NEW YORK SUPREME COURT - QUEENS COUNTY

Present: HONORABLE PETER J. O'DONOGHUE IA Part MD
Justice

KRISZTINE STAAB and JESSE STAAB,

Plaintiff
-against-

LONG ISLAND JEWISH MEDICAL CENTER, et. al.,

Defendants

Index Number 701455 2019

Motion Date July 21, 2021

Motion Seq. No. 2

X

The following papers read on this motion by defendants Lauren Scanlon, M.D., Reena Malhotra, M.D., and Long Island Jewish Medical Center (LIJMC) for an order granting summary judgment in their favor; granting summary judgment dismissing the claim of lack of informed consent; granting summary judgment dismissing the claim for punitive damages; and granting partial summary judgment dismissing all individual claims which the moving defendants make a prima facie showing and plaintiffs do not rebut. Plaintiffs cross move for an order granting partial summary judgment in their favor against Lynda Piboon, Lauren Scanlon, M.D. and LIJMC on the claim for negligence per se.

	Papers Numbered
Notice of Motion-Affirmations-Statement of Material Facts-Exhibits..	EF 43-59
Notice of Cross Motion-Statement of Material Facts-Counter Statement of Material Facts-Affirmation-Affidavits-Exhibits.....	EF 120-144
Opposing Affirmation-Exhibit.....	EF 173-174
Response to Statement of Material Facts-Affirmation.....	EF 178-179
Reply Affirmation-Exhibits.....	EF 180- 182

Upon the foregoing papers the motions and cross motion are determined as follows:

Plaintiffs' commenced this action on January 25, 2019, and assert causes of action against all defendants for negligence, medical malpractice, lack of informed consent, negligence per se, negligent infliction of emotional distress, intentional infliction of emotional distress, assault, battery and loss of services. In addition, plaintiffs allege a cause of action against LIJMC for negligent retention and supervision, the failure to formulate

rules and regulations and the failure to supervise the treatment of plaintiff Krisztina Staab.

Plaintiffs, in essence, allege that defendants misdiagnosed an ectopic pregnancy in Ms. Staab's left fallopian tube based, in part, on an ultrasound performed in the Emergency Department of LIJMC that resulted in the performance of an unnecessary and unauthorized bilateral salpingectomy. Plaintiffs also allege that the defendants failed to obtain proper informed consent from the patient prior to the procedure. It is alleged that defendants' acts of negligence and/or omissions occurred approximately from March 12, 2018 through March 28, 2018. As to all defendants it is alleged that plaintiff Krisztina Staab sustained the following injuries and complications as a result of the defendants' alleged negligence: unnecessary sterilization; removal of both fallopian tubes; loss of her child; excruciating uterine pain; effects of morphine administrations; surgery; inability to have children; severe emotional distress and anguish; severe physical distress and anguish; physical impairment; shock and trauma; excruciating abdominal pain; internal bleeding and blood loss; severe chest pain; uterine rupture; internal muscle tears; mental and emotional anguish; emotional trauma; depression; anxiety; and severe physical pain and suffering.

Issue has been joined as to all defendants.

Plaintiff, Krisztina Staab began treatment at co-defendant, Mayer J. Saad, M.D., P.C. d/b/a The Woman's Health Pavilion (WHP) on April 28, 2007, at which time she reported that one week earlier, she had a positive pregnancy test; however, she was symptomatic with cramps and bleeding upon presentation. Her obstetrical history was significant for one prior Cesarean section (2003), one spontaneous abortion, and one termination of pregnancy. At the time of her 2003 Cesarean section, and verified through imaging thereafter, plaintiff was diagnosed with a bicornuate and septate uterus. The sonogram performed on April 28, 2007 revealed a potential heterotopic pregnancy (an ectopic pregnancy and intrauterine pregnancy that exist simultaneously). A follow up ultrasound showed evidence of fetal demise and on May 29, 2007, Ms. Staab underwent a dilation and curettage (D & C) for a missed abortion. On August 20, 2008, plaintiff presented to Woman's Health Pavilion for a followup, at which time it was noted that plaintiff had taken "Plan B" two weeks earlier. Plaintiff gave birth to a second child on April 1, 2009, at which time she had a Cesarean delivery. .

The WHP's records note that on July 21, 2010, plaintiff was considering a bilateral tubal ligation versus Essure (bilateral occlusion of the fallopian tubes). On March 9, 2011, these procedures were again discussed, with a plan for elective sterilization and it was noted that the patient was to be recommended for pre-operative testing. A laparoscopic bilateral tubal ligation scheduled for May 16, 2011, was rescheduled to be performed on June 13, 2011. Dr. Stephen E. Scarantino was to perform said procedure. However, Ms. Staab did not go through with this procedure.

On March 12, 2018, Ms. Staab presented to the WHP with complaints of amenorrhea, stomach pain and bleeding, with her last menstrual period on March 10, 2018. The medical records note that this was a "desired pregnancy." Her medical records state that she reported light brown/red vaginal bleeding, but heavier bleeding over the weekend similar to her menses. On speculum examination, there was moderate brown-red blood noted (50-100 cc in the vaginal vault). Nurse Practitioner Courtney Haggerty ordered a transvaginal ultrasound which revealed a retroverted fibroid uterus. Said ultrasound revealed a possible gestational sac consistent with a 5 week 4 day gestation, but with no yolk sac, fetal pole or fetal heartrate. The ultrasound was unable to rule out an ectopic pregnancy. The beta hCG blood test taken that day was 13,812 mIU/mL, consistent with gestation of approximately six weeks. On March 14, 2018, Ms. Staab returned to the WHP for a repeat blood test, at which time her beta hGC level was 14,167.

WHP's records include an untimed note for March 16, 2018, stating that "pt. didn't want to f/u anymore and desires D&C. Spoke to pt and told her that it is important to f/u today for b-hCG and sonogram to confirm missed abortion vs. ectopic. Pt. states she is bleeding now." Ms. Staab went to the WHP that day for a repeat sonogram which indicated that there was no evidence of an intrauterine pregnancy. Another untimed note indicated the possibility of a missed abortion or ectopic pregnancy. The patient was given strict ectopic precautions, and surgical management was being planned for Monday or Tuesday.

On March 16, 2018, Ms. Staab went to the emergency room of LIMCJ at 7:24pm, accompanied by her sister. Ms. Staab testified at her deposition that her sister had called WHP and that she had been told to go the emergency room for at worsening pelvic pressure and lumbar and suprapubic pain. At LIJMC, Ms. Staab reported that her last visit to her OB/GYN was the prior Monday (March 12th) at which time she understood that her b-hCG level was increasing, but there was no intrauterine pregnancy. She reported that a prior ultrasound reportedly demonstrated increased blood flow to the fallopian tube; that she experienced nausea/vomiting, and vaginal bleeding with clots several days prior to March 16; and was experiencing light spotting at the time of the presentation. She reported a history of three prior miscarriages, but no ectopic pregnancies. An ectopic was to be ruled out.

LIJMC's medical records establish that the emergency department attendings (Dr. Daniel Dexeus and Dr. Mir Raza) documented that the patient had pelvic pain for a day, mostly in the left lower quadrant. She reported menstrual cramps and vaginal bleeding. An intrauterine pregnancy had not been confirmed as of yet, but her b-hCG was up-trending in

the office. She was sent to the ED due to pain and concern for an ectopic pregnancy. She was then noted to report right lower quadrant tenderness (in the ED she reported bilateral lower quadrant tenderness, more on the left), and there is a reference to "declines right pelvic management". She had a prior history of pelvic infection following a miscarriage. Dr. Raza ordered a transvaginal ultrasound that was reviewed by Dr. Reena Malhotra. The ultrasound report was electronically signed by a radiology resident, and was reviewed, edited, and electronically signed by Dr. Malhorta, the attending radiologist. The ultrasound report was re-directed to Dr. Piboon. Dr. Malhorta testified at her deposition that she was employed by LIJMC; that on March 16, 2018, she working from home and was not physically present in LIJMC when she reviewed the ultrasound images and report; and that she never met Ms. Staab or had any contact with her.

The clinical information in the ultrasound report included a report of left-sided pain since the morning; it was noted that Ms. Staab had multiple prior pregnancies and prior cesarian section; that she had experienced mild vaginal bleeding since Saturday (March 10); that there was a question of whether there was an ectopic pregnancy; that the b-hCG was 17,811 and the gestational age by the last menstrual period was 6 weeks, 1 day. The uterus was noted to have several fibroids, measuring 5.2 x 4.5 x 5.0, 5.6 x 4.3 x 6.0, and 6.7 x 6.4 x 6.4 cm; that there was no gestational sac identified in the endometrial cavity. The report states that the left adnexa demonstrated marked dilation of the left fallopian tube with ill-defined echogenic material within the tube concerning for hemorrhagic material; a rounded anechoic focus was identified within the left tube, which was likely an ectopic pregnancy. The report's impression was "no intrauterine gestational sac. Left tubal ectopic pregnancy. Echogenic, likely hemorrhagic, material in the left fallopian tube". The report does not suggest the possibility of any uterine anomaly, such as septate uterus or bicornuate uterus.

Ms. Staab was admitted to LIJMC at about 12:57 a.m. on March 17, 2018, in order to undergo surgery with a private attending obstetrician, Dr. Lynda Piboon. Dr. Piboon testified at her deposition that she is employed by WHP and that she also takes voluntary calls from LIJMC. She stated that on March 16-17, 2018, she was on-call solely for WHP (Tr 25); that she received a she got a call from Ms. Staab's sister via WHP's answering service, stating that Ms. Staab was having pain and bleeding and that they were going to the emergency room at LIJMC. Dr. Piboon stated that she called the residents at LIJMC's to make them aware that this patient was coming in, in order to expedite matters, and that Dr. Scanlon called her back that evening to inform her that this was an ectopic pregnancy (Tr 17- 20). Dr. Piboon stated that she arrived at the hospital after 9:00 p.m., at which time she understood that she was needed for surgical intervention. She further stated that when she operated on Ms. Staab she

was acting a private attending, strictly as an employee of WHP (Tr. 26). Prior to surgery, she saw Ms. Staab once in the emergency room and once in the pre-op area right before they went into the operating room. She stated that while in the emergency room, she spoke to Ms. Staab about what was going on with her situation or case, the treatment options, the surgery and its risks, and her history at WHP. She stated that Ms. Staab asked who she was, as she had not met her before at WHP, and that she told Ms. Staab that "I am Dr. Piboon. I am with the Women's Health Pavilion" (Tr 30).

Dr. Piboon stated that WHP is a group practice; that in March 2018, Ms. Staab was seen by Courtney Haggerty, a nurse practitioner; and that as Staab was a patient at WHP for years she could have been taken care of by physician assistants, nurse practitioners and attending OBs; and that she did not know if a specific OB had been assigned to Ms. Staab at this time (Tr 30-31). Dr. Piboon further stated that Ms. Staab verbally consented to the laproscopic removal of an ectopic pregnancy; that Staab told her that she wanted both her fallopian tubes removed; and that Staab signed the consent form.

The consent form signed by Ms. Staab authorized Dr. Piboon, with the assistance of "residents" to perform a "diagnostic laparoscopy, removal of ectopic pregnancy, possible removal of bilateral fallopian tubes". The operative report was dictated by Dr. Scanlon on March 19, 2018 at 5:12 a.m. and electronically signed by Dr. Piboon on March 21, 2018 at 8:37 p.m. The pre-operative diagnosis was noted to be "left ectopic pregnancy, desire for permanent sterilization". The indications for the surgery included the history that the patient presented with pelvic pain and pregnancy of unknown location. Id. Her b-hCG was 17,000 and a transvaginal ultrasound confirmed a left tubal ectopic pregnancy and no intrauterine gestational sac was identified. A pathology report returned on March 23, 2018 found that there were no products of contraception noted in the left fallopian tube. The right fallopian tube was unremarkable.

On March 22, 2018, Ms. Staab presented to Dr. Teresita Santiago-Escalera at WHP. Her status was documented as " post laparoscopic bilateral salpingectomy for left ectopic pregnancy seen on US and undesired future fertility." It was noted that Ms. Staab had a now rising b-hCG trend with a level of 24,875 two days earlier (up from 19,488 on March 16th). An ultrasound performed in the office showed "no definite evidence of IUP. Fluid filled endometrium, no vascular flow noted unable to determine if retained products present…Cannot r/o ectopic pregnancy." The patient was offered and declined an endometrial biopsy. Dr. Santiago-Escalera discussed the case with Dr. Piboon who stated that she would follow-up with the patient regarding her next step. Another b-hCG blood test

resulted a level of 26,045.

Ms. Staab was seen at NSUH Plainview on March 28, 2018 for a same day surgery. Dr. Piboon was noted to be the admitting physician. Ms. Staab was diagnosed with a missed abortion based on an "inappropriate rise in b-hCG and a suspected gestational sac in the right uterine horn" and she was scheduled for a D & C. Prior to the procedure, a b-hCG was performed and was consistent with a pregnancy of 4-5 weeks gestation (26,996). Dr. Piboon performed the D & C without any apparent complications, and documented in the "Postoperative Diagnoses" section of her operative report "suspected gestational sac in right uterine horn". During the procedure, the patient was noted to have a uterine septum, which divided the uterus into left and right portions (i.e. a left and right horn of a Mullerian anomaly). Dr. Piboon noted that the right portion of the cavity was smaller and contained a suspected gestational sac in the fundal portion. Under ultrasound guidance, the cervix was dilated to allow entry into the right horn of the uterus and suction curettage removed "copious amounts of products of conception". Ms. Staab was discharged with instructions to follow with Dr. Piboon in two weeks.

Ms. Staab presented to Dr. Piboon on April 13, 2018, with a complaint of slight abdominal pain. Dr. Piboon documented that she explained the circumstances of the surgeries, pathology report, and ultrasound findings to the patient, her husband, and her mother-in-law. This conversation was recorded by Mr. Staab on his cell phone without Dr. Piboon's knowledge.

Defendants Lauren Scanlon, M.D., Reena Malhotra, M.D., and LIJMC now move for summary judgment dismissing the complaint in its entirety. In support of the within motion defendants submit, among other things an affirmation from their expert, Mark Levie, a physician licensed to practice medicine in the State of New York, who is Board Certified in Obstetrics and Gynecology.

Plaintiffs cross move in opposition and seeks summary judgment on their cause of action for negligence per se against defendants Lynda Piboon, M.D., Lauren Scanlon, M.D. and LIJMC. In opposition to the defendants motion, plaintiffs submit an affidavit from a name-redacted physician who is licensed to practice medicine in the State of Massachusetts and is Board Certified in Obstetrics and Gynecology. Plaintiffs also submit an audio CD of a conversation between the plaintiffs, Ms. Staab's sister and Piboon, that was recorded by Mr. Staab on his cell phone, without Piboon's knowledge.

Defendants in their reply assert, among other things, that the affidavit of the plaintiffs' medical expert is defective in that said physician has failed to state that he or she is familiar with the standard of care in the State of New York, as it existed in 2018.

" 'In order to establish the liability of a physician for medical malpractice, a plaintiff must prove that the physician deviated or departed from accepted community standards of practice, and that such departure was a proximate cause of the plaintiff's injuries' " (*M.C. v Huntington Hosp*., 175 AD3d 578, 579 [2d Dept 2019], quoting *Stukas v Streiter*, 83 AD3d 18, 23 [2d Dept 2011]; *see Joyner v Middletown Med., P.C.*, 183 AD3d 593 [2d Dept 2020] *Simpson v Edghill*, 169 AD3d 737, 738[2d Dept 2019]). "A defendant seeking summary judgment in a medical malpractice action must make a prima facie showing either that he or she did not depart from the accepted standard of care or that any departure was not a proximate cause of the plaintiff's injuries" (*M.C. v. Huntington Hosp*., 175 AD3d at 579). "Where the defendant has satisfied that burden, a plaintiff must 'submit evidentiary facts or materials to rebut the defendant's prima facie showing'" (id., quoting *Stukas v Streiter*, 83 A.D.3d at 30; *see Carradice v Jamaica Hosp. Med. Ctr.*, AD3d , 2021 NY Slip Op 05688 [2d Dept 2021]). " 'Expert testimony is necessary to prove a deviation from accepted standards of medical care and to establish proximate cause' " (*M.C. v Huntington Hosp*., 175 AD3d at 579, quoting *Novick v South Nassau Communities Hosp*., 136 AD3d 999, 1000 [internal quotation marks omitted]). In order not to be considered speculative or conclusory, expert opinions in opposition should address specific assertions made by the movant' experts, setting forth an explanation of the reasoning and relying on "specifically cited evidence in the record" (*Tsitrin v New York Community Hosp*., 154 AD3d 994, 995-96 [2d Dept 2017], quoting *Roca v Perel*, 51 AD3d 757, 759 [2d Dept 2008]; *see Brinkley v Nassau Health Care Corp*., 120 AD3d 1287, 1290 [2d Dept 2014]).

Defendants LIJMC, Scanlon and Malhotra have established their prima facie entitlement to judgment as a matter of law dismissing the complaint, by submitting among other things, the affirmation of its expert Dr. Mark Levie, a physician licensed to practice in the State of New York and Board Certified in Obstetrics and Gynecology, who opines, based upon his review of the pleadings, bills of particulars, deposition testimony and relevant medical records, imaging that said defendants assessment, care and treatment of plaintiff Krisztina Staab was appropriate in all respects and comported with good and acceptable standards of medical and gynecological practice, and that no act or omission by the moving defendants was a substantial factor in causing injury to Ms. Staab.

With respect to defendant LIJMC, "[i]n general, under the doctrine of respondeat

superior, a hospital may be held vicariously liable for the negligence or malpractice of its employees acting within the scope of employment, but not for negligent treatment provided by an independent physician, as when the physician is retained by the patient himself " (*Seiden v Sonstein,* 127 AD3d 1158, 1160 [2d Dept 2015]; *see Hill v St. Clare's Hosp.,* 67 NY2d 72, 79 [1986]; *Fuessel v Chin,* 179 AD3d 899, 901 [2d Dept 2020]; *Dupree v Westchester County Health Care Corp.,* 164 AD3d 1211, 1213 [2d Dept 2018]). " 'As a general rule, a hospital is not vicariously liable for the malpractice of a private attending physician who is not its employee' " (*Gaelic v Grossman,* 161 AD3d 1049, 1052 [2d Dept 2018], *quoting Padua v Baikal,* 266 AD2d 524, 524, [2d Dept 1999]; *see Kinnock v Mercy Med. Ctr*., 180 AD3d 1088, 1092-93 [2d Dept 2020] *Sampson v Costello,* 55 AD3d 588, 589 [2d Dept 2008]). However, a hospital may be held vicariously liable for the acts of independent physicians where a patient enters the hospital through the emergency room seeking treatment from the hospital and not from a particular physician of the patient's choosing (*see Kinnock v Mercy Med. Ctr*., 180 AD3d at 1092-93; *Gaelic v Grossman,* 161 AD3d at 1052; *Salvatore v Winthrop Univ. Med. Ctr.,* 36 A.D.3d 887, 888 [2d Dept 2007]). "Thus, in order to establish its entitlement to judgment as a matter of law defeating a claim of vicarious liability, a hospital must demonstrate that the physician alleged to have committed the malpractice 'was an independent contractor and not a hospital employee' " (*Muslim v Horizon Med. Group, P.C.,* 118 AD3d 681, 683 [2d Dept 2014], *quoting Alvorada v Beth Israel Med. Ctr.,* 78 AD3d 873 [2d Dept 2010] "and that 'the exception to the general rule did not apply' " (*Muslim v Horizon Med. Group, P.C.,* 118 AD3d at 683, *quoting Rizzo v Staten Is. Univ. Hosp.,* 29 AD3d 668, 668–669 [2d Dept 2006]; *see Kinnock v Mercy Med. Ctr*., 180 AD3d at 1092-93).

Here, the evidence presented establishes that Ms. Staab went to the emergency room of LIJMC on March 16, 2018, after calling WHP. Although she was initially treated and examined by the hospital's employees, including defendants Scanlon and Malhotra, the surgery was performed by Dr. Piboon, who acted solely as a private attending physician employed by WHP. There is no evidence that Ms. Staab was unaware of Dr. Piboon's relationship to WHP. This Court therefore finds that LIJMC has properly established that the Dr. Piboon was an independent contractor and not a hospital employee, and therefore the exception to the general rule is not applicable here.

A hospital cannot be held concurrently liable with a private attending physician unless its employees committed independent acts of negligence or the attending physician's orders are contraindicated by normal practice (*see Zhuzhingo v Milligan*, 121 AD3d 1103, 1106 [2d Dept 2014]; *Corletta v Fischer*, 101 AD3d 929, 930 [2d Dept 2012]; *Cerny v Williams*, 32

AD3d 881, 883 [2d Dept 2006]). "When supervised medical personnel are not exercising their independent medical judgment, they cannot be held liable for medical malpractice unless the directions from the supervising superior or doctor so greatly deviates from normal medical practice that they should be held liable for failing to intervene" (*Bellafiore v Ricotta*, 83 AD3d 632, 633 [2d Dept 2011]; *see Costello v Kirmani*, 54 AD3d 656, 657 [2d Dept 2008]).

With respect to Dr. Scanlon, it is undisputed that in March 2018, she was a second year resident, employed by LIJMC. "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" (*Quille v New York City Health & Hosp. Corp*., 152 AD3d 808, 809 [2d Dept 2017] [quotation marks and citations omitted]; *see Tsocanos v Zaidman*, 180 AD3d 841 [2d Dept 2020]; *Poter v Adams*, 104 AD3d 925 [2d Dept 2013]). "Even where a resident plays an active role in [the] plaintiff's procedure, the resident cannot commit malpractice unless he or she was shown to have exercised some independent medical judgment" (*Blendowski v Wiese*, 158 AD3d 1284, 1285,[4th Dept 2018] [quotation marks, citations, and alterations omitted]; *see Tsocanos v Zaidman, supra*).

Here, defendants' expert, Dr. Lavie opines that Dr. Scanlon was acting under the direct supervision and control of Attending Physician Lynda Piboon, M.D., when she treated Ms. Staab; that Dr. Piboon made all treatment decisions and directly instructed Scanlon on what treatment she wanted to be provided to Ms. Staab; and that Scanlon did not commit any independent acts. He opines that there was nothing about Piboon's treatment decisions that was so clearly contraindicated that would require Scanlon to question or refuse to follow the orders as by Piboon; and that since Scanlon was acting under the direct supervision of an Attending Physician, did not commit any independent act of malpractice, and implemented a seemingly appropriate treatment plan set by the Attending Physician, all claims against her should be dismissed.

Dr. Lavie states that an ultrasound is the "gold standard" for the diagnosis of ectopic pregnancy. As regards Dr. Malhorta, Dr. Lavie opines with a reasonable degree of medical certainty that she properly read the transvaginal ultrasound performed in the LIJMC emergency department; that said ultrasound did not demonstrate the presence of a gestational sac; failed to identify any signs of a viable intrauterine pregnancy; and demonstrated a dilated and edematous left fallopian tube along with an abnormal adnexa mass. Dr. Lavie opines with a reasonable degree of medical certainty that "based upon the absence of a visible gestational sac on ultrasound, a dilated and edematous left fallopian tube, an abnormal left adnexal mass,

an abnormal trending of the b-hCG which was inconsistent with a normal intrauterine pregnancy, and the patient's clinical presentation to the ED which consisted of left lower quadrant abdominal pain, vaginal bleeding and passing of clots", that "the impression of the radiologists of a left tubal ectopic pregnancy was entirely appropriate and the decision of the clinicians to proceed with surgical intervention to remove the suspected ectopic pregnancy was consistent with good and accepted standards of medical care and practice". He further opines that surgical removal of the left fallopian tube was warranted based upon the patient's ultrasound and clinical findings upon presentation and was within the standard of care, as the patient was experiencing abdominal pain and there was reasonable concern over an actual rupture or pending rupture of the left fallopian tube associated with the diagnosis of an ectopic pregnancy. He states that conservative treatment was not an option for Ms. Staab based upon her abnormal but still elevatedb-hCG and her clinical symptoms of left lower quadrant abdominal pain, and that treatment with Methotrexate was not a viable option as the efficacy of Methotrexate as a treatment option deteriorates with b-hCG levels exceeding 10,000 and Ms. Staab's b-hCG level exceeded 10,000 and she was in pain with evidence of guarding on examination.

Dr. Lavie further opines that Ms. Staab's pregnancy was non-viable as confirmed by abnormal b-hCG testing which demonstrated levels that were not rising within the standard time frames consistent with a viable pregnancy. He opines that irrespective of whether it was subsequently determined that there was an intrauterine pregnancy present in the left fallopian tube the pregnancy was nevertheless non-viable such that a diagnostic laparoscopy was warranted, and that since the patient still has her uterus and ovaries, pregnancy via in vitro fertilization with her own eggs is an option. In addition, Dr. Lavie opines that even if the bilateral salpingectomy had not been performed, Ms. Staab's chances of becoming pregnant and carrying a viable pregnancy are extremely low and unlikely. He states that her advanced maternal age, history of fibroids, prior pelvic infection, miscarriages, dilated fallopian tube, and septate uterus would have significantly decreased her already low probability for carrying a viable pregnancy.

Dr. Lavie also opines that the care and treatment rendered by defendants LIJMC, Malhotra and Scanlon was at all times reasonable and within the accepted standards of medical care, and did not exhibit any gross recklessness, wanton, malicious, evil or repugnant conduct.

As regards plaintiffs' third cause of action predicated on lack of informed consent, "where a private physician attends his or her patient at the facilities of a hospital, it is the duty

of the physician, not the hospital, to obtain the patient's informed consent" (*Salandy v Bryk*, 55 AD3d 147, 152 [2d Dept 2008]; *see Cynamon v Mount Sinai Hospital*, 163 AD3d 923 [2d Dept 2018]; Doria v Benisch, 130 AD3d 777, 778; *Tomeo v Beccia,* 127 AD3d at 1074 ; *Sita v Long Is. Jewish–Hillside Med. Ctr*., 22 AD3d 743 [2d Dept 2005]). It is only where the hospital knew or should have known that the private physician was acting or would act without the patient's informed consent that it may be held liable (see *Cynamon v Mount Sinai Hospital*, 163 AD3d at 923; *Tomeo v Beccia*, 127 AD3d at 1074; *Bradshaw v Lenox Hill Hosp.*, 126 AD3d 484, 485 [1st Dept 2015]; *Salandy v Bryk*, 55 AD3d at 152; *Sita v Long Is. Jewish–Hillside Med. Ctr*., 22 AD3d at 743). Here, LIJMC, Scanlon and Malhotra have established prima facie their entitlement to judgment dismissing the cause of action for lack of informed consent. Dr. Lavie has opined that it was the duty of the patient's private attending physician and not the hospital to obtain the patient's informed consent; that there is no evidence to suggest that LIJMC knew or should have known that Piboon was acting without Ms. Staab's informed consent; and that hospital's chart evidenced her consent had been obtained.

Plaintiffs' in opposition proffer a name redacted affidavit from a physician licensed in Massachusetts. An expert need not be from the exact same locality where the occurrence took place . "It is sufficient if the expert attests to familiarity with either the standard of care in the locality or to a minimum standard applicable locally, statewide, or nationally" (*M.C. v Huntington Hosp*., 175 AD3d at 580-581; *see McCullough v University of Rochester Strong Mem. Hosp*., 17 AD3d 1063 [4d Dept 2005]; *Payant v Imobersteg*, 256 AD2d 702 [3d Dept 1998]; *Hoagland v Kamp*, 150 AD2d 148 [2d Dept 1990]). Plaintiffs' expert states in his/her affidavit that he/she is familiar with "the standard of care" without attesting to a familiarity with the standard of care in New York, or to a minimum standard applicably locally, statewide or nationally, as it existed in 2018. The affidavit of plaintiffs' expert therefore is deficient and is rejected.

This Court further finds that plaintiffs' expert improperly relies upon an audio cd submitted by plaintiffs' in support of the motion. Said audio cd does not constitute evidence in the record. Moreover, this Court will not consider said audio cd, as there is no evidence that the conversation recorded by Mr. Staab on his cell phone is accurate or that it was fairly and accurately reproduced (*see generally Oi Tai E1 Entertainment U.S. LP v Real Talk Entertainment, Inc*., 42 Misc 3d 1210(A) [Sup Ct New York County 2013]; *Chan v Socy. of Shaolin Temple, Inc*., 30 Misc.3d 244, 252–53 [Sup Ct, Queens County 2010]). Plaintiffs' thus have failed to raise a triable issue of fact with respect to the second and third causes of action for medical malpractice and lack of informed consent.

Plaintiffs' first cause of action for negligence is based upon the alleged medical malpractice and lack of informed consent. As no independent acts of a negligence are alleged, the first cause of action for negligence is also dismissed as to defendants LIJMC, Scanlon and Malhotra.

As regards plaintiffs' fourth cause of action against LIJMC, a hospital is required to review an independent physician's qualifications before granting or renewing privileges (Public Health Law §§ 2805–j; 2805–k; *see Ortiz v Jaber*, 44 AD3d 632, 633 [2d Dept 2007]; *Condolff v State of New York,* 18 AD3d 797 [2d Dept 2005]). In the absence of any evidence that LIJMC acted in violation of its by-laws or the Public Health Law in credentialing or re-credentialing Piboon, or that it acted this claim must be dismissed as no basis for liability exists (*see Ortiz v Jaber*, 44 AD3d 632, 633 [2d Dept 2007]).

Furthermore, "[g]enerally, where an employee is acting within the scope of his or her employment, the employer is liable for the employee's negligence under a theory of respondeat superior and no claim may proceed against the employer for negligent hiring, retention, supervision or training" (*Talavera v Arbit*, 18 AD3d 738, 738 [2d Dept 2005]; *see Henry v Sunrise Manor Ctr. for Nursing and Rehabilitation*, 147 AD3d 739, 741-42 [2d Dept 2017]; *Quiroz v Zottola*, 96 AD3d 1035, 1037 [2d Dept 2012]; *see also Weinberg v Guttman Breast & Diagnostic Inst.*, 254 AD2d 213, 213 ([1st Dept 1998]). Here, defendants have established prima facie that LIJMC's employees, including Scanlon and Malhotra, were acting within the scope of their employment, and plaintiffs in opposition have failed to raise a triable issue of fact. While an exception exists to the above general principle where the plaintiff seeks punitive damages from the employer "based on alleged gross negligence in the hiring or retention of the employee" (*Talavera v Arbit*, 18 AD3d at 738), that exception is inapplicable here, as plaintiff does not allege gross negligence in the hiring or retention of its employees, and does not seek to recover punitive damages with respect to this cause of action.

Defendants also seek to dismiss the claims for punitive damages. The sixth cause of action for negligent infliction of emotional distress and the seventh cause of action for intentional infliction of emotional distress seek to recover compensatory and punitive damages.

A cause of action for negligent infliction of emotional distress requires a showing that a breach of duty resulted in unreasonable endangerment of the plaintiff's safety, or fear for the plaintiff's safety (*Sacino v Warwick Valley Cent. School Dist.*, 138 AD3d 717 [2nd Dept 2016]). There must be a direct link between the mental injury and the defendant's negligence,

together with a genuine emotional injury (*Taggart v Costabile*, 131 AD3d 243 [2nd Dept. 2015]). Here, plaintiffs base this claim upon the alleged malpractice and the alleged lack of informed consent. As to Mr. Staab, this claim must be dismissed as he cannot reasonably claim that his safety was endangered or that he was in fear for his safety based upon his wife treatment and surgery at LIJMC. As to Ms. Staab, her claim must fail as well, as she cannot establish that the movants were responsible for obtaining her consent to the surgery performed by the private attending physician, and cannot be liable for the alleged medical malpractice.

"The elements of intentional infliction of emotional distress are (1) extreme and outrageous conduct; (2) the intent to cause, or the disregard of a substantial likelihood of causing, severe emotional distress; (3) causation; and (4) severe emotional distress" (*Klein v Metropolitan Child Servs*., Inc., 100 AD3d 708, 710 [2d Dept 2012]; *see Marmelstein v Kehillat New Hempstead: Rav Aron Jofen Community Synagogue*, 11 NY3d 15, 22–23 [2008]; *Howell v New York Post Co.*, 81 NY2d 115, 121 [1993]; *Petkewicz v Dutchess County Dept. of Community & Family Services*, 137 AD3d 990, 990-91 [2d Dept 2016]; *Taggart v Costabile*, 131 AD3d at 243). This claim is also based upon the alleged malpractice and lack of informed consent. As plaintiffs cannot establish that the movants were responsible for obtaining Ms. Staab's consent to the surgery performed by a private attending physician and were not responsible for obtaining her consent to said surgery, this claim must also be dismissed, as plaintiffs cannot establish that defendants' conduct was so extreme or outrageous as to satisfy the first element of intentional infliction of emotional distress.

Turning now to the fifth cause of action and plaintiffs' cross motion, said cause of action for negligence per se, is based upon violations of 18 NYCRR § 505.13(e) and 42 CFR §§ 50.203, 50. 204 and 50.205. Plaintiffs' in their cross motion for summary assert violations of the 30 day waiting period for elective sterilizations set forth in 18 NYCRR § 505.13(e) and Section 17-404 of the Administrative Code of the City of New York. In their reply, plaintiffs' also seek relief based upon a violation of 42 C.F.R. §50.203.

Both 18 NYCRR § 505.13(e) and 42 C.F.R. §50.203 provide that absent a premature delivery or emergency abdominal surgery, any consent to an elective sterilization by Medicaid patients must be given at least 30 but no more than 180 days before the procedure is performed (*see also Hare v Parsley,* 157 Misc 2d 277 [Sup Ct, Albany County 1993]). Here, plaintiffs neither allege nor have they established that Ms. Staab was a Medicaid patient at the time she received treatment from the moving defendants. Notably, Ms. Staab testified at her deposition that she was never a Medicaid recipient (Tr 28). Therefore, as Ms. Staab is not a member of the class of persons that the Federal and State regulations are intended to protect,

plaintiffs cannot establish prima facie their entitlement to summary judgment on the fifth cause of action for negligence per se. In addition, neither plaintiffs' verified complaint nor the bills of particulars allege a violation of Section 17-404 of the Administrative Code of the City of New York, and plaintiffs have not sought to amend their complaint or bills of particulars. Plaintiffs therefore may not seek relief based upon an unpled claim. Defendants, however, are entitlement to the dismissal of said cause of action (*see* CPLR 3212 [b]).

As regards defendant Lynda Piboon, M.D., said defendant has not moved for relief under motion sequence number 2. Therefore, plaintiffs' cross motion is an improper vehicle to seek relief against this defendant within the context of this motion (*see* CPLR 2215; *Mango v Long Island Jewish-Hillside Medical Center*, 123 AD2d 843 [2d Dept 1986]).

Plaintiffs' eighth and ninth causes of action are for assault and battery. "To sustain a cause of action to recover damages for assault, there must be proof of physical conduct placing the plaintiff in imminent apprehension of harmful contact" (*Cayruth v City of Mount Vernon*, 188 AD3d at 1140-41 quoting, *Cotter v Summit Sec. Servs., Inc.*, 14 AD3d 475, 475 [2d Dept 2005] [internal quotation marks omitted]). "To recover damages for battery, a plaintiff must prove that there was bodily contact, made with intent, and offensive in nature" (*Cotter v Summit Sec. Servs. Inc.*, 14 AD3d at 475). Notwithstanding the Ms. Saab's allegations and testimony that she never gave permission for the removal of both of her fallopian tubes, the signed consent form clearly authorized such a procedure, and she admitted that she signed the consent form. Therefore, these causes of action must be dismissed (*see Thaw v N. Shore Univ. Hosp.*, 129 AD3d 937, 939 [2d Dept 2015]).

Finally, as all of the causes of action asserted by Ms. Staab have been dismissed, the tenth cause of action for loss of services is also dismissed.

In view of the foregoing, defendants' motion to dismiss the complaint is granted in its entirety and plaintiffs' cross motion for summary judgment on their fifth cause of action for negligence per se, is denied.

Dated: November 19, 2021

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Peter J. O'Donoghue, J.S.C.