetal heart monitor data is to "accurately chart patient data and inform the attending physician of the patient's condition whether the doctor is physically present within the hospital or is monitoring the patient from the outside." (See Dr. Brickner Affirmation, submitted in support of plaintiff's Affirmation in Opposition, p. 7). Dr. Brickner asserts that the first departure from the standard of care was NYMH's staff's failure to accurately chart the series of late decelerations between 7:30pm and 10:30pm on December 16, 2013. The inaccurate chart entries describing the fetal

[4] Brain-cooling is used in an infant displaying clear signs of hypoxic ischemic encephalopathy ("HIE"). Such treatment would typically start within six hours of life and be maintained for seventy-two hours.
[5] Tests to determine this would include blood testing on the cord blood for pH and base deficit.

heart monitor strips, which Dr. Fayez Guirguis was relying on as he monitored Ms. Youssef remotely, delayed the infant E.A.'s delivery for several hours, extending his exposure to placental insufficiency, late heart rate decelerations, decreased cerebral perfusion and hypoxia/ischemia. In addition, Dr. Brickner claims it was also a departure from the standard of care for NYMH's staff to fail to appropriately react earlier to the Category II fetal heart rate that developed after 6:30pm. Based on the Category II fetal heart rate pattern at 6:30pm—which Dr. Brickner claims did not improve with resuscitation measures such as change in position, oxygen, and increased IV fluids—the delivery of the infant E.A. was indicated by no later than 7:30pm. The record reflects that the infant was not delivered until 1:11am. Plaintiff's other medical expert, Dr. Sims, agrees with Dr. Bricker and states that, based upon the fetal heart monitor data, the infant E.A. was exposed to several hours of intrauterine asphyxia. Dr. Bricker asserts that this prolonged exposure to a hypoxic/ischemic environment was due to NYMH's staff's failure to accurately interpret and record the fetal heart monitor data, which therefore proximately caused the infant's neurological injuries. Further, Dr. Sims claims that the fetal heart monitor tracings, in addition to the infant E.A.'s central depression at birth, cord acidosis, and clinical course at NYMH (which included seizures and IR studies) suggests the infant E.A. sustained HIE before birth.

Dr. Sims asserts that it was a departure from the standard of care for NYMH staff to withhold anticonvulsant medication on December 22, 2013, which resulted in seizures continuing the following day. (See Dr. Sims Aff., annexed to plaintiff's opposition, p. 4.) These seizures exacerbated or compounded the hypoxic ischemic brain injury that Dr. Sims claims was already present at birth. While the contribution of seizures to the injury that was later depicted on the infant E.A.s brain MRI studies cannot be measured, Dr. Sims argues the seizures were more

likely than not a substantial contributing factor in the microhemorrhages and white matter damage shown. Dr. Brickner notes that the EEG on December 23 – 24 showed twenty electrographic seizures, and the brain MRI on December 24 showed extensive diffusion restriction on the diffusion weighted imaging. According to Dr. Brickner, these results are strong evidence of perinatal HIE. Dr. Sims rejects the opinion of Dr. Ellington that the injury to the infant E.A. occurred before birth and argues that the deteriorating status of the fetus during labor is entirely consistent with the placental pathology findings. It is Dr. Sim's contention that the infant E.A. was a normal fetus upon entering NYMH, and that because of the prenatal course of preeclampsia he remained in a hostile situation for hours, resulting in hypoxic-ischemic encephalopathy and subsequent deficits. Due to the lack of diagnosing and appreciating the seizures in a timely way, and lack of treatment for the seizures, Dr. Sims claims NYMH contributed to the infant E.A.'s adverse outcome.

In its reply to plaintiff's opposition, the defendant asserts plaintiff's theory that NYMH failed to appropriately monitor and evaluate Ms. Youssef is incorrect, as is plaintiff's allegation that, had Ms. Youssef been more closely monitored, co-defendant Dr. Fayez Guirguis would have delivered the infant sooner. Defendant NYMH claims this argument must fail because Dr. Fayez Guirguis waited seventy minutes after his arrival at the hospital to deliver the infant E.A., despite having examined Ms. Youssef and having access to the fetal heart strips. Further, defendant NYMH argues the plaintiff's theory that NYMH staff failed to appreciate the infant E.A.'s seizure disorder and failed to appropriately treat the infant E.A. for seizures must also fail, given that plaintiff's expert Dr. Sims concedes the seizures resolved and were not observed again, and the brain imaging taken before and after the initial observation of the seizures remained essentially the same.

This Court finds that the plaintiff has raised triable issues of fact as to the treatment rendered to Ms. Youssef which conflict with defendant's experts' opinions, sufficient to warrant denial of summary judgment and a dismissal of the causes of action pertaining to claims of malpractice as to NYMH. See Contreras v Adeyemi, 102 AD3d 720, 721 [2d Dept. 2013]; Shahid v NYC Health & Hosps. Corp., 47 AD3d 798 [2d Dept. 2008]).

In reaching this determination, the Court considered the defendant's argument that the NYMH staff are not responsible for the treatment rendered by private attending physician Dr. Fayez Guirguis. This Court also considered the defendant's contention that the Category II tracings needed to be evaluated in the context of all clinical circumstances, and that the NYMH staff intervened with appropriate treatment. This Court considered defendant's argument regarding the absence of evidence that would typically indicate a hypoxic ischemic injury. This Court further considered defendant's assertion that an extremely abnormal placenta caused chronic ischemia, which injured the infant E.A. prior to birth.

These arguments and defenses were likewise rejected by the plaintiffs, who offered two expert opinions as to the alleged negligence of NYMH and the departures that occurred. This Court considered the assertion by plaintiff that the entries made by NYMH staff regarding the fetal heart monitor strips were inaccurate, which plaintiff claims delayed the infant E.A.'s delivery for several hours, to his detriment. This Court also considered plaintiff's contention that the NYMH staff should have reacted earlier to the Category II tracings. This Court further considered plaintiff's argument that anticonvulsant medication should have been administered to the infant E.A. to prevent further seizures.

The Court recognizes that a patient admitted to the hospital by their personal attending physician "is a private" and not considered the patient of the hospital and its employee doctors.

Rodrigo v Brookdale Hospital, 194 AD2d 774 [2d Dept. 1993]. Under such circumstances, the hospital does not control the private patient's course of treatment and, in the absence of an employment relationship between the physician and the hospital, the hospital cannot be legally responsible for the actions of the private physician (see Rodrigo v Brookdale Hospital, 194 AD2d at 774; Hicks v Fraser Clinic 169 AD2d 558 [1st Dept. 1991]). When treatment is rendered by a private attending physician, not an employee of the hospital, the general rule is that the hospital is not liable for the acts of malpractice which are committed in carrying out the independent physician's orders (see Sarivola v Brookdale Hospital & Med. Center, 204 AD2d 245 [1st Dept. 1994]).

However, it is well settled that where parties to a medical malpractice action offer conflicting expert opinions on the issue of malpractice and causation, issues of credibility require resolution by the factfinder (see Loaiza v Lam, 107 AD3d 951, 953 [2013]; Omane v Sambaziotis, 150 AD3d 1126, 1129 [2d Dept. 2017]; Dandrea v Hertz, 23 AD3d 332, 333 [2005]). Summary judgment is not appropriate in a medical malpractice action where the parties adduce conflicting medical opinions (see Elmes v Yelon, 140 AD3d 1009, 1011 [2d Dept. 2016], Feinberg v Feit, 23 AD3d 517, 519 [2d Dept. 2005]; Shields v Baktidy, 11 AD3d 671, 672 [2d Dept. 2014]). Here, the plaintiff's medical experts have pointed to possible departures by the hospital staff as to fetal monitoring and administering anticonvulsant medication, which raises a factual issue that would require a jury determination.

With regard to proximate cause, where causation is often a difficult issue, a plaintiff need do no more than offer sufficient evidence from which a reasonable person might conclude that it was more probable than not the injury was caused by the defendant (see Johnson v Jamaica Hosp. Med. Ctr., 21 AD3d 881, 883 [2005]) quoting Holton v Sprain Brook Manor Nursing

Home, 253 AD2d 82 [1998], lv. Denied 92 NY2d 818 [191]). The plaintiff opposing a defendant physician's motion for summary judgment must only submit evidentiary facts or materials to rebut the defendant's prima facie showing (see Stukas v Streiter, 83 AD3d 18, 24-26 [2d Dept. 2011]).

Conclusion:

While the defendant has met its burden for establishing a prima facie case for summary judgment, the plaintiff, in opposition, has met its burden to offer admissible evidence raising a question of fact as to whether NYMH departed from good and acceptable medical practice in the treatment of Ms. Youssef. The issue of credibility regarding conflicting expert testimony must be submitted to the trier of fact. Accordingly, the motion by defendant NYMH for summary judgment and a dismissal of plaintiff's complaint, pursuant to CPLR §3212, is denied.

The plaintiff's attorneys have conceded during oral argument that informed consent is no longer a part of this cause of action. Accordingly, the plaintiff's claim for lack of informed consent is dismissed. As aforesaid, the complaint against Dr. Peter Guirguis is dismissed without opposition.

This shall constitute the decision and order of this Court.

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KINGS COUNTY CLERK
FILED

Dated: November 1, 2019
Brooklyn, NY

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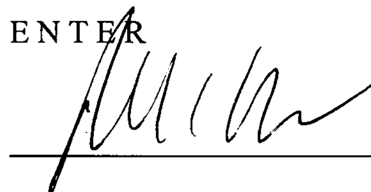

Hon. Bernard J. Graham, Justice
Supreme Court, Kings County

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