Merhige v Close
2021 NY Slip Op 31753(U)
May 20, 2021
Supreme Court, New York County
Docket Number: 805628/2015
Judge: John J. Kelley

SUPREME COURT OF THE STATE OF NEW YORK
NEW YORK COUNTY

PRESENT: HON. JOHN J. KELLEY **PART** IAS MOTION 56EFM

Justice

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ELIAS MERHIGE and NADJA MERHIGE,

Plaintiffs,

- v -

LANNY GARTH CLOSE, M.D., LUKE DONATELLI, M.D., and NEW YORK-PRESBYTERIAN HOSPITAL/THE UNIVERSITY HOSPITAL OF COLUMBIA AND CORNELL,

Defendants.

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INDEX NO. 805628/2015

MOTION DATE 03/30/2021

MOTION SEQ. NO. 001

DECISION + ORDER ON MOTION

The following e-filed documents, listed by NYSCEF document number (Motion 001) 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73

were read on this motion to/for SUMMARY JUDGMENT.

In this action to recover damages for medical malpractice based on departures from good medical practice and lack of informed consent, and to recover for negligent hiring, supervision, and credentialing, the defendants move pursuant to CPLR 3212 for summary judgment dismissing the complaint. The plaintiffs oppose the motion. The motion is granted to the extent that the complaint is dismissed insofar as asserted against the defendants Luke Donatelli, M.D., and New York-Presbyterian Hospital/The University Hospital of Columbia and Cornell (NYPH), and the causes of action to recover for lack of informed consent and negligent hiring, supervision, and credentialing are dismissed as against the defendant Lanny Garth Close, M.D., as well. The motion otherwise is denied, and the plaintiffs may proceed on the causes of action that are premised on allegations that Close departed from good and accepted medical practice.

The plaintiffs allege that the defendants departed from good and accepted medical practice in connection with a September 13, 2013 sinus surgery performed on the plaintiff Elias Merhige (the patient) at NYPH. Close, a private attending otolaryngologist and head and neck

surgeon, performed the procedure, assisted by Donatelli, a third-year resident at NYPH. While in the recovery room after the procedure, the patient developed a retro-orbital hemorrhage. As a result of the hemorrhage, the patient required additional surgeries and therapies, and developed permanent vision impairment. The plaintiffs' primary claim is that, by engaging in the improper and overly aggressive use of a microdebrider during the surgery, Close cut through the patient's lateral rectus muscle and/or ethmoid bone, thus causing bleeding into the patient's left orbital area. The complaint and bills of particulars also include allegations that the defendants failed to obtain the patient's informed consent, and that NYPH negligently hired, supervised, and credentialed its employees. The complaint and bills of particulars also set forth derivative claims asserted on behalf of the patient's wife, Nadja Merhige.

The court agrees with the defendants that the claims against Donatelli must be dismissed. The defendants established that Donatelli was a resident who assisted with the subject surgery under the direct supervision of a private attending physician and that he did not exercise any independent medical judgment. The plaintiffs failed to raise a triable issue of fact in opposition to that showing. Moreover, the defendants established that Donatelli properly followed Close's orders at all times during the surgery, and that none of those orders were clearly contraindicated. The plaintiffs failed to raise a triable issue of fact in opposition to that showing as well.

As to the claims against NYPH, the defendants established, prima facie, that NYPH's employees properly fulfilled their responsibilities before, during, and after the surgery, and that they engaged in no independent act or omission that caused or contributed to the injuries alleged by the patient. In opposition to that showing, the plaintiffs failed to raise a triable issue of fact. Hence, like Donatelli, NYPH cannot be found liable for Close's negligent acts or omissions. The defendants also established their prima facie entitlement to judgment as a matter of law dismissing the negligent hiring, supervision, and credentialing cause of action by showing, in the first instance, that there was no underlying negligence on the part of its

employees, but also by demonstrating that Close was properly credentialed, and that it did not know, nor should it have known, that Donatelli had a propensity for the conduct causing the patient's injury. Again, the plaintiffs raised no triable issue of fact in opposition to that showing.

Although the defendants made a prima facie showing that Close did not depart from good and accepted medical practice by submitting expert testimony that he correctly determined that patient was a candidate for the surgery, properly performed the sinus surgery, and quickly recognized and responded to the bleed, the plaintiffs raised a triable issue of fact through their expert's affirmation that Close's improper and overly aggressive debridement constituted a departure from good practice and proximately caused the patient's injuries.

Nonetheless, the defendants, including Close, demonstrated that they obtained the patient's informed consent to the procedure, and the plaintiffs failed to raise a triable issue of fact in opposition to the defendants' showing in that regard.

It is well settled that the movant on a summary judgment motion "must make a prima facie showing of entitlement to judgment as a matter of law, tendering sufficient evidence to eliminate any material issues of fact from the case" (*Winegrad v New York Univ. Med. Ctr.*, 64 NY2d 851, 853 [1985] [citations omitted]). The motion must be supported by evidence in admissible form (*see Zuckerman v City of New York*, 49 NY2d 557, 562 [1980]), as well as the pleadings and other proof such as affidavits, depositions, and written admissions (*see* CPLR 3212). The facts must be viewed in the light most favorable to the non-moving party (*see Vega v Restani Constr. Corp.*, 18 NY3d 499, 503 [2012]). In other words, "[i]n determining whether summary judgment is appropriate, the motion court should draw all reasonable inferences in favor of the nonmoving party and should not pass on issues of credibility" (*Garcia v J.C. Duggan, Inc.*, 180 AD2d 579, 580 [1st Dept 1992]). Once the movant meets his burden, it is incumbent upon the non-moving party to establish the existence of material issues of fact (*see Vega v Restani Constr. Corp.*, 18 NY3d at 503). A movant's failure to make a prima facie

showing requires denial of the motion, regardless of the sufficiency of the opposing papers (see *id.*; *Medina v Fischer Mills Condo Assn.,* 181 AD3d 448, 449 [1st Dept 2020]).

"The drastic remedy of summary judgment, which deprives a party of his [or her] day in court, should not be granted where there is any doubt as to the existence of triable issues or the issue is even 'arguable'" (*De Paris v Women's Natl. Republican Club, Inc.*, 148 AD3d 401, 403-404 [1st Dept 2017]; *see Bronx-Lebanon Hosp. Ctr. v Mount Eden Ctr.*, 161 AD2d 480, 480 [1st Dept 1990]). Thus, a moving defendant does not meet his or her burden of affirmatively establishing entitlement to judgment as a matter of law merely by pointing to gaps in the plaintiff's case. He or she must affirmatively demonstrate the merit of his or her defense (see *Koulermos v A.O. Smith Water Prods.*, 137 AD3d 575, 576 [1st Dept 2016]; *Katz v United Synagogue of Conservative Judaism,* 135 AD3d 458, 462 [1st Dept 2016]).

It is well established that a hospital is not vicariously liable for the negligent acts of a private attending physician, such as Close (*see Hill v St. Clare's Hosp.*, 67 NY2d 72, 79 [1986]; *Filippone v St. Vincent's Hosp. & Med. Ctr.*, 253 AD2d 616, 618 [1st Dept 1998]; *Georges v Swift*, 194 AD2d 517, 518 [2d Dept 1993]). Hence, even if Close is found to have committed malpractice, NYPH cannot be held liable solely on account of Close's negligence.

> "Further, a hospital is sheltered from liability in those instances where its employees follow the directions of the attending physician (*Filippone v St. Vincent's Hosp. & Med. Ctr.*, 253 AD2d 616, 618; *Christopher v St. Vincent's Hosp. & Med. Ctr.*, 121 AD2d 303, 306, *appeal dismissed* 69 NY2d 707), unless that doctor's orders '"are so clearly contraindicated by normal practice that ordinary prudence requires inquiry into the correctness of the orders"' (*Warney v Haddad*, 237 AD2d 123, quoting *Toth v Community Hosp.*, 22 NY2d 255, 265 n 3; *see also, Somoza v St. Vincent's Hosp. & Med. Ctr.*, 192 AD2d 429, 431)"

(*Walter v Betancourt*, 283 AD2d 223, 224 [1st Dept 2001]; *see Irizarry v St. Barnabas Hosp.,* 145 AD3d 529, 530 [1st Dept 2016]; *MacDonald v Beth Israel Med. Ctr.*, 136 AD3d 516, 516-517 [1st Dept 2016]; *Suits v Wyckoff Hgts. Med. Ctr.*, 84 AD3d 487, 488 [1st Dept 2011]; *Sela v Katz*, 78 AD3d 681, 682 [2d Dept 2010]; *cf. Burnett-Joseph v McGrath*, 158 AD3d 526, 527 [1st

Dept 2018] [attending physician's deposition testimony raised triable issue of fact as to whether resident exercised independent judgment]). Similarly,

> "A resident who assists a doctor during a medical procedure, and who does not exercise any independent medical judgment, cannot be held liable for malpractice so long as the doctor's directions did not so greatly deviate from normal practice that the resident should be held liable for failing to intervene"

(*Soto v Andaz*, 8 AD3d 470, 471 [2d Dept 2004]; *see Murphy v Drosinos*, 179 AD3d 461, 462 [1st Dept 2020] [resident did not exercise her own medical judgment or otherwise operate outside the realm of ordinary prudence so as to trigger individual liability]; *Lorenzo v Kahn*, 74 AD3d 1711, 1713 [4th Dept 2010]; *Buchheim v Sanghavi*, 299 AD2d 229, 230 [1st Dept 2002]).

The defendants established that Donatelli, in his capacity as a resident, exercised no independent judgment and did not implement any directives issued by Close that so greatly deviated from normal practice that Donatelli should have intervened. At his deposition, Close testified that, during the surgery, Donatelli would have assisted only to "hold onto something or push something out of the way." The plaintiffs' retained expert otolaryngologist cited to Donatelli's deposition testimony, in which Donatelli explained that, while working with Close on endoscopic sinus surgeries, Close would have him perform tasks that "were appropriate" for a resident of his experience. Contrary to the plaintiffs' contention, however, this testimony is insufficient to raise a triable issue of fact as to whether Donatelli handled the surgical instrumentation at the time that the entry into the patient's orbital area was made, or when injury to the left medial rectus muscle occurred. Even if Donatelli did more than merely hold instruments or push something out of the way, the vague expression that he performed "appropriate" tasks does not reflect the existence of a triable issue of fact as to whether Donatelli performed an independent act, exercised independent judgment, or failed to intervene to prevent clearly contraindicated treatment. Hence, summary judgment must be awarded to Donatelli dismissing the complaint insofar as asserted against him, as well as to NYPH with respect to claims that it should be held vicariously liable for Donatelli's acts or omissions.

NYPH established its prima facie entitlement to judgment as a matter of law with respect to the plaintiffs' claims arising from the conduct of the operating room staff by showing that those employees did not depart from good and accepted practice with regard to the patient's care. In opposition, the plaintiffs' expert did not address the issue of any independent negligence of NYPH's non-physician employees. Hence, summary judgment must be awarded to NYPH dismissing those claims as well.

Nonetheless, the court must deny that branch of the defendants' motion seeking summary judgment dismissing the claims against Close based on his alleged departure from good and accepted medical practice.

"To sustain a cause of action for medical malpractice, a plaintiff must prove two essential elements: (1) a deviation or departure from accepted practice, and (2) evidence that such departure was a proximate cause of plaintiff's injury" (*Frye v Montefiore Med. Ctr.*, 70 AD3d 15, 24 [1st Dept 2009]; *see Roques v Noble*, 73 AD3d 204, 206 [1st Dept 2010]; *Elias v Bash*, 54 AD3d 354, 357 [2d Dept 2008]; *DeFilippo v New York Downtown Hosp.*, 10 AD3d 521, 522 [1st Dept 2004]). A defendant physician moving for summary judgment must make a prima facie showing of entitlement to judgment as a matter of law by establishing the absence of a triable issue of fact as to his or her alleged departure from accepted standards of medical practice (*Alvarez v Prospect Hosp.*, 68 NY2d 320, 324 [1986]; *Frye v Montefiore Med. Ctr.*, 70 AD3d at 24) or by establishing that the plaintiff was not injured by such treatment (*see McGuigan v Centereach Mgt. Group, Inc.*, 94 AD3d 955 [2d Dept 2012]; *Sharp v Weber*, 77 AD3d 812 [2d Dept 2010]; *see generally Stukas v Streiter*, 83 AD3d 18 [2d Dept 2011]).

To satisfy the burden, a defendant must present expert opinion testimony that is supported by the facts in the record, addresses the essential allegations in the complaint or the bill of particulars, and is detailed, specific, and factual in nature (*see Roques v Noble*, 73 AD3d at 206; *Joyner-Pack v. Sykes*, 54 AD3d 727, 729 [2d Dept 2008]; *Koi Hou Chan v Yeung*, 66 AD3d 642 [2d Dept 2009]; *Jones v Ricciardelli*, 40 AD3d 935 [2d Dept 2007]). If the expert's

opinion is not based on facts in the record, the facts must be personally known to the expert and, in any event, the opinion of a defendant's expert should specify "in what way" the patient's treatment was proper and "elucidate the standard of care" (*Ocasio-Gary v Lawrence Hospital*, 69 AD3d 403, 404 [1st Dept 2010]). Stated another way, the defendant's expert's opinion must "explain 'what defendant did and why'" (*id.*, quoting *Wasserman v Carella*, 307 AD2d 225, 226, [1st Dept 2003]).

Furthermore, to satisfy his or her burden on a motion for summary judgment, a defendant must address and rebut specific allegations of malpractice set forth in the plaintiff's bill of particulars (*see Wall v Flushing Hosp. Med. Ctr.*, 78 AD3d 1043 [2d Dept 2010]; *Grant v Hudson Val. Hosp. Ctr.*, 55 AD3d 874 [2d Dept 2008]; *Terranova v Finklea*, 45 AD3d 572 [2d Dept 2007]).

Once satisfied by the defendant, the burden shifts to the plaintiff to demonstrate the existence of a triable issue of fact by submitting an expert's affidavit or affirmation attesting to a departure from accepted medical practice and opining that the defendant's acts or omissions were a competent producing cause of the plaintiff's injuries (*see Roques v Noble*, 73 AD3d at 207; *Landry v Jakubowitz*, 68 AD3d 728 [2d Dept 2009]; *Luu v Paskowski*, 57 AD3d 856 [2d Dept 2008]). Thus, to defeat a defendant's prima facie showing of entitlement to judgment as a matter of law, a plaintiff must produce expert testimony regarding specific acts of malpractice, and not just testimony that contains "[g]eneral allegations of medical malpractice, merely conclusory and unsupported by competent evidence tending to establish the essential elements of medical malpractice" (*Alvarez v Prospect Hosp.*, 68 NY2d at 325; *see Frye v Montefiore Med. Ctr.*, 70 AD3d at 24).

In most instances, the opinion of a qualified expert that the plaintiff's injuries resulted from a deviation from relevant industry or medical standards is sufficient to preclude an award of summary judgment in a defendant's favor (*see Murphy v Conner*, 84 NY2d 969, 972 [1994]; *Frye v Montefiore Med. Ctr.*, 70 AD3d at 24). Where the expert's "ultimate assertions are

speculative or unsupported by any evidentiary foundation, however, the opinion should be given no probative force and is insufficient to withstand summary judgment" (*Diaz v New York Downtown Hosp.*, 99 NY2d 542, 544 [2002]; *see Frye v Montefiore Med. Ctr.*, 70 AD3d at 24). Consequently, where the parties' conflicting expert opinions are adequately supported by the record, summary judgment must be denied (*see Frye v Montefiore Med. Ctr.*, 70 AD3d at 24 *Cruz v St. Barnabas Hospital,* 50 AD3d 382 [1st Dept 2008]).

The defendants' retained expert otolaryngologist, Dr. David W. Kennedy, opined that the patient's intraorbital hemorrhage was not a result of a departure from the accepted standard of medical practice, but, rather, was due to a known risk that may occur despite competent surgical care having been provided. As he explained, it

> "Dr. Close used a scope with a camera on the end of it and a Blakesley instrument to perform the surgery on Mr. Merhige. The Blakesley is rounded and somewhat blunted. He also used a microdebrider. Prior to and during the procedure, Dr. Close performed stereotactic navigation. During the procedure, he could not visualize directly (e.g. without the use of the stereotactic navigation) the anterior ethmoid artery. The fusion images are similar to a CT-scan in the sense that there is a sagittal, axial and coronal view and he could see the tip of the instrument as it traversed those areas. Dr. Close placed ocular-friendly ointment in the eyes and small steri-strips in the sterile field and observed the eyes at all times. Dr. Close observed microscopic entry of fat into the orbital space, which is a common occurrence and not a considered in the medical community to be a complication, but served to caution him to use care around the rest of the orbital bone and not allow any further fat infiltration. Thus, Dr. Close used even more caution than necessary around this structure. At no time during the procedure did he or anyone else in the operating room note a sudden pronounced proptosis (eye bulging), particularly during the ethmoidal part of the surgery.
>
> "The procedure was performed without incident. There was no manifestation of the complication at the time of the ethmoidectomy or any other part of the procedure. Rather, it manifested after the completion of the procedure and the patient was woken from anesthesia."

The plaintiff's retained expert, an otolaryngologist, opined that Close departed from good and accepted medical practice in the negligent performance of the patient's endoscopic sinus surgery on September 18, 2013, consisting of nasal septoplasty, bilateral endoscopic frontal sinusotomies, bilateral endoscopic total ethmoidectomies, bilateral endoscopic

sphenoidotomies, bilateral endoscopic maxillary antrostomies, and bilateral inferior turbinate submucous resection. The expert avers that Close departed from good and accepted medical practice in that he negligently failed to utilize appropriate and proper surgical technique, failed to recognize and be aware of anatomical structures and landmarks, and negligently caused serious injury to the patient's left medial rectus muscle as a result of his invasion into the patient's orbit during surgery. The expert concluded that that the patient suffered injury to his left medial rectus muscle and thus also sustained certain sequelae, including loss of vision and impaired vision of the left eye.

The plaintiff's expert noted that the patient had a medical history significant for hypothyroidism, non-cirrhotic liver disease, portal hypotension, esophageal bleeds, splenomegaly (undergoing a splenectomy in 2010), and insertion of a Rex Shunt in 2010. On January 24, 2012, the patient underwent a left lobe living donor liver transplant at NYPH. As a result of the transplant, the patient required continuous immunosuppressant medication to prevent his immune system from rejecting the donor organ.

Following the transplant, the patient experienced symptoms of a cough and fever while traveling in Germany in the summer of 2013. The patient went to Charité University Hospital in Berlin, where he was seen and evaluated by Director of Transplantation, Dr. P. Neuhaus, at that hospital's emergency outpatient clinic. After it was suspected that the patient might be suffering from a severe upper respiratory infection, he was admitted to the transplant surgical ward for diagnostic studies and work-up. He was further started on intravenous antibiotics after a chest x-ray showed mild signs of pneumonia. As part of the work-up at Charité University Hospital, a CT scan of the patient's head, taken on August 24, 2013, confirmed suspected sinusitis. The patient was prescribed nasal drops and steam inhalation and was scheduled to return to the otolaryngology outpatient clinic. The records from Charité University Hospital further indicate the patient's sinus condition warranted future surgical intervention.

Upon returning to the United States, the patient consulted with liver specialists at NYPH, where it was recommended that the patient undergo evaluation for possible sinus surgery. He was referred to Close, an otolaryngologist and head and neck surgeon, who had admitting privileges at NYPH.

As explained by the plaintiff's expert, on September 18, 2013, the patient underwent endoscopic sinus surgery consisting of nasal septoplasty, bilateral frontal sinusotomies, bilateral total ethmoidectomies, bilateral sphenoidotomies, bilateral maxillary antrostomies, and bilateral submucosal turbinate resection. The surgery was performed by Close, with assistance from Donatelli, who was then a third-year resident at NYPH. Close performed the surgical procedures with the use of surgical instrumentation, including a microdebrider for the purposes of resecting the soft tissue and bone, as well as image guidance. Close documented in his operative report that, at about the midway point of the surgery, "orbital fat was found herniating into the ethmoid sinus in the mid ethmoid sinus area," which according to the plaintiffs' expert, indicated an invasion or entry through the lamina papyracea and periorbita of the left orbit. At the conclusion of surgery, and around the time that the patient was being awaked by the anesthesia team, it was observed that the patient was suffering swelling and proptosis (protrusion) of the left eye, indicative of intraorbital hemorrhage. Although an ophthalmology consult was arranged, the patient was again sedated, and Close thereafter performed a lateral canthotomy, cutting the outer portion of the eye, as well as an orbital decompression to relieve pressure from the orbital hemorrhage and address the patient's proptosis.

Over the following weeks, the patient was reported to have sustained "deformity of the left medial orbital wall" as well as "deformity and medial deviation of the swollen medial rectus muscle into the left medial wall defect," as well as double vision. He underwent revision surgery in October 2013 consisting of a left lower lid ectropion repair necessitated by scar tissue left by the September 18, 2013 surgery, which prevented the eyelid from returning to its normal

position. By November 2013, he showed signs of decreased movement of his medial rectus muscle on the left side.

A permanent defect was noted three years later after the patient continued to sustain impaired vision and recurring sinusitis. An examination and radiological imaging demonstrated a right frontal mucocele eroding the skull base posteriorly, necessitating further sinus and orbital surgeries, which the patient underwent on October 20, 2016 and November 8, 2016. The surgeries apparently went well, but "duction of the left eye will always be limited."

As the plaintiff's expert explained it, a physician must take due care and caution, utilizing proper and appropriate surgical technique in performing sinus surgery to avoid injury to surrounding organs and anatomical structures. In this regard, the expert noted that the surgeon must make sure to recognize and be aware of the patient's anatomy both pre- and intra-operatively, taking great care to identify certain anatomical landmarks within the surgical site to avoid injury to a number of crucial structures and organs in the sinus and immediate surrounding areas. According to the plaintiff's expert, the standard of care further requires, particularly in situations where the physician elects to use a microdebrider in the performance of sinus surgery, that the surgeon take extreme caution to use appropriate surgical technique and identify anatomical landmarks as the use of such instrumentation can cause extensive damage to tissue, structures, and organs in and around the sinuses. The expert opined, within a reasonable degree of medical certainty, that Close departed from good and accepted medical practice in failing to utilize appropriate and proper surgical technique, in failing to identify anatomical landmarks and be aware of the patient's anatomy intra-operatively, and in negligently invading and perforating the left orbit, thus causing injury to the patient's orbital bone and medial rectus muscle.

The plaintiffs' expert agreed that the 2013 surgery was indicated, but that Close did not take sufficient care to avoid damage to the ethmoid bone, which is thin and makes up a portion of the orbital, nor did he take sufficient care to avoid injury to the lateral rectus muscle, which

allows the eye to move from side to side. As the expert noted, injury to the medial rectus muscle due to improper use of suction-assisted instruments, such as microdebriders, is one of the most devastating iatrogenic injuries from sinus surgery, and that that was the injury sustained by the patient here. Specifically, the expert opined that Close misused, over-aggressively used, and/or improperly placed the microdebrider, causing the blade to cut the lamina of the ethmoid bone and/or the lateral rectus muscle, thus damaging 75% of the muscle. The expert rejected Dr. Kennedy's opinion that the patient suffered from a "known complication" of "weakness and protrusion of the medial rectus muscle" or that Close "utilized every available precaution" to prevent orbital hemorrhage.

In light of the sharply conflicting opinions of the parties' retained experts (*see Severino v Weller*, 148 AD3d 272, 273 [1st Dept 2017]), there exists a triable issue of fact as to whether Close departed from good and accepted medical practice, thus precluding an award of summary judgment on that cause of action against Close. The plaintiffs' allegations that Close improperly employed surgical instruments that ended up in cutting through bone and tissue that should have remained intact present a question for a jury to decide.

The elements of a cause of action for lack of informed consent are

> "(1) that the person providing the professional treatment failed to disclose alternatives thereto and failed to 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 he or she had been fully informed, and (3) that the lack of informed consent is a proximate cause of the injury"

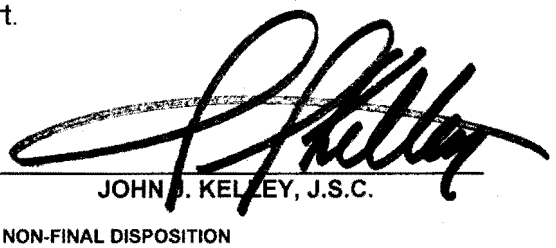
(*Spano v Bertocci*, 299 AD2d 335, 337-338 [2d Dept 2002]). For the claim to be actionable, a defendant must have engaged in a "non-emergency treatment, procedure or surgery" or "a diagnostic procedure which involved invasion or disruption of the integrity of the body" (Public Health Law § 2805-d[2]). Dr. Kennedy explained that, inasmuch as the patient executed a consent form on two separate occasions, and Close testified that he explained the risks, benefits, and alternatives to surgery to the patient, Close properly obtained the patient's consent

for the surgery. Dr. Kennedy further reasoned that, given the patient's severe sinus condition and the threat it posed because the patient was immunocompromised, a reasonably prudent person in the patient's position would not have declined to undergo the sinus surgery (*see Muniz v Katlowitz*, 49 AD3d 511, 513 [2d Dept 2008]). Inasmuch as the plaintiffs' expert does not address the issue of informed consent, they have failed to raise a triable issue of fact in opposition to Close's prima facie showing of entitlement to judgment as a matter of law. Hence, the court awards summary judgment to Close dismissing the lack of informed consent cause of action insofar as asserted against him.

In light of the foregoing, it is

ORDERED that the defendants' motion for summary judgment is granted to the extent of dismissing the complaint insofar as asserted against the defendants Luke Donatelli, M.D., and New York-Presbyterian Hospital/The University Hospital of Columbia and Cornell and dismissing the causes of action to recover for lack of informed consent and negligent hiring, supervision, and credentialing, the complaint is dismissed insofar as asserted against the defendants Luke Donatelli, M.D., and New York-Presbyterian Hospital/The University Hospital of Columbia and Cornell, the causes of action to recover for lack of informed consent and negligent hiring, supervision, and credentialing are dismissed, all derivative claims premised on the dismissed causes of action are themselves dismissed, and the motion is otherwise denied.

This constitutes the Decision and Order of the court.



5/20/2021
DATE

JOHN J. KELLEY, J.S.C.

CHECK ONE:		CASE DISPOSED			X	NON-FINAL DISPOSITION	
		GRANTED		DENIED	X	GRANTED IN PART	OTHER
APPLICATION:		SETTLE ORDER				SUBMIT ORDER	
CHECK IF APPROPRIATE:		INCLUDES TRANSFER/REASSIGN				FIDUCIARY APPOINTMENT	REFERENCE