

Carpentier v North Shore Univ. Hosp.

2010 NY Slip Op 33048(U)

October 20, 2010

Supreme Court, Nassau County

Docket Number: 600023/07

Judge: Michele M. Woodard

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She alleges, *inter alia*, that the defendants Dr. Sisselman and his Family Practice failed to properly diagnose and treat Alfred from February 3, 2005 through March 22, 2005, more specifically, that they improperly cleared him for surgery, and as a result of the surgery he died.

The defendants Dr. Sisselman and Family Practice seek summary judgment dismissing the complaint against them.

“On a motion for summary judgment pursuant to CPLR §3212, the proponent must make a *prima facie* showing of entitlement to judgment as a matter of law, tendering sufficient evidence to demonstrate the absence of any material issues of fact.” *Sheppard-Mobley v King*, 10 AD3d 70, 74 (2d Dept 2004), *aff’d. as mod.*, 4 NY3d 627 (2005), *citing Alvarez v Prospect Hosp.*, 68 NY2d 320, 324 (1986); *Winegrad v New York Univ. Med. Ctr.*, 64 NY2d 851, 853 (1985). “Failure to make such *prima facie* showing requires a denial of the motion, regardless of the sufficiency of the opposing papers.” *Sheppard-Mobley v King*, *supra*, at p. 74; *Alvarez v Prospect Hosp.*, *supra*; *Winegrad v New York Univ. Med. Ctr.*, *supra*. Once the movant’s burden is met, the burden shifts to the opposing party to establish the existence of a material issue of fact. *Alvarez v Prospect Hosp.*, *supra*, at p. 324. The evidence presented by the opponents of summary judgment must be accepted as true and they must be given the benefit of every reasonable inference. *See, Demishick v Community Housing Management Corp.*, 34 AD3d 518, 521 (2d Dept 2006), *citing Secof v Greens Condominium*, 158 AD2d 591, 593 (2d Dept 1990).

“To establish a *prima facie* case of liability for medical malpractice, a plaintiff must prove that the defendant deviated from accepted practice, and that such deviation proximately caused his or her injuries.” *Dehaarte v Ramenovskiy*, 67 AD3d 724, 725 (2d Dept 2009), *citing Novik v Godec*, 58 AD3d 703 (2d Dept 2009); *Monroy v Glavas*, 57 AD3d 631 (2d Dept 2008); *Rabinowitz v*

Elimian, 55 AD3d 813 (2d Dept 2008); *see also*, *Castro v New York City Health and Hospitals Corp.*, 74 AD3d 1005 (2d Dept 2010); *Ellis v Eng*, 70 AD3d 887 (2d Dept 2010). “On a motion for summary judgment dismissing the complaint in a medical malpractice action, a defendant physician has the burden of establishing the absence of any departure from good and accepted medical practice, or, if there was a departure, that the plaintiff was not injured thereby.” *Shectman v Wilson*, 68 AD3d 848, 849 (2d Dept 2009), citing *Murray v Hirsch*, 58 AD3d 701 (2d Dept 2009), *lv den.*, 12 NY3d 709 (2009); *Shahid v New York City Health & Hospitals Corp.*, 47 AD3d 800 (2d Dept 2008); *Alvarez v Prospect Hosp.*, 68 NY2d 320 (1986); *see also*, *Castro v New York City Health and Hospitals Corporation*, *supra*; *Ellis v Eng*, *supra*.

Pursuant to New York Public Health Law § 2805-d, a cause of action for lack of informed consent is limited to cases involving non-emergency treatment, procedure or surgery or a diagnostic procedure involving an invasion or disruption of the patient’s body. Thus, the “plaintiff must allege that the wrong complained of arose out of some affirmative violation of [his or her] physical integrity.” *Iazzetta v Vicenzi*, 200 AD2d 209 (3d Dept 1994), *lv den.*, 85 NY2d 857 (1995); *see also*, *Flanagan v Catskill Regional Medical Center*, 65 AD3d 563, 566-567 (2d Dept 2009); *Smith v Fields*, 268 AD2d 579 (2d Dept 2000); *Campea v Mitra*, 267 AD2d 190, 191 (2d Dept 1999); *Schel v Roth*, 242 AD2d 697 (2d Dept 1997). Public Health Law § 2805-d(3) provides that “[f]or a cause of action it must . . . be established that a reasonably prudent person in the patient’s position *would not* have undergone the treatment or diagnosis if he had been fully informed (emphasis added).” *Ellis v Eng*, *supra* at p. 892; *Jaycox v Reid*, 5 AD3d 994, 995 (4th Dept 2004), *rearg den.* 8 AD3d 1132 (4th Dept 2004).

“[M]edical expert affidavits or affirmations, submitted by a defendant, which fail to address

the essential factual allegations in the plaintiff's complaint or bill of particulars fail to establish prima facie entitlement to summary judgment as a matter of law." *Rogue v Noble, M.D.*, 73 AD3d 204 (1st Dept 2010), citing *Cregan v Sachs*, 65 AD3d 101, 108 (1st Dept 2009); *Wasserman v Carella*, 307 AD2d 225 (1st Dept 2003); see also, *James v Wormuth, M.D.*, 74 AD3d 1895 (4th Dept 2010). "[B]are allegations which do not refute the specific factual allegations of medical malpractice in the bill of particulars are insufficient to establish entitlement to judgment as a matter of law." *Grant v Hudson Valley Hosp. Center*, 55 AD3d 874 (2d Dept 2009), citing *Berkey v Emma*, 291 AD2d 517, 518 (2d Dept 2002); *Drago v Chung Ho King*, 283 AD2d 603, 603-604 (2d Dept 2001); *Terranova v Finklea*, 45 AD3d 572 (2d Dept 2007); *Kuri v Bhattacharya*, 44 AD3d 718 (2d Dept 2007). If the moving defendant meets his burden, "[i]n opposition, a plaintiff must submit the affidavit of a physician attesting to a departure from good and accepted practice, and stating the physician's opinion that the alleged departure was a competent producing cause of the plaintiff's injuries." *Shectman v Wilson, supra*, citing *Sweezey v Montague Rehab & Pain Management, P.C.*, 59 AD3d 431 (2d Dept 2009); *Murray v Hirsch, supra*; *Shahid v New York City Health & Hospitals Corp., supra*; see also, *Ellis v Eng, supra*. "[G]eneral allegations of medical malpractice which are conclusory in nature and unsupported by competent evidence tending to establish the elements of medical malpractice" do not suffice. *Shectman v Wilson, supra*, citing *Alvarez v Prospect Hosp., supra*; *Shahid v New York City Health & Hospitals Corp., supra*; see also, *Diaz v New York Downtown Hosp.*, 99 NY2d 542 (2002); *Romano v Stanley*, 90 NY2d 444 (1997); *Amatulli by Amatulli v Delhi Const. Corp.*, 77 NY2d 525 (1991). The plaintiff's expert must set forth the medically accepted standards of care or protocol and explain how it was departed from. *Geffner v North Shore University Hosp.*, 57 AD3d 839, 842 (2d Dept 2008), citing *Mustello v Berg*, 44 AD3d

1018, 1019 (2d Dept 2007), *lv den.*, 10 NY3d 711 (2008); *Behar v Coren*, 21 AD3d 1045, 1047 (2d Dept 2005), *lv den.*, 6 NY3d 705 (2006); *LaMarque v North Shore University Hosp.*, 227 AD2d 594, 594-595 (2d Dept 1996). And, the plaintiff's expert must address all of the key facts relied on by the defendant's expert. *See, Kaplan v Hamilton Medical Associates, P.C.*, 262 AD2d 609 (2d Dept 1999); *see also, Geffner v North Shore University Hosp., supra; Rebozo v Wilen*, 41 AD3d 457 (2d Dept 2007).

An expert's affidavit which lacks evidentiary support in the record or is contradicted thereby is not sufficient to raise a triable issue of fact. *Micciola v Sacchi*, 36 AD3d 869, 871 (2d Dept 2007), citing *Schroder v Sunnyside Corp.*, 297 AD2d 369, 371 (2d Dept 2002), *lv dism.*, 100 NY2d 553 (2003), citing *Fhima v Maimonides Medical Center*, 269 AD2d 559 (2d Dept 2000). "[H]indsight reasoning . . . is insufficient to defeat summary judgment." *Miccola v Sacchi, supra* at p. 871, citing *Zawadzki v Knight*, 76 NY2d 898 (1990).

"To establish proximate cause, the plaintiff must present 'sufficient evidence from which a reasonable person might conclude that it was more probable than not that' the defendant's deviation was a substantial factor in causing the injury." *Alicea v Liguori*, 54 AD3d 784, 785 (2d Dept 2008), quoting *Johnson v Jamaica Hosp. Med. Ctr.*, 21 AD3d 881, 883 (2d Dept 2005), citing *Sprain Brook Manor Nursing Home*, 253 AD2d 852 (2d Dept 1998), *lv den.*, 92 NY2d 818 (1999). The plaintiff's expert need not quantify " 'the extent to which the defendant's act or omission decreased the plaintiff's chance of a better outcome or increased [the] injury, as long as evidence is presented from which the jury may infer that the defendant's conduct diminished the plaintiff's chance of a better outcome or increased [the] injury.' " *Alicea v Liguori, supra*, at p. 786, quoting *Flaherty v Fromberg*, 46 AD3d 743 (2d Dept 2007), citing *Barbuto v Winthrop University Hosp.*, 305 AD2d

623, 624 (2d Dept 2003); *Wong v Tang*, 2 AD3d 840, 841 (2d Dept 2003).

“Summary judgment is not appropriate in a medical malpractice action where the parties adduce conflicting expert opinions Such credibility issues can only be resolved by a jury.” *Feinberg v Feit*, 23 AD3d 517, 519 (2d Dept 2005), citing *Shields v Baktidy*, 11 AD3d 671 (2d Dept 2004); *Barbuto v Winthrop University Hosp.*, *supra*; *Halkias v Otolaryngology-Facial Plastic Surgery Associates, P.C.*, 282 AD2d 650 (2d Dept 2001); *see also, Roca v Perel*, 51 AD3d 757, 759 (2d Dept 2008); *Graham v Mitchell*, 37 AD3d 408 (2d Dept 2007).

The pertinent facts here are as follows:

Alfred began treatment at the Family Practice on or about May 1, 1996. On February 1, 2005, Dr. Sisselman gave Alfred medical clearance for a colectomy to be performed by Dr. Sullivan on February 3rd based upon his examination which revealed no shortness of breath or chest pain and the normal results of Alfred’s thallium stress test done in August, 2003, his MUGA scan screening also done in August, 2003 and his echocardiogram done in July 2003. No x-rays were taken. Dr. Sisselman, in fact, found Alfred to be in “optimum condition for proposed surgery.” Alfred’s Family Practice chart indicates that it was contacted by North Shore University Hospital on February 8, 2005 advising that Alfred had experienced an arrhythmia after his colectomy surgery by Dr. Sullivan. He, in fact, developed a tension pneumothorax, i.e., free air in the chest outside the lung which caused his lung to collapse. He remained in the hospital until March 22, 2005. No one from Family Practice saw Alfred during that time at North Shore University Hospital. However, Dr. Sisselman visited socially with plaintiff Eva Carpentier to inquire as to how Alfred, who was still hospitalized, was doing. During this visit, Dr. Sisselman did not examine Alfred, review his chart, render any treatment or discuss his care with any of his doctors or hospital staff. Alfred was

discharged from North Shore University Hospital to a rehabilitative facility on March 22, 2005. A letter so advising Dr. Greco of Family Practice was sent by Health Care Partners Management Services Organization on March 24, 2005. Alfred was subsequently readmitted to North Shore University Hospital on April 19, 2005 with respiratory distress and for treatment of pneumonia and congestive heart failure. He developed Stage IV sacral decubitus ulcers, clostridium diffide colitis, worsening pneumonia and pseudomonas sepsis. Alfred died on September 30, 2005. His autopsy report identified the most likely cause of his death as ongoing sepsis. In the interim, on April 22, 2005, Health Care Partners Management Services again wrote to Dr. Greco of Family Practice inquiring of Alfred's status based upon Dr. Greco's "admissions" to North Shore University Hospital on February 3rd and April 14th, to which Dr. Greco responded on June 29, 2005 that it was Dr. Sullivan who had admitted Alfred, not him.

A wrongful death cause of action based on a claim of medical malpractice is timely where at the time of the patient's death, he had a cause of action to recover damages for medical malpractice that was not time-barred and the patient's representative asserts the wrongful death claim within two years of the patient's death. *Mikus v Rosell*, 62 AD3d 674 (2d Dept 2009); *Scanzano v Horowitz*, 49 AD3d 855 (2d Dept 2008); *Norum v Landau*, 22 AD3d 650 (2d Dept 2005). In contrast, claims for medical malpractice and conscious pain and suffering remain viable for only one year following a patient's death, assuming the claims were timely at the time of his demise. CPLR §210(a); *Caprece v Nash*, 70 AD3d 743 (2d Dept 2010).

Alfred died on September 30, 2005 and was possessed of valid claims for both medical malpractice and conscious pain and suffering. This action was not commenced until September 12,

2007 at which time the wrongful death claim (which survived for two years following Alfred's death) remained viable (EPTL 5-4.1) but the medical malpractice and conscious pain and suffering claims (which expired one year after Alfred's death) had not (CPLR §210[a]). This stands even if as the plaintiff maintains the correspondence between the Family Practice and Health Care Partners Management Services Organization which ceased on June 29, 2005 extended the moving defendants' care of the decedent via the continuous treatment doctrine for Statute of Limitations purposes. For the record, however, this court notes that administrative errors of that nature do not suffice to establish the applicability of the continuous treatment doctrine, particularly where, like here, there is not a scintilla of evidence that the defendant Family Practice participated in the patient's continued care at all. Accordingly, the defendant Dr. Sisselman and Family Practice's motion is **granted** to the extent that the medical malpractice and conscious pain and suffering claims are dismissed pursuant to CPLR §214-a, 210(a).

Turning to the merits of the wrongful death and informed consent claims, via this motion, the plaintiffs have identified Dr. Sisselman and the Family Practice's wrongful acts as having occurred between February 3, 2005 and March 22, 2005. While their complaint encompassed the period February 1, 2005 through September 30, 2005, this court will not so limit the plaintiffs here.

A cause for wrongful death is predicated upon a death of a human being who was born alive which was caused by the wrongful act or omission of a person or corporation, who, by reason of _____ that wrongful act or omission, would have been liable to the deceased for the injury had death not ensued. EPTL 5-4.1. Proximate cause of the death is required. *Lutwin v Perelman*, _____ AD3d _____, 2010 WL 3583399, 907 NYS 2d 505 (2d Dept 2010), citing *Mazzone v Lazaroff*, 305 AD3d 558, 599 (2d Dept 2003); *Dubi v Jericho Fire Dist.*, 22 AD3d 631 (2d Dept 2005), *lv dismiss.*, 9 NY3d

906 (2007).

The defendant Dr. Sisselman and the Family Practice's alleged wrongful act that is alleged to have caused Alfred's death sounds in medical malpractice, more specifically, the clearance for surgery.

In support of their motion for summary judgment, the defendants Dr. Sisselman and the Family Practice have submitted the affirmation of Board Certified internist Barry Grossman, M.D. Having reviewed Alfred's pertinent medical records, the plaintiffs' Bill of Particulars and the testimony provided at the examinations-before-trial, Dr. Grossman opines that the surgery for which Dr. Sisselman gave medical clearance was not only indicated but medically necessary to treat his colon cancer. He explains that a colonoscopy performed on January 4, 2005 by Dr. Beckerman revealed that Alfred had infiltrating moderately differentiated adenocarcinoma in the descending colon which Dr. Sullivan found had the potential to metastasize thereby requiring surgery. Dr. Grossman further opines to a reasonable degree of medical certainty that the information reviewed and considered by Dr. Sisselman in giving Alfred medical clearance for surgery was within the standard of care and was not a departure from good and accepted medical practice. He explains Dr. Sisselman "questioned Alfred, performed a physical examination, reviewed pre-operative testing received from North Shore University Hospital, portions of his medical chart, recent blood work, a chest CT of February 17, 2004, and reviewed information received from the gastro-enterologist, Dr. Beckerman. In addition, Dr. Sisselman reviewed a recent EKG study and compared it to previous EKG studies, concluding that there had been no significant changes. Furthermore, Dr. Sisselman reviewed recent cardiac studies, including a MUGA scan, an echocardiogram, and a thallium stress test, all of which were found to be normal. Dr. Grossman further notes that Alfred was a non-

smoker and that he did not exhibit shortness of breath nor did he complain of breathing trouble or chest pains when questioned. He notes that Dr. Sisselman utilized a stethoscope to check Alfred's heart and lungs with negative results. Like the surgeon Dr. Sullivan opined, Dr. Grossman concludes that no further exams were warranted for the issuance of surgical clearance for Alfred. Dr. Grossman opines that absent a lack of a prior chest exam, an acute change in a patient's respiratory status, or obvious respiratory difficulties, a chest x-ray is not customary or routine for operative medical care; the procedure employed by Dr. Sisselman is. Thus, Dr. Grossman concludes that the information reviewed by Dr. Sisselman was within the standard of care and that his issuance of medical clearance to Alfred to undergo a colectomy without any additional pre-operative work-up, testing or referral to a pulmonologist was not a departure from good and accepted medical practice.

Dr. Grossman notes that Nurse Practitioner Jane Hall of North Shore University Hospital testified that when she assessed Alfred on January 28, 2005, he denied shortness of breath, sleep apnea and difficulty with stairs and his lungs were clear. He notes that she, too, found that Alfred was not in acute respiratory distress, his pulmonary status was stable and an x-ray and further pulmonary testing were not warranted. And, he also notes that Ms. Hall testified that the Director of pre-surgical testing in the Department of Anesthesia is the one who actually provides final clearance for a patient's suitability for surgery and the anesthesiologist Dr. Vitiello himself testified that his pre-anesthetic evaluation revealed no indication for a chest x-ray. In fact, Dr. Vitiello acknowledged that he did not even review the medical clearance form and it would not necessarily have been of interest to him as he already knew that Alfred was morbidly obese and had a history of asthma and pneumonia in 2004, which alone necessitated precautions. He testified that additional

information regarding lung abnormalities would have had no affect.

Dr. Grossman also opines that Dr. Sisselman properly prepared the clearance because “all significant information regarding [Alfred’s] condition to undergo the colectomy procedure was included and relayed,” including Nurse Hall’s negative cardiac studies’ results and EKG studies. He opines that Alfred’s February 17, 2004 chest CT findings were omitted because they were not significant since Alfred had been without respiratory complaints and the surgery was to his abdominal cavity. Dr. Grossman specifically opines that “although the CT study had an anatomic lung abnormality,” it was not significant in light of Alfred’s respiratory status. He explains “the standard of care does not require an internist to note any and all abnormalities or problems that are asymptomatic and do not cause cardiac concern or respiratory difficulties in a patient, or place them at a heightened risk.”

Dr. Grossman also remarks that it was not Dr. Sisselman’s responsibility as an internist giving surgical clearance to procure informed consent but it was the surgeon, Dr. Sullivan’s.

Dr. Grossman also concludes that, in any event, proximate cause between Dr. Sisselman’s alleged negligence and Alfred’s death is lacking because any additional tests, even a chest x-ray, would not have offered any additional significant information and affected Alfred’s surgical clearance. Indeed, Dr. Sullivan essentially testified as such: He testified that knowledge of Alfred’s anatomic abnormalities or a history of hypertension would not have affected his approach, his discussion with Alfred regarding the procedure or change his risks. In fact, Dr. Sullivan testified that the surgery went as expected and no intraoperative complications occurred during the surgery itself. Alfred experienced a hypotensive episode following the completion of surgery, which was eventually traced to a tension pneumothorax, which, Dr. Sullivan explained at his examination-

before-trial could have had many causes and remains unknown. Dr. Sullivan testified that neither post-operative hypotensive episode nor the tension pneumothorax were related to the unanticipated anatomical findings he had to deal with during surgery. Dr. Grossman notes that in any event, Dr. Sullivan testified and the North Shore University Hospital records reveal that Alfred's pneumothorax completely resolved prior to his discharge.

Dr. Grossman notes that while Alfred's January 28, 2005 pre-operative EKG done at North Shore University Hospital revealed a "cardiac condition of concern," it was found to be insignificant when compared to a previous EKG. And, Alfred's anesthesia record notes a "request cardiac anesthesia" indicating that cardiac concerns and precautions were being addressed. And, Dr. Grossman opines that no matter, "the procedure would have been discussed, prepared for, approached, and performed the same way it had been and that nothing Dr. Sisselman did or did not include in the medical clearance evaluation and form would have changed the procedure's outcome." Finally, Dr. Grossman concludes that Alfred's injuries, i.e., "death, conscious pain and suffering, hypotension, cardiac arrest, left tension pneumothorax, tracheostomy, respiratory distress, ventilator support, pneumonia, chronic/ongoing sepsis, ulcerated and chronic inflammation of the lower back, Stage IV sacral decubitus ulcers, bilateral heel ulcers, right pulmonary congestion and edema with adhesions to the parietal pleura" were not caused by anything Dr. Sisselman did or failed to do.

Via the affirmation of Dr. Grossman, Dr. Sisselman and the Family Practice have established their entitlement to summary judgment dismissing the complaint against them thereby shifting the burden to the plaintiff to establish the existence of a material issue of fact.

In opposition, the plaintiffs have submitted the affirmation of Board Certified Internist

Edward C. Weissman. Having reviewed Alfred's pertinent medical records, the autopsy report and his death certificate, he opines to a reasonable degree of medical certainty that Dr. Sisselman departed from good and accepted medical practice in his issuance of medical clearance for Alfred on February 1, 2005 and in failing to order a pre-operative chest x-ray prior to issuing said clearance. He explains as follows: He notes that Alfred had a history of asthma and breathing difficulties and that his most recent chest x-ray study was done on February 17, 2004 by the Family Practice which noted abnormal findings of eventration of the left diaphragm and bibasilar discord atelectasis. Dr. Weissman notes that these findings had been consistently noted on Alfred's prior chest x-ray reports. In fact, Dr. Weissman notes that Alfred's medical clearance for seed implantation for treatment for prostate cancer which was prepared by Dr. Dreizen of the Family Practice in May 2000 noted the finding of "elevated left hemidiaphragm" as did his pre-surgical chest x-ray report which was prepared by North Shore University Hospital-Syosset in preparation for that surgery. Dr. Weissman notes that not only did Dr. Sisselman fail to order a chest x-ray, in his clearance he made no mention of the chronic abnormal lung conditions and instead described him as being in "optimal condition" for the proposed surgery. Dr. Weissman notes that Alfred's surgery was complicated by Dr. Sullivan's unanticipated finding of the herniation of the left lung through the diaphragm and its obstruction of the splenic fixture as well as the finding of a very large cystic mass in the left retroperitoneum. He notes that the operative report states that the combined effect of these unanticipated findings was that the left lung herniation through the diaphragm obstructed the left upper quadrant and required additional surgical exploration and removal of Alfred's spleen. He notes that "at the conclusion of the surgery, while the decedent was still in the operating room, and prior to extubation, he suffered a series of hypotensive episodes requiring

extensive resuscitation measures for approximately two (2) hours until the blood pressure and breathing stabilized [and that a] chest x-ray performed on the patient in the Recovery Room found a left tension pneumothorax.” Dr. Weissman concludes that that was a consequence of the “surgical complications.” Alfred remained in surgical ICU until March 22, 2005, during which time he required ventilator support, tracheostomy and close monitoring. He was then transferred to a rehabilitative facility until April 15, 2005 when he was hospitalized with respiratory distress. He remained in the hospital until his death on September 30, 2005. Sepsis is listed as the primary cause of death along with pneumonia, and Stage IV bed sores of the sacrum and bilateral heel ulcers.

Dr. Weissman concludes that Dr. Sisselman’s clearance without an x-ray or mention of previous abnormal lung findings “led to significant unanticipated anatomic findings at the time of the colon surgery, significantly prolonging the surgery and necessitating performance of additional surgical exploration and . . . procedures.” This, Dr. Weissman opines “caused [Alfred] to suffer left pneumothorax, or collapsed lung at the conclusion of the surgery” which necessitated prolonged confinement and ultimate respiratory distress. Dr. Weissman opines that “as a result of the preventable surgical complications, and prolonged confinement of seven months post surgery, decedent developed general sepsis and pneumonia with severe bed sores of the sacrum and heels, the combination of which caused his death on September 30, 2005.” Therefore, it is Dr. Weissman’s opinion to a reasonable degree of medical certainty “that the departures from good and accepted practice in improperly using the medical clearance and failing to include the abnormal chest findings on the clearance constituted a proximate cause of the extensive surgical and post surgical complications and ultimately death of this patient.”

Dr. Weissman’s expert opinion does not fault Dr. Sisselman for clearing Alfred for surgery:

He only challenges the manner in which he did so, more specifically, his failure to have a chest x-ray done and/or note his persistent lung complications. Dr. Weissman, however, has failed to explain what would have been different and how the complications could have or would have been avoided had the surgical clearance noted Alfred's lung condition and Dr. Sullivan's inevitable findings were not "unanticipated." Indeed, again, even the surgeon Dr. Sullivan testified at his examination-before-trial that his knowledge of the lung abnormality would have changed nothing.

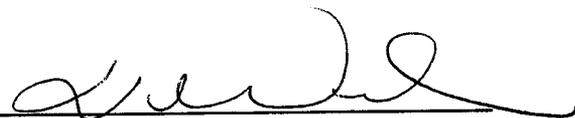
Under the circumstances, the crucial element of proximate cause is lacking. As such, it is hereby

ORDERED, that defendant Dr. Sisselman and the Family Practice's motion to dismiss the complaint is *granted* in its entirety.

This constitutes the Decision and Order of the Court.

DATED: October 20, 2010
Mineola, N.Y. 11501

ENTER:


HON. MICHELE M. WOODARD
J.S.C.

ENTERED

OCT 26 2010

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