Gomez v Beaton
2021 NY Slip Op 32196(U)
November 5, 2021
Supreme Court, New York County
Docket Number: Index No. 805455/2017
Judge: John J. Kelley
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SUPREME COURT OF THE STATE OF NEW YORK
NEW YORK COUNTY

PRESENT: HON. JOHN J. KELLEY **PART** 56M

Justice

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MODESTO GOMEZ, as Administrator of the Goods, Chattels, and Credits which were of MAGDA GOMEZ, deceased,

Plaintiff,

- v -

HOWARD BEATON, M.D., JAMES SMITH, M.D., MELANIE ONGCHIN, M.D., BENJAMIN SAMSTEIN, M.D., JENNIFER MURPHY, M.D., NEW YORK-PRESBYTERIAN/LOWER MANHATTAN HOSPITAL, and NEW YORK PRESBYTERIAN HOSPITAL,

Defendants.

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INDEX NO. 805455/2017

MOTION DATE 06/15/2021

MOTION SEQ. NO. 002

DECISION + ORDER ON MOTION

The following e-filed documents, listed by NYSCEF document number (Motion 002) 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 132, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 152, 153, 154

were read on this motion to/for JUDGMENT - SUMMARY.

In this action to recover damages for medical malpractice and wrongful death, based upon departures from good and accepted medical care, lack of informed consent, and the evidentiary doctrine of res ipsa loquitur, the defendant Howard Beaton, M.D., moves pursuant to CPLR 3212 for summary judgment dismissing the complaint insofar as asserted against him. The plaintiff opposes the motion. The motion is granted to the extent that Beaton is awarded summary judgment dismissing the cause of action premised upon lack of informed consent and the claim of medical malpractice premised upon the evidentiary doctrine of res ipsa loquitur insofar as asserted against him, and the motion is otherwise denied.

In his bill of particulars as to Beaton, the plaintiff, Modesto Gomez, alleges that his decedent, Magda Gomez (hereinafter the decedent or the patient), was under Beaton's care at New York-Presbyterian Lower Manhattan Hospital on August 19, 2016. He asserts that, on that

date, Beaton performed an elective laparoscopic cholecystectomy upon the patient, also known as the removal of the gallbladder, and that, during the surgery, Beaton transected both the patient's right hepatic artery and her common bile duct. He alleged that, as a consequence of these transections, the patient developed a severe bacterial infection, she consequently went into septic shock and cardiac and respiratory failure, and died on August 29, 2016.

The plaintiff's bill of particulars asserted that, in the first instance, the laparoscopic cholecystectomy either was not indicated or was contraindicated for the decedent. As more specifically described in the bill of particulars, the plaintiff asserted that, even if the procedure were indicated, Beaton departed from good and accepted medical care

> "in improperly clipping and dividing the common bile duct; in improperly clipping and dividing the hepatic duct; in causing and/or allowing the plaintiff to continue to leak bile into her abdominal cavity; in perforating, lacerating, tearing, clipping, and/or transecting the common bile duct; in causing trauma and injury to the common bile duct; in failing to timely recognize that the common bile duct had been perforated, lacerated, torn, clipped and/or transected; in failing to timely repair injury to the common bile duct; in failing to isolate and protect the common bile duct so as to spare it from injury; in perforating, lacerating, tearing, clipping, and/or transecting the hepatic duct; in causing trauma and injury to the hepatic duct; in failing to timely recognize that the hepatic duct had been perforated, lacerated, torn, clipped and/or transected; in failing to timely repair injury to the hepatic duct; in failing to isolate and protect the hepatic duct so as to spare it from injury; in perforating, lacerating, dividing, tearing, clipping and/or transecting the hepatic artery; in failing identify anatomical structures; in failing to skeletonize the anatomical area of the cystic duct, common bile duct, cystic artery, and Triangle of Calot; in failing to use means available to identify anatomy prior to surgical clipping; in failing to perform complete dissection prior to surgical clipping; [and] in failing to trace out the cystic duct during performance of a laparoscopic cholecystectomy."

The plaintiff further alleged that Beaton failed to undertake or achieve "the clear view of safety technique," and failed timely to convert the procedure into a laparotomy. He averred that Beaton also departed from good and accepted practice in failing to repair his decedent's bile leak in a timely manner, and in failing properly to place clips so as to prevent the onset of the leak and the continued leak of bile. In addition, the plaintiff claimed that Beaton's failure to perform an intraoperative cystic duct choliangiogram constituted a departure from good and accepted practice, as did his failure timely to administer antibiotics to treat bacterial infection

caused by the perforation of the patient's hepatic duct and common bile duct, and that all of the aforementioned departures from good practice caused iatrogenic, that is, surgically induced, injury.

In addition to the more general allegations that Beaton failed properly to examine, monitor, diagnose, and treat the surgically induced injuries, the plaintiff also asserted that Beaton's departures included his failure to consult proper specialists or perform requisite tests and studies, including blood studies, blood cultures, x-rays, ultrasound, CT scans, MRI scans, ERCP, and/or endoscopies. The plaintiff further averred that it was a departure for Beaton to fail to supervise the health care professionals working under his aegis in a proper and adequate fashion.

The plaintiff, in addition, alleged that Beaton failed to obtain the decedent's informed consent to a laparoscopic cholecystectomy. He asserted that he would also be relying upon the evidentiary doctrine of res ipsa loquitur, and thus establish, among other things, that the injuries sustained by his decedent were not those that usually occurred in the absence of negligence.

In support of his summary judgment motion, Beaton relies upon the pleadings, the transcripts of the parties' depositions, emergency services, medical, and hospital records, including films of relevant scans, and the decedent's autopsy report, as well as his own affidavit.

In his affidavit, Beaton explained that

> "[a]t the time of the initial visit for consultation in contemplation of surgery, I noted that Ms. Gomez was a 66-year-old female with a long history of peptic ulcers and taking Zantac. She had a significant change in her pain 3 weeks before this visit and a sonogram performed 2 weeks before was positive for [gall]stones. Her history included C-Section x 3, her weight was 130 pounds, she was 4' 11" tall. She had a scar from . . . prior Cesarean Sections. She also had a recent gallbladder attack which was ongoing."

As he described the procedure,

> "[a]fter the surgery was commenced, the omentum was taken off the gallbladder and the ampulla of the gall bladder was identified. After considering all options, I made the decision to proceed with the cholecystectomy. The serosa of the gallbladder was incised using blunt and sharp dissection and the gallbladder was

> dissected free from the liver bed in routine fashion. The gallbladder was then removed and the specimen inspected. It was noted the cystic duct was short or absent and a possible segment of the common bile duct was noted to [sic] part of the specimen. I inspected the operative field and confirmed a common bile duct injury with clipping of the duct distally and an open hepatic duct near the confluence of the right and left hepatic ducts was clearly visible.

Beaton asserted that he thereafter requested the assistance of codefendants James Smith, M.D., and Melanie Ongchin, M.D., he "confirmed the anatomy" with those codefendants, and determined to transfer the patient to the uptown Weill Cornell Medical Center campus for reconstructive surgery, where codefendant Benjamin Samstein, M.D., performed that surgery on the next day.

Beaton explained that the reasons for the transections included the positioning and location of the hepatic artery and the patient's condition at the time of the subject surgery. As he framed the issue,

> "[t]he presence of chronic inflammation can lead to thickening of the tissues in the area and fibrosis that make it harder to identify the structures. Furthermore, upon review of the subsequent CT angiogram that was taken at Cornell Hospital on August 19, 2016, I noted that the left hepatic artery was replaced and rose directly from the celiac artery 1.1 cm from its origin.
>
> "Thus, the altered location of the right hepatic artery further contributed to the outcome as a direct result of the existence of unavoidable known risks. In other words, the occurrence of injury to the associated structures constitutes a known potential risk so that such an outcome does not constitute malpractice."

Beaton went on to assert that, during the surgery, he noted both unusually severe subacute and chronic cholelithiasis, that is, the presence of gallstones, which suggested to him that a surgical transection injury was a common, known, and unavoidable risk. Beaton reiterated that, after the patient was transferred from his care to Weill Cornell Medical Center, she underwent a hepaticojejunostomy, i.e., bile duct repair and reconstruction, but that, after her discharge from Cornell, she developed respiratory distress at home, requiring a return to the hospital. He explained that the patient died while in transit to the hospital.

With respect to his own conduct and techniques during the surgery that he performed, Beaton averred that he utilized proper sterile techniques at all times while treating the patient,

and that there was "no indication in the medical records relevant to the period of my surgical involvement in her care on August 19, 2016, that the patient's death was in any manner related to any act or omission on my part, proximate or otherwise." After reiterating that any injury that the patient sustained during the procedure that he performed constituted a known and unavoidable risk that was "not indicative of negligence," Beaton stated that, when the patient was discharged from his care on August 19, 2016, she was fully stable, had no evidence of any ongoing infection, and had post-surgical drains in place, as requested by Samstein to prepare her for the subsequent reconstructive surgery. Beaton avers that the transection injury was "subsequently treated and resolved by Dr. Samstein, who repaired it," and noted that "the patient's death did not occur until after approximately four [sic] days after hepaticojejunostomy surgery was performed on August 20, 2016, by Dr. Samstein . . .at a separate facility that was handled by other physicians over whom I exercised no supervisory responsibility." Beaton asserted that the post-operative care provided by these medical care providers "was also entirely orchestrated by persons and facilities other than me and I had no responsibility for those care providers' conduct." He asserted that he played no role whatsoever in decisions made in connection with the plaintiff's treatment after she was discharged from New York-Presbyterian Lower Manhattan Hospital on August 19, 2016, including decisions involving the administration of medication.

With respect to the issue of whether the patient was fully informed of the risks associated with the surgery that Beaton performed, he asserted that

> "Ms. [Gomez] signed a consent form on the day of surgery. Contrary to the plaintiff's allegations, I am aware that on August 9, 2016, as documented by my 'Consultation Report' prepared for Forest Manheimer, M.D., I provided Ms. Gomez with information and responses to her questions thereby obtaining her informed consent regarding the laparoscopic cholecystectomy. I provided complete information to this patient regarding the nature of the surgery, the potential benefits and the related risks. Specifically, I informed the patient that this type of procedure is associated with a known risk for injury or damage to adjacent organs and anatomic structures."

In opposition to Beaton's motion, the plaintiff relied on the same pleadings, bills of particulars, deposition transcripts, medical records, emergency responder records, and autopsy report as Beaton. He also submitted the affirmation of a physician licensed to practice medicine in New York who is board certified by the American Board of Surgery. The plaintiff provided an unredacted copy of that affirmation to the court for in camera review, and uploaded a redacted copy to the New York State Courts Electronic Filing (NYSCEF) system.

In his affirmation, the plaintiff's expert asserted that he is familiar with the standards of care and degree of diligence required by surgeons performing cholecystectomies, both laparoscopic and open, and that he personally had performed such procedures. After noting that the patient had undergone a laparoscopic cholecystectomy on August 19, 2016 at New York-Presbyterian Lower Manhattan Hospital that was converted into an open surgery (laparotomy), was transferred to Weill Cornell Medical Center later that day and underwent a hepaticojejunostomy on August 20, 2016, was released to home on August 24, 2016, and died on August 29, 2016 en route to the hospital after suffering from respiratory and cardiac failure brought on by infection and concomitant sepsis, the expert pointed out that the patient's cause of death, as set forth in the autopsy report, arose from "complications of elective cholecystectomy for the treatment of cholelithiasis with acute and chronic cholecystitis."

The plaintiff's expert recounted that the patient initially presented to Beaton on August 9, 2016, with a history of peptic ulcer disease and several cesarean sections. He noted that, for the three weeks prior to that visit, the patient had been experiencing epigastric pain radiating to her back, along with nausea and vomiting, and that a sonogram revealed the presence of gallstones. Based on his review of Beaton's records, the expert asserted that Beaton's impression was that the patient suffered from cholelithiasis (gallstones) and chronic cholecystitis (inflammation of the gallbladder), and that Beaton scheduled the plaintiff for a laparoscopic cholecystectomy for August 19, 2016.

With respect to the surgery itself, the plaintiff's expert quoted from the operative report, which indicated that the gallbladder wall was thickened, edematous (filled with fluid), and erythematous (reddish in hue), consistent with acute inflammation, and that the omentum adhered to the bottom of the gallbladder, consistent with chronic inflammation. He further quoted from that report, which, although stating that the cystic duct and cystic artery were identified and carefully dissected free of gallbladder, also noted that "the common bile duct, although . . . thought to be the cystic duct at the time, was clipped and divided. Similarly, the [hepatic] artery was clipped and divided." As recounted by the expert, the report continued that, during the dissection of the gallbladder from the liver, "significant bleeding was noted from a blood vessel in the liver," at which point Beaton determined that, rather than continuing with laparoscopic surgery, it would be "safest to perform an open cholecystectomy for the removal of the gallbladder and control of the bleeding."

After recounting in detail the specifics of the surgery, the details of the patient's post-operative transfer from New York-Presbyterian Lower Manhattan Hospital to Weill Cornell for reconstructive surgery, the reconstructive surgery itself, and the patient's post-operative deterioration after her discharge from Weill Cornell, the plaintiff's expert opined, within a reasonable degree of medical certainty, that

> "Dr. BEATON departed from good and accepted medical practice in the performance of the August 19, 2016 laparoscopic cholecystectomy. As acknowledged by Dr. BEATON, the common bile duct should be avoided during the performance of a laparoscopic cholecystectomy, and he unintentionally transected it in the course of the procedure. . . . Similarly, Dr. SMITH testified that the goal in a laparoscopic cholecystectomy is to cut the cystic duct and not the common bile duct.
>
> "The critical view of safety is a technique of identification of the anatomy that must be completed prior to clipping or diving any tubular structures (ducts and blood vessels) in the performance of a laparoscopic cholecystectomy so as to avoid inadvertent injury. It is achieved by clearing the triangle of Calot (bordered by the common hepatic duct, the cystic duct, and the inferior surface of the liver) of fat and tissue and dissecting the gallbladder off the bottom of the cystic plate (liver bed). Once this is done, there will be only two structures attached to the gallbladder and they can be visualized. These are the cystic artery and the cystic duct. As Dr. BEATON failed to appreciate that he was clipping the common bile

> duct and not the cystic duct, it is clear that he did not achieve the critical view of safety."

Inasmuch as neither the operative report nor Beaton's affidavit states that he dissected the gallbladder off the bottom of the cystic plate, the plaintiff's expert concluded that Beaton's contention that "the critical view of safety was obtained" was inaccurate, and that the failure to achieve the required dissection also constituted a failure to achieve the critical view of safety, which together constituted a departure from good and accepted practice.

The expert continued that, in the absence of Beaton's achievement of the critical view of safety, questions arose as to which anatomical structures he was required to clip, that good and accepted medical practice required Beaton to perform a cholangiogram, as Beaton himself conceded that performance of such a technique is used occasionally to help identify anatomical structures, including the cystic duct and common bile duct, and that his failure to perform such an examination also constituted a deviation from good practice. The expert additionally opined that, while conversion from a laparoscopic to open surgical procedure is indicated where the anatomy is uncertain, Beaton did not make that conversion "until after he had begun clipping and dividing structures and encountered bleeding." According to the plaintiff's expert, Beaton's conduct in this regard also constituted a departure from good practice, as the clipping and division of the common bile duct would not have occurred had Beaton actually identified the anatomy in a proper manner or converted the procedure to open surgery after he could not and did not properly identify the anatomy.

In addition, the plaintiff's expert concluded that Beaton departed from good and accepted medical practice

> "in clipping and dividing the hepatic artery when he intended to clip and divide the cystic artery. Dr. BEATON attempt to justify his confusion because the CT Angiogram performed postoperatively showed that Ms. GOMEZ's left hepatic artery came off the celiac axis [artery] as opposed to the common hepatic artery. However, this attempted justification is without merit. The CT Angiogram report states that the right hepatic artery (which Dr. BEATON injured) "*arises normally from the celiac axis* [artery]" . . . Thus, the findings of the CT Angiogram performed postoperatively do not show any anatomic anomaly of the right

> hepatic artery and do not excuse Dr. BEATON's mistake and hi[s] unintended clipping and dividing this vessel. . . . Accordingly, I disagree with his statement that . . . 'the altered location of the right hepatic artery further contributed to the outcome as a direct result of unavoidable known risks [and that] the occurrence of injury to the associated structures constitutes a known potential risk so that such an outcome does not constitute malpractice.'"

With respect to the issue of causation, the plaintiff's expert opined that Beaton's departures were either singularly, or in combination, a proximate cause of the patient's injuries, including her death. According to the expert,

> "By clipping and dividing the common bile duct and hepatic artery, Ms. GOMEZ was caused to leak bile into her abdominal cavity, have additional bleeding, develop geographic liver necrosis [caused by decreased perfusion of the liver due to the transection of the right hepatic artery], required that her surgery be converted to a laparotomy, and required an additional surgery, specifically, a Roux-en-Y hepaticojejunostomy. Furthermore, Ms. GOMEZ's post-operative course including elevated white blood cell counts while at NYPH-Cornell, fever, and cardiac arrest, make clear that Ms. GOMEZ died of sepsis as a result of the bile which was caused to leak into her abdominal cavity."

The expert agreed with the defendant Samstein's deposition testimony that the placement of drains "do[es] not result in the complete drainage of bile away from the abdominal cavity, there would likely be some bile leaking even with drains, and bile is a medi[um] for the growth of bacteria." The expert agreed with the opinion of the Medical Examiner that the patient's death was "causally related to [the] laparoscopic cholecystectomy performed by Dr. BEATON and was a therapeutic complication thereof." He concluded that Beaton's departures from good practice were both a proximate cause of, and substantial contributing factor in, the patient's severe injuries and death, as they diminished her chances for a more favorable prognosis, leading to the necessity of reconstructive surgery, peritonitis, sepsis, liver necrosis, and death. The expert expressly disputed Beaton's contention that injury to anatomical structures adjacent to the gallbladder, such as the common bile duct and hepatic artery, were known and unavoidable risks that were not indicative of negligence, or that the patient's existing subacute and chronic cholelithiasis made a transection injury a common, known, or unavoidable risk of surgery. As

the expert explained it, inflammation, no matter how severe, does not excuse the transection of the common bile duct and hepatic artery.

The plaintiff's expert did not address the issue of whether the patient was fully informed of the risks of the procedure performed by Beaton. Nor did the expert explicitly opine that the injuries that the patient sustained during that surgery could not have occurred in the absence of negligence or that she was under Beaton's exclusive control in the course of that procedure.

In reply, Beaton submits his attorney's affirmation, that incorporates by reference the expert affirmations that were submitted in support of the summary judgment motion made by Beaton's codefendants under motion sequence 003. Beaton's attorney noted that the plaintiff's expert did not address either the lack of informed consent cause of action or the issue of res ipsa loquitur. Counsel also argues that these additional expert affirmations establish that the transection of the patient's hepatic artery and common bile duct was not the proximate cause of the patient's injuries.

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 or her 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]).

"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]).

A defendant physician, as "a party who is qualified by reason of education or training in a specific field[,] may serve as his own expert" in rebutting the plaintiff's prima face case (*Bade v Partridge*, 2009 NY Slip Op 52435[U],*5, 25 Misc 3d 1236[A] [Sup Ct, Nassau County, Nov. 23, 2009]), and may rely upon his or her own affidavit in support of a summary judgment motion, as long as the affidavit is "detailed, specific and factual in nature" and addresses the plaintiff's specific claim of malpractice (*Webb v Scanlon*, 133 AD3d 1385, 1386 [4th Dept 2015]; *see Campbell v Bell-Thomson,* 189 AD3d 2149, 2150 [4th Dept 2020]; *Suib v Keller,* 6 AD3d 805, 806 [3d Dept 2004]; *Napierski v Finn,* 229 AD2d 869, 870 [3d Dept 1996]; *Rodriguez v Pacificare, Inc.*, 980 F2d 1014, 1019 [5th Cir 1993]; *cf. Corcino v Filstein*, 32 AD3d 201, 202 [1st Dept 2006] [the court assumed, for purposes of defendant physician's summary judgment motion, that his affidavit was sufficient to establish his prima facie entitlement to judgment dismissing complaint in medical malpractice action]).

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]).

Beaton established his prima facie entitlement to judgment as a matter of law dismissing so much of the medical malpractice cause of action as was premised upon his departure from good and accepted medical practice. He made this showing with his own affidavit, in which he asserted that he employed proper surgical technique and that the transections that resulted were known and unavoidable risks of surgery in light of the complexity of the procedure that he had performed (*see Szarfharc v Beaton*, 2019 NY Slip Op 30826[U], *7, 2019 NY Misc LEXIS 1434, *10 [Sup Ct, Kings County, Mar. 20, 2019]; *Milo v New York City Health & Hosps. Corp.*,

2009 NY Slip Op 30334[U], *3, 2009 NY Misc LEXIS 4030, *6 [Sup Ct, N.Y. County, Feb. 17, 2009]).

The plaintiff, however, raised a triable issue of fact in connection with this claim with his expert's affirmation, as his expert's opinion specifically described numerous departures that Beaton allegedly committed in failing to identify and preserve the hepatic artery and common bile duct, in failing to achieve a critical view of safety, in failing to perform an intraoperative cystic duct choliangiogram, and in belatedly converting the procedure from a laparoscopic procedure to a laparotomy, an opinion that was supported by the medical records and the autopsy report, and was not merely speculative (*see Szarfharc v Beaton*, 2019 NY Slip Op 30826[U], *Milo v New York City Health & Hosps. Corp.*, 2009 NY Slip Op 30334[U]). Moreover, even though Beaton suggested that the quick deterioration of the plaintiff's condition subsequent to the cholecystectomy was not caused by that procedure, but was due to the treatment rendered by others over whom he had no supervisory authority, the affirmation of the plaintiff's expert nonetheless raised a triable issue of fact as to whether the inadvertent transections of the common bile duct and hepatic artery set in motion a chain of events that foreseeably led to sepsis and death (*see generally Torres v Cergnul*, 146 AD3d 509 [1st Dept 2017]), as "there is no break in causation where intervention is invited or induced by the misconduct" (*Bell v New York City Health & Hosps. Corp.*, 90 AD2d 270, 285 [2d Dept 1982]).

Hence, that branch of Beaton's motion seeking summary judgment dismissing the medical malpractice cause of action, to the extent based on departures from good and accepted medical practice, must be denied.

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]; *see Zapata v Buitriago*, 107 AD3d 977, 979 [2d Dept. 2013]). 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]). "'The mere fact that the plaintiff signed a consent form does not establish the defendants' prima facie entitlement to judgment as a matter of law'" (*Huichun Feng v. Accord Physicians*, 194 AD3d 795, 797 [2d Dept 2021], quoting *Schussheim v Barazani*, 136 AD3d 787, 789 [2d Dept 2016]). Nonetheless. a defendant may satisfy his or her burden of demonstrating his or her prima facie entitlement to judgment as a matter of law in connection with such a cause of action where, as here, a patient signs a detailed consent form, and there is also evidence that the necessity of the procedure, along with known risks and dangers, was discussed prior to the surgery (*see Bamberg-Taylor v Strauch*, 192 AD3d 401, 401-402 [1st Dept 2021]).

In opposition to Beaton's showing in this regard, the plaintiff's expert did not address the issue of informed consent and, hence, the plaintiff failed to raise a triable issue of fact sufficient to deny summary judgment dismissing that cause of action as against Beaton. Hence, that branch of Beaton's motion seeking summary judgment dismissing the cause of action alleging lack of informed consent insofar as asserted against him must be granted.

As explained above, ordinarily, a plaintiff asserting a medical malpractice claim must demonstrate that the doctor deviated from acceptable medical practice, and that such deviation was a proximate cause of the plaintiff's injury (*see Rivera v Kleinman*, 16 NY3d 757, 759, [2011]; *Frye v Montefiore Med. Ctr.*, 70 AD3d at 24; *Terranova v Finklea*, 45 AD3d at 572; *Zellar v Tompkins Community Hosp.*, 124 AD2d 287, 288-289 [3d Dept 1986]). Nonetheless, the theory of res ipsa loquitur may be applied to occurrences "[w]here the actual or specific cause of an accident is unknown" (*Kambat v St. Francis Hosp.*, 89 NY2d 489, 494 [1997]). Under such circumstances, "a jury may . . . infer negligence merely from the happening of an event and the

defendant's relation to it" (*id.*; *see States v Lourdes Hosp.*, 100 NY2d 208, 211-212 [2003]; Restatement [Second] of Torts § 328D). To establish a prima facie case of negligence in support of a res ipsa loquitur charge, plaintiff must establish three elements:

> "[1.] the event must be of a kind that ordinarily does not occur in the absence of someone's negligence;
>
> "[2.] it must be caused by an agency or instrumentality within the exclusive control of the defendant; and
>
> "[3.] it must not have been due to any voluntary action or contribution on the part of the plaintiff"

(*Kambat v St. Francis Hosp.*, 89 NY2d at 494; *see James v Wormuth*, 21 NY3d 540, 545-546 [2013]; *Ebanks v New York City Tr. Auth.*, 70 NY2d 621, 623 [1987]; Prosser and Keeton, Torts § 39 at 244 [5th ed]). Res ipsa loquitur, a doctrine of ancient origin (*see Byrne v Boadle*, 2 H & C 722, 159 Eng Rep 299 [1863]), derives from the understanding that some events ordinarily do not occur in the absence of negligence (*see id.; see also Dermatossian v New York City Tr. Auth.*, 67 NY2d 219, 226 [1986]). Once a plaintiff satisfies the burden of proof on these three elements, the res ipsa loquitur doctrine permits the jury to infer negligence from the mere fact of the occurrence (*see States v Lourdes Hosp.*, 100 NY2d at at 211-212; *Kambat v St. Francis Hosp.*, 89 NY2d at 495). Thus, for example, where "a foreign object is left in the body of the patient, or the patient, while anesthetized, experiences an unexplained injury in an area which is remote from the treatment site" (*McCarthy v Northern Westchester Hosp.*, 139 AD3d 825, 827 [2d Dept 2016] [citation omitted]), the invocation of the doctrine of res ipsa loquitur may be warranted (*see id.; see also Mattison v OrthopedicsNY, LLP*, 189 AD3d 2025, 2027 [3d Dept 2020]; *Swoboda v Fontanetta*, 131 AD3d 1042, 1045 [2d Dept 2015]; *DiGiacomo v Cabrini Med. Ctr.*, 21 AD3d 1052, 1054 [2d Dept 2005]; *Escobar v Allen*, 5 AD3d 242, 243 [1st Dept 2004]; *Leone v United Health Servs.*, 282 AD2d 860, 860-861 [3d Dept 2001]; *Hill v Highland Hospital*, 142 AD2d 955, 956 [4th Dept 1988]).

In the instant dispute, no foreign object was left inside the patient's body after Beaton performed the subject surgical procedure, and the injuries she sustained were near to, rather than remote from, the treatment site. In addition, Beaton provided an explanation as to why he believed the injuries occurred, and opined that those injuries could indeed have been incurred in the absence of negligence. Moreover, he established that he was not the only person who had "control" over the patient, as at least two other physicians were involved in the surgery. Even though the plaintiff's expert raised a triable issue of fact as to whether, in this case, Beaton departed from good and accepted medical practice in performing the surgery, he did not render an opinion as to whether it was impossible for the patient to have sustained the injuries complained of in the absence of negligence, or any opinion as to whether Beaton maintained exclusive control over the conditions leading to the patient's injuries. Thus, in opposition to Beaton's showing of entitlement to judgment as a matter of law dismissing any claim premised upon the doctrine of res ipsa loquitur, the plaintiff's expert failed to raise a triable issue of fact. Summary judgment must thus be awarded to Beaton dismissing that claim.

In light of the foregoing, it is

ORDERED that the motion of the defendant Howard Beaton, M.D., is granted only to the extent that he is awarded summary judgment dismissing the cause of action alleging lack of informed consent and the claim alleging medical malpractice premised upon the evidentiary doctrine of res ipsa loquitur insofar as asserted against him, that cause of action and that claim are dismissed insofar as asserted against the defendant Howard Beaton, M.D., and the motion is otherwise denied.

This constitutes the Decision and Order of the court.

11/5/2021
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