Gist v Santiago
2023 NY Slip Op 33891(U)
August 29, 2023
Supreme Court, Kings County
Docket Number: Index No. 500810/2020
Judge: Consuelo Mallafre Melendez
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SUPREME COURT OF THE CITY OF NEW YORK
COUNTY OF KINGS
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CHEVONNA GIST,

Plaintiff,

-against-

ALLAN R. SANTIAGO, M.D., HOPE MEDICAL OF NEW YORK, P.C., INTERFAITH MEDICAL CENTER, BISHOP ORRIS G. WALKER JR. HEALTH CARE CENTER AND NEW YORK CITY HEALTH AND HOSPITALS CORPORATION (KINGS COUNTY HOSPITAL),

Defendants.
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DECISION & ORDER
Index No. 500810/2020

Motion Sequences: 003, 004, 005, 006

HON. CONSUELO MALLAFRE MELENDEZ, J.S.C

Recitation, as required by CPLR §2219 [a], of the papers considered in the review: NYSCEF #s: 106, 107-127; 131, 132-150, 176; 152, 153-162; 165, 166-169, 173-174.

Defendant INTERFAITH MEDICAL CENTER moves this court for an Order pursuant to CPLR §3212, dismissing the plaintiff's complaint with prejudice and directing that summary judgment be entered in its favor (Sequence 003).

Defendant NEW YORK CITY HEALTH AND HOSPITALS CORPORATION s/h/a NEW YORK CITY HEALTH AND HOSPITALS CORPORATION ("NYCHHC") (KINGS COUNTY HOSPITAL ("KCH") moves this court for an Order pursuant to CPLR §3212, granting partial summary judgment dismissing all claims as against it that predate September 2, 2017 pursuant to CPLR § 3211(a)(5) and Uncon. Laws § 7401(2) as time barred; pursuant to CPLR § 3211(a)(2), Uncon. Laws § 7401(2) and General Municipal Law §§ 50-e, 50-i, and 50-k, dismissing all claims herein that pre-date September 2, 2017 as against it for failure to file a timely Notice of Claim; pursuant to CPLR § 3212(b) granting summary judgment in its favor and dismissing Plaintiff's complaint as against said defendant on the merits (Sequence 004).

Defendants ALLAN R. SANTIAGO, M.D., and HOPE MEDICAL OF NEW YORK, P.C., move this court for an Order pursuant to CPLR §3212 granting them summary judgment

and dismissing Plaintiff's complaint on the grounds that the claims made against said defendants lack merit and there are no triable issues of fact for a jury to resolve; and/or alternatively pursuant to CPLR §3211(a)(5) and §214-a, granting partial summary judgement to the moving defendants due to the expiration of the statute of limitations; and severing the action against these defendants (Sequence 005).

Plaintiff submits opposition to the above motions however, Plaintiff does not oppose the motion seeking dismissal of claims relating to the alleged negligent care rendered by ALLAN R. SANTIAGO, M.D., and HOPE MEDICAL OF NEW YORK, P.C. Accordingly, summary judgment is granted and all claims relating to ALLAN R. SANTIAGO, M.D., and HOPE MEDICAL OF NEW YORK, P.C. are dismissed, as unopposed (Sequence 005).

Plaintiff moves this court by cross motion for an Order deeming the Notice of Claim previously served on defendant NYCHHC on March 5, 2019, timely served; or, in the alternative, deeming the Notice of Claim previously served on defendant NYCHHC on March 5, 2019, timely served, *nunc pro tunc*; or granting Plaintiff leave to serve a new Notice of Claim, *nunc pro tunc* (Sequence 006). Defendant NYCHHC submits opposition to Plaintiff's cross motion.

In this case, Plaintiff claims that Defendants failed to timely diagnose Plaintiff's endometriosis causing Plaintiff to undergo a more extensive surgery including insertion of a percutaneous nephrostomy tube and subsequent surgical reinsertion of the ureter, and a colostomy. Defendants argue there are no departures from the standard of care and that an earlier diagnosis would not have changed the treatment Plaintiff received.

Turning first to the issue of whether the Notice of Claim was timely filed and whether the action was timely commenced by the Plaintiff, the court finds that both the statute of limitations and the time to file a Notice of Claim were tolled by the continuous treatment doctrine. Furthermore, as treatment was still ongoing at the time the Notice of Claim dated March 5, 2019 was filed, it was timely filed. Furthermore, as demonstrated below, the statute of limitations did not begin to run until April 19, 2019, and was continuous from February 22, 2016.

Pursuant to General Municipal Law § 50–e(1)(a), a party seeking to sue a public corporation must serve a Notice of Claim on the prospective defendant within 90 days after the claim arises. See *Matter of Newcomb v. Middle Country Cent. Sch. Dist*., 28 N.Y.3d 455, 460 [2016]. However, under the continuous treatment doctrine, the time to file a Notice of Claim upon a municipal entity does not begin until the end of the course of treatment. *Baltzer v. Westchester Medical Center*, 209 AD3d 815, 816 [2d Dept. 2022] [internal citation omitted]. Additionally, "[a]n action against a public corporation to recover damages for medical malpractice or conscious pain and suffering must be commenced within one year and 90 days after the accrual of the cause of action [internal citations omitted]." *Watts v. City of New York*, 186 AD3d 1574, 1576 [2d Dept. 2020]. The continuous treatment doctrine may toll both the time to file the Notice of Claim and the statute of limitations so long as "'(1) the patient continued to seek, and in fact obtained, an actual course of treatment from the defendant physician during the relevant period; (2) the course of treatment was for the same conditions or complaints underlying the plaintiff's medical malpractice claim; and (3) the treatment is continuous.'" *Weinstein v. Gewirtz*, 208 AD3d 717, 719 [2d Dept. 2022][internal citations omitted].

In the instant matter, Defendant NYCHHC argues that the continuous treatment doctrine does not apply to the treatment the plaintiff received in this case. Specifically, Defendant correctly argues that the continuous treatment doctrine is meant to avoid putting the patient in the position of choosing between commencing a lawsuit and thus destroying the relationship of trust and confidence between the patient and the healthcare provider, or foregoing the lawsuit or claim in order to continue treatment with a provider knowledgeable about the patient's condition. See *Rizk v. Cohen*, 73 N.Y.2d 98, 104 [1989]; see also *Young v. New York City Health & Hosps. Corp.*, 91 N.Y.2d 291, 296 [1998]]. Defendant further argues that all of Plaintiff's visits to the KCH emergency department and the KCH GYN clinic prior to September 2, 2017 were discrete and sporadic and that continuous treatment is only applicable "when further treatment is explicitly anticipated by both the physician and the patient as manifested in the form of regularly scheduled appointments for the near future, agreed upon during that last visit, in conformance with the periodic appointments which characterized the treatment in the immediate past".

Richardson v. Orentreich, 64 N.Y.2d 896, 898-899 [1985]; *Cox v. Kingsboro Medical Group*, 88 N.Y.2d 904, 906 [1996].

In opposition, Plaintiff argues that Ms. Gist has "repeatedly made complaints regarding the same or similar symptoms, [and] it is not determinative that the plaintiff also sought relief for those complaints from other providers." Plaintiff further argues that continuous treatment is applicable where, as here, she returned to KCH and "continued to complain of the same or related symptoms". *See Glasby v. Fogler*, 303 AD2d 718 [2d Dept. 2003][citing Klotz v. Rabinowitz, 252 AD2d 542. 543 [2d Dept. 1998]["The continuous treatment doctrine will be applied where the patient initiates a timely visit to complain about and seek treatment for a problem related to the initial treatment."].

According to Plaintiff's expert's timeline of treatment, to which the Defendant NYCHHC does not object, Plaintiff first visited the emergency room at KCH, owned and operated by NYCHHC, on February 22, 2016, with complaints of rectal pain for two weeks, abdominal pain for two days, headache and abdominal tenderness. On that date, she was told to follow up with the GYN clinic within three days. Three days later, on February 25, 2016, Plaintiff presented to the KCH GYN clinic, as instructed, and was diagnosed with "Leiomyoma [fibroid] of uterus, unspecified." On March 28, 2016, just over one month later, Plaintiff again presented to the KCH GYN Clinic with complaints of right sided abdominal pain with menses and was diagnosed with Leiomyoma of uterus, unspecified Dysmenorrhea, unspecified and abnormal uterine and vaginal bleeding. A VABRA evaluation, which Plaintiff's expert describes as a biopsy of endometrial tissue, was scheduled. The following month, on April 12, 2016, Plaintiff presented to the KCH emergency room with complaints of severe radiating lower abdominal pain for one day and a CT scan and a physical exam revealed palpable fibroids. Plaintiff was discharged with pain medication.

Two months later, on June 17, 2016, Plaintiff presented to KCH and the VABRA evaluation was conducted. On October 29, 2016, four months after the previous visit, Plaintiff presented to KCH emergency room with complaints of worsening severe abdominal pain, non-bloody emesis, and decreased urination with dysuria, and a "[p]elvic sonogram show[ed] simple

right ovarian cyst and large anterior fibroid." The patient's pain was deemed secondary to the fibroid and constipation. The patient was discharged with pain medications and Miralax. A mere four days later, on November 2, 2016, Plaintiff again presented to KCH emergency room with complaints of chronic constipation for two weeks and was given an enema, stool softeners, and a laxative. Plaintiff was discharged with a laxative. Later that month, on November 20, 2016, Plaintiff presented to the KCH emergency room with complaints of lower abdominal pain, straining to have bowel movements and blood coming out of her rectum. KCH noted the patient had hemorrhoids, lab work was recommended, and Plaintiff was referred to KCH GYN clinic for management. Two days later, on November 22, 2016, Plaintiff presented to the KCH GYN clinic and was diagnosed with Dysmenorrhea, unspecified, and options for treatment were discussed. Just over two weeks later, on December 5, 2016, Plaintiff presented to the KCH GYN clinic where she agreed to and scheduled a diagnostic laparoscopy, which was subsequently cancelled by the patient in January of 2017. On December 5, 2016, the patient also agreed to Lupron injections and had her first Lupron injection. According to Defendant's expert, Dr. Menzin, "Lupron is an injectable, manufactured hormone that can be used to treat various diagnoses including endometriosis." On March 21, 2017, Plaintiff presented to the KCH emergency room with complaints of abdominal and lower abdominal pain. She left before being examined. The next time Plaintiff presented to KCH was September 2, 2017 with complaints of constant abdominal pain, dysuria and diarrhea and was admitted until September 5, 2017. A CT scan was performed which found right hydronephrosis and hydroureter. An ultrasound was performed and found no obstructing lesion or blockage. A percutaneous nephrostomy (PCN) tube was inserted and anterograde nephrostogram was performed and the patient was referred to the gynecology and urology clinics.

In between the above-described visits to KCH, Plaintiff presented to several other facilities. Plaintiff presented to the emergency room at co-defendant Interfaith on July 12, 2016, complaining of abdominal pain for six days. Plaintiff then presented to the Hope Clinic on July 18, 2016, July 25, 2016, and August 22, 2016, with complaints of back, neck, knee and chest pain. On October 3, 2016 and on October 28, 2016, Plaintiff presented to Hope Clinic with

complaints of constipation, abdominal pain, back and neck pain as well as weight loss associated with flatulence. Plaintiff also presented to the USA Vein Clinic on November 8, 2016 for examination for possible embolization treatment of fibroids. Those records indicated that Plaintiff identified Kings County Hospital as her gynecologist. Plaintiff presented to the USA Vein Clinic on December 19, 2016, and the embolization procedure was performed. At about this same time, she was again seen at KCH, in the emergency room on November 20, 2016, and at KCH GYN clinic on November 22, 20216 and December 5, 2016, as mentioned above. Plaintiff again presented to the emergency room at co-defendant Interfaith May 14, 2017, June 8, 2017 - July 9, 2017, and July 10 - 12, 2017. Plaintiff again presented to the Hope Clinic on July 13, 2017, with complaints of blood in stool.

On September 25, 2017, Plaintiff presented to the KCH GYN clinic and a transabdominal and a transvaginal ultrasound was performed with unremarkable results and no blockages found. Ms. Gist declined an offer for surgical management and opted for a course of Lupron instead and the first dose was administered that day. On October 17, 2017, Plaintiff presented to the KCH emergency room with severe abdominal pain and constipation and a CT scan with contrast was performed which indicated a mass. On October 23, 2017, Plaintiff presented to KCH Radiation and Oncology where the results of her October 17, 2017 CT scan were reviewed and found to be highly suspicious for malignant neoplasm. An MRI of the pelvis with IV contrast was recommended for further evaluation and performed. On October 25, 2017, Plaintiff was admitted to KCH until November 16, 2017. During this admission Plaintiff had a vaginal biopsy which was consistent with endometriosis. On November 1, 2017, Plaintiff underwent an "[e]xploratory laparotomy, total abdominal hysterectomy, bilateral salpingo oophorectomy, lysis of adhesions, loop colostomy, and reimplantation of the ureter into bladder." Thereafter, Plaintiff presented to KCH for scheduled follow up appointments and post operative complications on November 19 – 21, 2017, November 30, 2017, December 4, 2017, December 7, 2017, December 14, 2017, and December 21, 2017. Plaintiff presented to KCH GYN Tumor clinic on January 11, 2018, the KCH Urology Department on January 29, 2018, the KCH Hematology Department on February 5, 2018, the KCH Tumor Clinic on November 1, 2018, and

the KCH emergency room on February 11, 2019, and April 19, 2019. During this period, she underwent another surgery for a cystoscopy, right retrograde pyelogram and right ureteral stent removal at the KCH Ambulatory Surgical Center on March 20, 2018.

Through their submissions, Plaintiff establishes that "'(1) the patient continued to seek, and in fact obtained, an actual course of treatment from the defendant physician during the relevant period; (2) the course of treatment was for the same conditions or complaints underlying the plaintiff's medical malpractice claim; and (3) the treatment is continuous.'" *Weinstein*, 208 AD3d at 719. According to the timeline above, Plaintiff followed up with the KCH GYN clinic within the time frames given by the treating physicians on multiple occasions, exhibiting her intention to return to KCH. Additionally, as supported by the record, Plaintiff went to KCH for scheduled follow up appointments and for post operative complications through April 19, 2019, including a second surgical procedure on March 20, 2018.

The Second Department has held that "[f]or the continuous treatment doctrine to apply, further treatment must be explicitly anticipated by both the physician and patient, as demonstrated by a regularly-scheduled appointment for the near future, which was agreed upon at the last visit and conforms to the periodic appointments relating to the treatment in the immediate past [internal citations and quotation marks omitted]." *Anderson v. Dental Brooklyn Medical Group*, 56 AD3d 500, 533 [2d Dept. 2008]. However, in *Ramos v. Rakhmanchik*, 48 AD3d 657, 658 [2d Dept. 2008] the Second Department also held that, "'[i]ncluded within the scope of 'continuous treatment' is a timely return visit instigated by the patient to complain about and seek treatment for a matter related to the initial treatment'" *Ramos v. Rakhmanchik*, 48 AD3d 657, 658 [2d Dept. 2008][citing *McDermott*, 56 NY2d 399 at 406][quoting *Couch v. County of Suffolk*, 296 AD2d 194, 196 [2d Dept. 2002]]. Notably, many of Plaintiff's visits prior to September 2, 2017, which Defendant describes as discrete and sporadic, occurred between dates for which procedures had been scheduled. Clearly, this shows Plaintiff's intention to return to KCH for further treatment while also instigating additional visits to complain about and seek treatment for gynecological issues relating to her fibroids and endometriosis.

Plaintiff presented to the emergency room at KCH with the same and/or similar symptoms each time, namely abdominal pain in varying degrees and constipation, among other things. Additionally, each time Plaintiff presented to the KCH facilities, she obtained treatment including testing, diagnoses, medications, and consultations for further treatment. Furthermore, the plaintiff's visits to the KCH facilities were continuous in that she presented to the facilities several times in certain months and the longest gap in treatment was approximately six months between March 21, 2017 and September 2, 2017. During that time Plaintiff had visited the emergency department at co-defendant Interfaith as well as the Hope Clinic. Notwithstanding the patient's history of non-compliance, the record shows she considered KCH as her provider of gynecological services. This is demonstrated by her return visits to KCH as well as Plaintiff identifying KCH as her gynecologist to the USA Vein Clinic on November 8, 2016, as noted above. Therefore, based on the submissions herein, the court finds that Plaintiff sought and obtained an actual course of continuous treatment from KCH between February 22, 2016 and April 19, 2019.

Defendant NYCHHC argues that because Plaintiff was being treated for fibroids and not the condition at issue, endometriosis, there is an absence of a continuous course of treatment. The court rejects Defendant's argument. It is established that a physician's failure to properly diagnose a condition that prevents treatment altogether does not toll the statute of limitations under this doctrine. *Gomez v. Katz*, 61 AD3d 108, 112 [2d Dept. 2009]; see *Young*, 91 NY2d at 297; *Nykorchuck v. Henriques*, 78 NY2d 255, 259 [1991]; *McDermott,* 56 N.Y.2d at 406. However, where a defendant doctor failed to make a correct diagnosis as to a patient's underlying condition, and "the defendant treated the plaintiff continuously over the relevant time period for symptoms that are ultimately traced to that condition" the continuous treatment doctrine is applicable. *Weinstein*, 208 AD3d at 719 [quoting *Cohen v. Gold*, 165 AD3d 879, 882 [2d Dept. 2018]]. The affirmations of the experts established that while Ms. Gist was treated for fibroids, constipation, and abdominal pain among other complaints, the symptoms that Ms. Gist sought and received treatment for throughout the relevant period were related to endometriosis, which is the condition underlying the medical malpractice claims in this case.

The records indicate that the last date Plaintiff was treated at KCH was April 19, 2019 which was subsequent to the filing of Notice of Claim. Therefore, as the plaintiff's treatment was ongoing at the time the Notice of Claim was filed on March 5, 2019, it is timely. Accordingly, Plaintiff's motion to deem the Notice of Claim timely filed is GRANTED as academic (Sequence 006).

Furthermore, the statute of limitations was also tolled by the continuous treatment doctrine; it was continuous from February 22, 2016, and did not begin to run until April 19, 2019. Plaintiff's claims regarding treatment rendered by NYCHHC during this time period are viable and will be reviewed by the court in the context of their summary judgment motion.

"'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 [internal citations omitted].'" *Hutchinson v. New York City Health and Hosps. Corp.*, 172 AD3d 1037, 1039 [2d Dept. 2019] [citing *Stukas v. Streiter*, 83 AD3d 18, 23 [2d Dept. 2011]]. "Thus, in moving for summary judgment, a physician defendant must establish, prima facie, 'either that there was no departure or that any departure was not a proximate cause of the plaintiff's injuries.'" *Hutchinson*, 172 AD3d at 1039 [citing *Lesniak v. Stockholm Obstetrics & Gynecological Servs., P.C.,* 132 AD3d 959, 960 [2d Dept. 2015]]. "Once a defendant has made such a showing, the plaintiff, in opposition, must submit evidentiary facts or materials to rebut the defendant's showing, but only as to those elements on which the defendant met the prima facie burden (see *Poter v Adams*, 104 AD3d 925, 926 [2d Dept. 2013]; *Stukas v Streiter*, 83 AD3d 18, 23-24 [2d Dept. 2011])." *Wagner v. Parker*, 172 AD3d 954, 954 [2d Dept. 2019]. "Expert testimony is necessary to prove a deviation from accepted standards of medical care and to establish proximate cause [internal citations omitted]." *Navarro v. Ortiz*, 203 AD3d 834, 836 [2d Dept. 2022]. "'When experts offer conflicting opinions, a credibility question is presented requiring a jury's resolution.'" *Stewart v. North Shore University Hospital at Syosset*, 204 AD3d 858, 860 [2d Dept. 2022] [citing *Russell v. Garafalo,* 189 A.D.3d 1100, 1102, [2d Dept. 2020]]; *Shields v. Baktidy*, 11 AD3d 671, 672 [2d Dept. 2004]. "Any conflicts in the testimony merely

raised an issue of fact for the fact-finder to resolve." *Palmiero v. Luchs*, 202 AD3d 989, 992 [2d Dept. 2022] [citing *Lavi v. NYU Hosps. Ctr.,* 133 A.D.3d 830, 832 [2d Dept. 2015]]. However, "expert opinions that are conclusory, speculative, or unsupported by the record are insufficient to raise a triable issue of fact [internal citations omitted]." *Wagner v. Parker*, 172 AD3d at 966.

Regarding Defendant NYCHHC's motion for summary judgment, Defendant NYCHHC's expert Andrew Menzin, M.D., a physician board certified in Obstetrics and Gynecology and holding a sub-specialty certification in Gynecology and Oncology, established that he is qualified to opine as to the care and treatment provided to Plaintiff in this case. Defendant NYCHHC's expert Kevin Mennitt, M.D., a physician board certified in Diagnostic Radiology, also established his expertise to opine as to the care and treatment rendered to Plaintiff in this case. Plaintiff's expert Bruce L. Halbridge, M.D., a physician board certified in Obstetrics and Gynecology, also established his expertise to opine as to the care and treatment that Plaintiff received in this case.

The court finds that Defendant NYCHHC met its *prima facie* burden, through the detailed affirmations of their experts, opining that NYCHHC did not depart from accepted medical practice. Defendant NYCHHC's expert Dr. Menzin, opines within a reasonable degree of medical certainty that "the timing of the work-up of this patient, including the timing of discussions regarding surgery, was completely appropriate by the KCH providers in this case." The expert opines that there was no delay in diagnosing endometriosis by KCH, no delay in performing surgery, and no failure to determine the etiology of her symptoms. He opines that the work-up of this patient at KCH in 2016 was appropriate. He opines that between February 2016 and September 2017, KCH appropriately addressed and evaluated Plaintiff's pain and properly assessed her not only to address the pain but also the underlying condition. He notes that Plaintiff refused to be examined on February 25, 2016 and was noted to be uncooperative on April 16, 2016. The expert opines that the patient's gynecologic symptoms were appropriately worked up and offered appropriate interventions, including diagnostic laparoscopy, offered in December 2016, and scheduled for January 2017, but was declined/cancelled by the plaintiff. The expert opines that a diagnostic laparoscopy is the gold standard for the diagnosis of endometriosis

explaining that "(o)perative visualization of lesions with biopsy is the gold standard for the diagnosis of endometriosis."

Dr. Menzin reviewed the deposition testimony of KCH's gynecological attending, Dr. Jed Cutler, who evaluated the Plaintiff on December 5, 2016 who testified that endometriosis was one of his differential diagnosis on December 5, 2016, and that his routine practice when he recommended surgery would be to discuss the different options with the patient. As it is conceded by the parties that a laparoscopy is the diagnostic tool for endometriosis, and a laparoscopy was scheduled in December 2016, the court accepts Dr. Menzin's opinion that Dr. Cutler included endometriosis as differential diagnosis for the planned laparascopy. Dr. Menzin further opined that the recommendation for a diagnostic laparoscopy, as well as including endometriosis as differential diagnosis, was appropriate as well.

Dr. Menzin notes that on March 17, 2017, Plaintiff re-presented to the KCH ED but elected to leave before she could be seen. On June 11, 2017, she presented with abdominal pain and constipation and was appropriately referred to her PCP. On September 2, 2017 plaintiff was admitted for right flank pain, was assessed with hydronephrosis and hydroureter on imaging, and underwent a percutaneous nephrostomy and anterograde nephrostogram. On September 25, 2017, she was again offered a diagnostic laparoscopy and again declined.

Dr. Menzin further opines that an earlier MRI was not warranted as the patient was being seen in the acute setting of the emergency department, she already had a CT scan and ultrasound, and her chronic condition could have been treated and evaluated as an outpatient. As Dr. Menzin previously opined, imaging may be suggestive of endometriosis but is not definitive.

Defendant NYCHHC's expert radiologist, Dr. Mennitt opines that "none of the radiological studies at CT scan showed evidence of endometriosis prior to the plaintiff's diagnosis on or about October 30, 2017, including the MRI dated October 19, 2017." The expert further opines that "(i)n general, endometriosis is not a radiological diagnosis. It is a diagnosis made by pathology following a surgical biopsy. It can very rarely be seen on a CT scan or MRI." The expert also notes that a laparoscopy was scheduled for January 18, 2017, but cancelled by the Plaintiff. Further the expert opines that all the radiological studies were properly interpreted.

Plaintiff's expert agrees and states that "a laparoscopy was the gold standard for a definitive diagnosis." He notes that the record indicates that during the December 5, 2016 KCH GYN Clinic visit, Plaintiff was offered and agreed to a diagnostic laparoscopy, scheduled for January 18, 2017 at KCH and that she subsequently cancelled the procedure on January 10, 2017. The expert then speculates that "had it been made clear to Ms. Gist that laparoscopy would be the most likely method to find out exactly what was causing her pain and to, therefore, cure it, she would have been more likely to undergo the procedure, if not when it was first scheduled, at least a few months later after her pain returned." This opinion is purely conjecture, especially in light of the plaintiff's history of lack of compliance and failure to continue with treatment plans. The expert further states that a laparoscopy should have been "promoted" to the plaintiff at each subsequent visit, and summarily assumes this was not done but claims that he did not see any evidence of this in the record. However, the absence of a notation in the decedent's hospital records is not proof that something was not done. See, *Krapivka v Maimonides Med. Ctr.,* 119 AD2d 801 [2d Dept. 1986]. Indeed, the submissions indicate and Plaintiff's expert concedes that, at least during two occasions, the KCH physicians discussed laparoscopy with the Plaintiff. Specifically on September 25, 2017, Plaintiff was counseled at the KCH GYN clinic about management options including Lupron and Depo-Provera injections as well as the surgical options including diagnostic laparoscopy or hysterectomy; additionally at a visit with Dr. Jacques at KCH GYN clinic on November 22, 2016 several treatment options were discussed, including laparoscopy. (See Dr. Halbridge's aff, para. 37 and 22, respectively).

Plaintiff's expert also states that "the performance of differential diagnosis would have made them aware that despite the presence of a fibroid, other conditions – in particular, endometriosis – could be causing or contributing to her symptoms and they could have tailored their inquiries and treatments accordingly." This statement is not based on the evidence submitted as discussed above, the deposition testimony of Dr. Jed Cutler indicated that endometriosis was included as a differential diagnosis on December 5, 2016. (NYSCEF Doc. 144, page 103, lines 16-23 to page 104, lines 3-6).

Plaintiff's expert opines that a significant deviation from the standard of care occurred with regards to the finding of abnormal test results from the VABRA evaluation on June 17, 2016. However, no discussion or opinion is offered by the expert as to whether this deviation resulted in any injury. Indeed, the purpose of Plaintiff's VABRA test was to detect abnormal cancer cells which were ultimately determined to be negative for malignancy. This case does not involve a failure to diagnose cancer.

Plaintiff's expert's opinion that she should have undergone an MRI or CT scan with contrast is belied by his opinion that a laparoscopy is the standard for diagnosing endometriosis. Despite this acknowledgment, the expert claims that it was a departure to fail to offer non-surgical methods of investigating the patient's complaints such as an MRI or CT scan with contrast. Plaintiff's expert further opines that by the time KCH performed an MRI with IV contrast on October 19, 2017, which finally showed a mass causing a distal large bowel obstruction, it was too late to avoid the resulting massive surgery. Plaintiff's expert does not state that endometriosis was diagnosed via the October 17, 2017 MRI with contrast. Indeed, the hospital records do not indicate that the MRI with contrast, which was performed on October 19, 2017 was diagnostic of endometriosis. Rather, plaintiff's endometriosis was diagnosed by laparoscopy which was performed days later. It is noted that Plaintiff's expert does not address that plaintiff's endometriosis would have been diagnosed in December 2016/January 2017 had she gone forward with the planned laparoscopy.

In conclusion, the court finds that the opinions of Plaintiff's expert are conclusory, speculative and not based on the evidence. As such, it was insufficient to raise a triable issue of fact to defeat summary judgment as to NYCHHC. Expert opinions that are conclusory, speculative, or unsupported by the record are insufficient to raise triable issues of fact. *Lowe v. Japal*, 170 AD3d 701 [2d Dept 2019]. "General and conclusory allegations of medical malpractice, ... unsupported by competent evidence tending to establish the essential elements of medical malpractice, are insufficient to defeat a defendant physician's summary judgment motion (Internal citations omitted)." *J.P. v. Patel*, 195 A.D.3d 852, 854 [2d Dept. 2021]. "In order not to be considered speculative or conclusory, expert opinions in opposition should address specific

assertions made by the movant's experts, setting forth an explanation of the reasoning and relying on specifically cited evidence in the record" [internal citations omitted]. *Wijesinghe v. Buena Vida Corp*., 210 AD3d 824, 825-826 [2d Dept. 2022][quoting *Tsitrin v. New York Community Hosp*., 154 AD3d 994 [2d Dept. 2017]]. Plaintiff fails to defeat defendant's showing that NYCHHC did not depart from accepted medical practice. Therefore, summary judgment is Granted to NYCHHC for all claims of medical malpractice.

Regarding Defendant Interfaith Medical Center's ("Interfaith") motion for summary judgment, Defendant Interfaith Medical Center's expert Gary Mucciolo, M.D., a physician board certified in Obstetrics and Gynecology, established his expertise to opine as to the care and treatment rendered to Plaintiff in this case. As noted above, Plaintiff's expert Bruce L. Halbridge, M.D., a physician board certified in Obstetrics and Gynecology, also established his expertise to opine as to the care and treatment that Plaintiff received in this case.

Defendant Interfaith's expert Gary Mucciolo, M.D., opines that Defendant Interfaith did not depart from the standard of care during Plaintiff's visits on multiple dates. At oral argument, Defendant Interfaith and Plaintiff indicated that out of all of Plaintiff's visits to Defendant Interfaith, the only visits that are claimed in the instant matter are the patient's admissions from June 8, 2017 to July 9, 2017 and from July 10, 2017 to July 12, 2017.

According to Interfaith's expert, Dr. Mucciolo, Plaintiff presented to Defendant Interfaith on June 8, 2017 with complaints of constipation and no appetite for ten days, and no urination for three days. Furthermore, on that same day the expert states that Plaintiff also complained of abdominal pain and Defendant Interfaith properly ordered a CT scan of the abdomen and pelvis and an abdominal x-ray to determine the etiology of Plaintiff's complaints. Defendant's expert further opines that "the radiologist correctly identified an overloaded colon and right hydroureteronephrosis" which was communicated to the Plaintiff. The expert further opines that "[f]urther imaging was not indicated given that the diagnoses of constipation, hydronephrosis and right ureteral obstruction, adequately explained the plaintiff's source of pain, thus making the need for further studies moot." Plaintiff was discharged a month later, on July 9, 2017. The expert further opines that, "[t]he decision to discharge the plaintiff with instructions to follow up

with a urologist and gastroenterologist was reasonable given that the plaintiff did not require emergent treatment and hydronephrosis, and right ureteral obstruction can be easily addressed as an outpatient."

The expert further opines that on July 10, 2017 Plaintiff's complaints of abdominal pain and constipation were properly addressed by Defendant Interfaith and that "Interfaith's plan to conduct an abdominal examination and order a urine analysis, renal sonogram and CT scan of the abdomen was appropriate considering her presenting symptoms." Plaintiff was admitted and received treatment until July 12, 2017, when she eloped without receiving discharge instructions.

As a preliminary matter, Plaintiff's expert incorrectly indicates in his affirmation that Plaintiff presented to Defendant Interfaith on July 8, 2017 and was discharged the next day on July 9, 2017. The records confirm that Plaintiff was admitted to Defendant Interfaith for approximately one month from June 8, 2017 until July 9, 2017.

Additionally, in opposition, Plaintiff's expert does not opine as to the treatment Plaintiff received during the month-long admission. Significantly, Plaintiff's expert does not opine that Defendant Interfaith departed from the standard of care during Plaintiff's hospitalization beginning June 8, 2017 (referred to as July 8, 2017) or the admission beginning July 10, 2017. Additionally, Plaintiff's expert merely states that during Plaintiff's admission between July 10, 2017 and July 12, 2017, Dr. Vasudevan at Interfaith concluded that Plaintiff "had a tumor or some other mass obstructing her urinary flow" and that the doctor informed Ms. Gist of her conclusion. Plaintiff's expert speculates that Ms. Gist misunderstood, leading to elopement from the hospital before further testing could be conducted. Plaintiff's expert opines that Defendant Interfaith's failure to attempt to contact the patient "to inform her that it was imperative that she promptly return because she had a potentially life-threatening condition," was a deviation from the standard of care. Plaintiff's expert points to Dr. Vasudevan's deposition testimony in which Dr. Vasudevan testified that this should have been done and entered into the record. In their reply, Defendant Interfaith correctly argues that it is speculative for the expert to state that if the patient had been contacted, she more than likely would have returned promptly for further investigation.

Based upon the submissions herein, Defendant's expert established their *prima facie* burden as to both visits. However, Plaintiff has failed to raise an issue of fact in opposition. Plaintiff's expert's does not opine as to any deviation regarding the treatment received during Plaintiff's month-long admission beginning June 8, 2017 and significantly, fails to review it as a month long admission as opposed to the few days stay he mistakenly opines it was. The expert also fails to opine, with any particularity, as to deviations from the standard of care that allegedly took place during the second admission beginning on July 10, 2017. Furthermore, the expert's opinion regarding Defendant Interfaith's failure to contact Plaintiff is speculative. Accordingly, summary judgment is granted as to the claims of medical malpractice relating to Defendant Interfaith Medical Center.

It is well established that in order to succeed on a claim of lack of informed consent, "plaintiff must prove (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." *Friedberg v. Rodeo*, 193 A.D.3d 825 [2d Dept. 2021]. "'The third element is construed to mean that the actual procedure performed for which there was no informed consent must have been a proximate cause of the injury'" *Figueroa-Burgos v Bieniewicz,* 135 AD3d 810, 811-812 [2d Dept. 2016][quoting Trabal v. Queens Surgi-Center, 8 AD3d 555, 556-557 [2d Dept. 2004]].

As discussed below, both Defendants, Interfaith and NYCHHC, submit expert opinions regarding Plaintiff's claims of lack of informed consent. In opposition, Plaintiff does not address the claim of lack of informed consent relating to Defendant Interfaith. Accordingly, summary judgment is granted as to the lack of informed consent claim relating to defendant Interfaith Medical Center and such claim is dismissed.

Regarding the lack of informed consent claim relating to defendant NYCHHC, Defendant's expert states that the medical providers appropriately discussed various treatment

options with Plaintiff. One of the claims is that KCH failed to inform Plaintiff that a full course of Lupron therapy included monthly Lupron injections for a period of six consecutive months and that there was a failure to schedule her for monthly follow up Lupron injections following the Lupron injection on December 5, 2016. However, the medical records belie that claim. At the conclusion of the December 5, 2016 GYN Clinic visit, Plaintiff was booked for surgery as opposed to continued Lupron injections. A month later, she cancelled and opted for uterine artery embolization, with another provider. The court fails to see how this claim resulted in an injury. Indeed, Plaintiff's expert does not opine or establish it.

Moreover, regarding the claim that Defendant NYCHHC failed to timely inform the patient how and when to schedule a follow up to see if the colostomy could be reversed, Defendant's expert states that Plaintiff has not returned to the clinic and has not requested colostomy reversal. Defendant further states that Plaintiff testified at her deposition that she planned to seek reversal through outside providers. Defendant further indicates that "[t]here are no claims for lack of informed consent regarding the October/November biopsies and surgical procedures and the Supplemental Bills of Particulars do not allege lack of informed consent."

In opposition, Plaintiff's expert opines that Defendant failed to "adequately inform Ms. Gist of the causes of her symptoms and each of the possible treatments available and to even urge her to take advantage of what was offered [which] deprived her of the opportunity to make reasonably informed consent with regard thereto." Plaintiff's expert further opines that a physician "must set forth a personalized investigative and treatment plan to the patient" and sell it to them because it has been determined to be the best course of action. Plaintiff's expert further opines that Defendant's failure to spend sufficient time with Ms. Gist and adequately communicate possible treatments with her "was a major factor in both her choice of and failure to continue on Lupron – the side effects were not fully explained and when they occurred, she was unprepared and unwilling to undergo them." Plaintiff argues that Defendant's failure to communicate also played a major role in Plaintiff's hesitation and cancellation of the laparoscopy. Plaintiff's expert further opines that if it had "been made clear to Ms. Gist that a laparoscopy would be the most likely method to find out exactly what was causing her pain and

to, therefore, cure it, she would have been more likely to undergo the procedure" even if it were a few months after it had first been scheduled.

Plaintiff's expert also states that the benefits of the laparoscopy were not discussed with the patient and opines that if they had been she would have been more likely to have undergone the procedure earlier than she did. The expert opines that Ms. Gist would have been more likely to undergo the laparoscopy if she had been told that it was the most likely way to find out what was causing her pain and if she had been convinced to undergo the procedure. Additionally, the expert opines that KCH failed to eliminate differential diagnoses on multiple occasions and that an MRI or CT scan with contrast would have been more likely to lead to a diagnosis of endometriosis than with the tests that were performed.

As discussed above, Plaintiff's expert bases his opinions on sheer speculation and on presumed facts not on evidence, thus the opinions lack probative value. Much of the stated opinions is based on conjecture as to what Plaintiff would have done based upon hypothetical situations. Additionally, the expert does not opine that any lack of information disclosed to the patient was the proximate cause of the plaintiff's injuries. Instead, Plaintiff's expert opines without specificity that by the time the procedure was performed, it was "long after a proper diagnosis would have prevented permanent injury." The court notes that this opinion refers more to claims sounding in medical malpractice (which nevertheless is speculative) than claims sounding in lack of informed consent. As to the cancelled laparoscopy, the expert does not opine as to whether a reasonably prudent patient in the plaintiff's position would not have declined to undergo the procedure if he or she had been fully informed. See *Walker v. Saint Vincent Catholic Med. Ctrs.,* 114 A.D.3d 669,671 [2d Dept. 2014]; *Orphan v. Pilnik*, 15 NY3d 907 [2010]; *Thaw v. N. Shore Univ. Hosp*., 129 AD3d 937 [2d Dept 2015]; *Guinn v. New York Methodist Hosp.,* 212 AD3d 787 [2d Dept 2023]. In conclusion, in addition to the aforementioned, Plaintiff does not submit an opinion as to whether any actual procedure performed, for which they claim there was no informed consent, was a proximate cause of the injuries. *See Figueroa-Burgos v. Bieniewicz*, 135 AD3d 810 [2d Dept. 2016].

Accordingly, summary judgment is granted as to the claim for lack of informed consent relating to defendant NYCHHC, and such claim is dismissed.

As to the Plaintiff's claim of Negligent Credentialing relating to defendants Interfaith and NYCHHC the court finds Defendants have each met their *prima facie* burden on this issue, and Plaintiff does not address this claim in opposition. Therefore, summary judgment is granted as to the claim of Negligent Credentialing as it relates to defendant Interfaith Medical Center and defendant New York City Health and Hospitals Corporation S/H/A New York City Health and Hospitals Corporation (Kings County Hospital), and such claims are dismissed as unopposed by Plaintiff.

In conclusion,

Plaintiff's motion to deem the Notice of Claim timely filed is GRANTED as academic (Sequence 006); and

Summary Judgment is GRANTED as to all claims of medical malpractice relating to defendant New York City Health and Hospitals Corporation S/H/A New York City Health and Hospitals Corporation (Kings County Hospital) (Sequence 004); and

Summary Judgment is GRANTED as to the claim of lack of informed consent as relating to New York City Health and Hospitals Corporation S/H/A New York City Health and Hospitals Corporation (Kings County Hospital) (Sequence 004); and

Summary Judgment is GRANTED as to the claim of Negligent Credentialing relating to New York City Health and Hospitals Corporation S/H/A New York City Health and Hospitals Corporation (Kings County Hospital) (Sequence 004); and

Summary Judgment is GRANTED as to all claims of medical malpractice relating to defendant Interfaith Medical Center (Sequence 003); and

Summary Judgment is GRANTED as to the claim of lack of informed consent relating to defendant Interfaith Medical Center, as unopposed (Sequences 003);

Summary Judgment is GRANTED as to the claim of Negligent Credentialing relating to defendant Interfaith Medical Center (Sequences 003);

Summary Judgment is GRANTED as to all claims against Allan R. Santiago, M.D., and Hope Medical Of New York, P.C. as unopposed (Sequence 005) and the complaint is dismissed in its entirety.

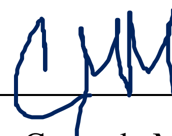
A stipulation of discontinuance was previously filed as to defendant Bishop Orris G. Walker Jr. Health Care Center; therefore, those claims were discontinued.

Accordingly, as the remaining Defendants have been granted summary judgment, the entire case is dismissed, and the Clerk is directed to enter judgment in favor of Allan R. Santiago, M.D., and Hope Medical of New York, P.C. (Sequence 005), Interfaith Medical Center, (Sequence 003) and New York City Health and Hospitals Corporation S/H/A New York City Health and Hospitals Corporation (Kings County Hospital) (Sequence 004).

This constitutes the Decision and Order of the Court.

Dated: August 29, 2023

ENTER.



Hon. Consuelo Mallafre Melendez,
J.S.C.