At an IAS Term, Part 63 of the Supreme Court of the State of New York, held in and for the County of Kings, at the Courthouse, at Civic Center, Brooklyn, New York, on the 11th day of April 2024

P R E S E N T: HON. ELLEN M. SPODEK, Justice

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VALERI V. PROKOPENKO as the Administrator of The Estate of VALERIY PROKOPENKO, deceased and ELENA PROKOPENKO,

Plaintiff(s),

DECISION AND ORDER

-against-

Index No. 505942/20

AUBREY CLAUDIUS GALLOWAY, M.D., TIMOTHY LEE, M.D., SHARI BARNETT BROSNAHAN, M.D., NYU LANGONE HEALTH SYSTEM and NYU SCHOOL OF MEDICINE,

Defendant(s).

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Defendant Dr. AUBREY CLAUDIUS GALLOWAY, M.D., moves pursuant to CPLR 3212 for an order granting summary judgment and dismissing the complaint against him. Defendant TIMOTHY LEE, M.D., also moves pursuant to CPLR 3212 for an order granting summary judgment and dismissing the complaint against him. Defendant SHARI BARNETT BROSNAHAN, M.D., additionally moves pursuant to CPLR 3212 for an order granting summary judgment and dismissing the complaint against her. Defendants NYU LANGONE HEALTH SYSTEM and NYU SCHOOL OF MEDICINE move pursuant to CPLR 3212 for an order granting summary judgment and dismissing the complaint against them. Plaintiffs VALERI PROKOPENKO, as administrator of the estate of VALERIY PROKOPENKO, and ELENA PROKOPENKO opposes the motion.

The decedent, Mr. Valeriy Prokopenko, first saw Dr. Aubrey Galloway on March 29, 2018, for a surgical evaluation of symptomatic severe aortic stenosis, a known bicuspid aortic valve, and a 5.4 cm ascending aortic aneurysm according to a February 22, 2018, chest CT scan and echocardiogram. Dr. Galloway performed the aortic valve and ascending aorta replacement at NYU Langone Hospital, a non-party, on April 23, 2018. A consent form was signed in both Russian and English with the assistance of a telephone interpreter. Dr. Galloway was assisted by Dr. Timothy Lee, and Dr. Lee's involvement in the surgery was limited to the opening and closing phases of the surgery. A post-bypass echocardiogram confirmed a successful surgery.

Postoperatively, Mr. Prokopenko developed continuous hypotension, tachycardia, and hypoxia. These conditions required nitric oxide to treat pulmonary hypertension, inotropic support to increase his systemic blood pressure and cardiac output, and substantial fluid resuscitation. Another echocardiogram confirmed no substantial pericardial hematoma, effusion, or tamponade. The decedent's left ventricle was mildly underfilled, he had right heart hypokinesis, and he had a bowing of the septum to the left but a normal ejection fraction. The decedent was intubated for ventilation support overnight, and successfully extubated on April 24, the first day post-operation. Two days later, the decedent was stable, inotropic support was halted, and the decedent was started on a beta blocker to regulate his blood pressure. However, the decedent continued to have sporadic tachycardia which was treated with Lopressor. On April 27, the decedent's chest tubes were removed and he was transferred from the intensive care unit to the step-down unit.

On April 29, he was transferred to the regular floor following two days of stable and improving lung exams, except for persistent atelectasis in the lower lobes of the lungs. The decedent's condition was deemed stable other than mild hypotension with white blood cell counts (WBC) of 10 for three days and 12.6 on April 30. The decedent's discharging physical exam was unremarkable with lungs clear bilaterally and a normal heart rate and rhythm. The decedent was discharged home on April 30 with instructions, provided in Russian and English, to call Dr. Galloway's office with any changes or complaints and to follow up with Dr. Galloway in ten days.

During the decedent's postoperative hospitalization, Dr. Galloway saw him every day. The decedent presented to the NYU Emergency Department (ED) on May 1, 2018. His wife and son reported overnight coughing, 6-7/10 pain, sweating, chills, talking in his sleep, and diarrhea. These symptoms resolved, but new shortness of breath, weakness, intermittent confusion, and two episodes of syncope and vomiting occurred that morning. In the ED, the decedent was hypotensive, tachypneic, lethargic, and pale with cool extremities. An initial exam revealed rales at the bilateral lung bases, distant heart sounds, and pitting edema. Diagnoses included pericardial tamponade, sepsis, cardiogenic shock, and pulmonary embolism (PE). After two echocardiograms were performed the same day, which ruled out a pericardial effusion or tamponade. Lab work showed elevated WBC of 15.8, creatinine, liver function tests, troponin, and lactate were revealed. was ruled out. The decedent started taking broad spectrum antibiotics and was admitted to the surgical ICU (SICU) after consulting a cardiothoracic surgeon and surgical intensivist.

In the SICU, the decedent was given medication to increase his blood pressure. A chest x-ray showed cardiomegaly, low lung volumes with vascular crowding, bibasilar atelectasis, and platelike atelectasis in the right mid-lung. The decedent was intubated for increased hypoxia and sedated and paralyzed for ventilator dyschroncy. The decedent's shock diagnosis was considered to be distributive shock due to an unidentified infection as it was not consistent with cardiogenic shock. A pulmonary embolism (PE) and sepsis evaluation were performed to rule out PE or sepsis.

Mr. Prokopenko remained intubated, sedated and paralyzed. He was on medication for his blood pressure and right heart failure associated with increased central venous and pulmonary arterial pressures, Heparin for a suspected PE (based on a doppler ultrasound positive for multiple veinous occlusions), broad-spectrum antibiotics for ARDS and a suspected infection of an unknown source and inhaled nitric oxide for pulmonary hypertension. Chest x-rays were performed and they continued to show unchanged moderate-sized bilateral pleural effusions and lung atelectasis, opacities, and bronchovascular markings. Mr. Prokopenko was started on IV Lasix for fluid overload as his renal function began to normalize. Deep bronchoalveolar lavage ("BAL") cultures were taken for worsening ARDS with extensive bilateral pulmonary congestion and moderate bilateral pleural effusions on a chest x-ray.

On May 8, the decedent's hypoxia worsened despite high ventilator settings, so he was transferred from the SICU to the medical ICU (MICU). At the MICU, the decedent was started on peripheral ECMO. His antibiotics were supplemented as the previous BAL cultures were positive for staph aureus, stenotrophomonas maltophilia, and candida albicans. He remained stable on ECMO until May 11 when he became suddenly and

severely hypotensive. An echocardiogram confirmed a cardiac tamponade (clot compressing the right atrium and ventricle). An emergent pericardial window with chest tube placement was performed at the bedside, and IV fluids, multiple units of blood product, and albumin were administered. The decedent's blood pressure improved and continued to improve throughout the day and he was weaned off the nitric oxide. A tracheostomy was placed that evening.

The MICU attending, Dr. Shari Brosnahan, saw the decedent on May 12 and May 13 acting as the covering weekend attending. Dr. Brosnahan repeated the standing orders, recommending continued diuresis for volume overload, continued weaning of pressors and sedation, continued antibiotics, and continued mechanical ventilation. On May 14, the decedent became more arousable, communicative, and oxygenation was improving. ECMO was weaned and successfully discontinued on May 17.

Over the next few weeks, the decedent continued to improve with rehabilitation therapies. As a result, planning for discharge to acute inpatient rehabilitation was started. A speaking valve was placed on his trach, and trach collar trials were started and tolerated. His diet was advanced to oral feedings. The decedent continued to be treated with a variety of antibiotic for persistent sputum and BAL cultures positive for stenotrophomonas of varying susceptibilities. He never had a positive blood culture.

One June 10, the decedent unexpectedly deteriorated rapidly on June 10, with transient desaturations that progressed to acute hypoxic respiratory failure and hypotension. He experienced multiple cardiac arrests overnight from June 13 to June 14. Mr. Prokopenko's wife and son requested a DNR and he died shortly thereafter in the

early morning hours of June 14. No specific cause of the sudden deterioration and demise was identified.

The plaintiffs submitted expert testimony of a medical doctor licensed to practice medicine in the State of New York, and board certified in Internal Medicine and Cardiovascular Disease. The plaintiffs' expert opined that Dr. Galloway departed from the accepted standard of care in failing to appreciate Mr. Prokopenko's elevated WBC suggestive of infection prior to discharge, and therefore, prematurely discharged Mr. Prokopenko from NYU on April 30, 2018. The expert opined that "[a]s a direct result of defendant's negligent and premature discharge on April 30, 2018, Mr. Prokopenko was readmitted one day later and diagnosed with Acute Respiratory Distress Syndrome (ARDS)." The expert further opines that Dr. Galloway's negligent premature discharge of Mr. Prokopenko on April 30, 2018, resulted in the development of ARDS which was a substantial contributing factor to Mr. Prokopenko's death.

The defendants submitted the expert testimony of Dr. John Elefteriades, duly licensed to practice medicine in the State of Connecticut and board certified in thoracic surgery. Dr. Elefteriades opined that "plaintiffs' claims against the [d]efendants are without merit or associated preventable injury as the defendants' care was performed timely, properly, and within [the] standard of care and no negligent act or omission by the [d]efendants directly caused or contributed to plaintiff's decedent's postoperative complications or demise." He stated that the decedent had no complaints or symptoms related to his comorbidities before the surgery, and the preoperative echocardiogram found no pulmonary hypertension. The decedent reported no preoperative complaints or symptoms suggestive of active airway disease or infection, such as a productive cough,

wheezing, secretions, or significant pulmonary dysfunction on imaging that warranted a separate pulmonary clearance. Dr. Elefteriades opined that a mild WBC elevation, after extensive cardiac surgery, and the postoperative complications encountered are anticipated. He stated that the decedent remained afebrile and had no signs of infection like cough, weakness, dysuria, or wound erythema. Further, Dr. Elefteriades asserts that the decedent's trending WBC over multiple days was stable, and the April 30 increase was not so substantial, alone, to warrant an infectious workup with imaging or continued inpatient care. The complications encountered immediately postoperatively are known risks of cardiac surgery, especially in a high-risk patient like the decedent.

On a motion for summary judgment dismissing a medical malpractice cause of action, a defendant has the prima facie burden of establishing that there was no departure from good and accepted medical practice, or, if there was a departure, the departure was not the proximate cause of the alleged injuries. *Brinkley v. Nassau Health Care Corp.*, 120 A.D.3d 1287 (2d Dept. 2014); *Stukas v Streiter*, 83 AD3d 18, 24-26 (2d Dept. 2011). Once the defendant has made such a showing, the burden shifts to the plaintiff to submit evidentiary facts or materials to rebut the prima facie showing made by the defendant, so as to demonstrate the existence of a triable issue of fact. *Alvarez v Prospect Hosp.*, 68 NY2d 320, 324 (1986); *Brinkley v. Nassau Health Care Corp.*, supra; *Fritz v. Burman*, 107 A.D.3d 936, 940 (2d Dept. 2013); *Lingfei Sun v. City of New York*, 99 AD3d 673, 675 (2d Dept. 2012); *Bezerman v. Bailine*, 95 AD3d 1153, 1154 (2d Dept. 2012); *Stukas v. Streiter*, at 24. A plaintiff will succeed in a medical malpractice action by showing that a defendant deviated from accepted standards of medical practice and that this deviation proximately caused the plaintiff's injury. *Contreras v Adeyemi*, 102 AD3d 720, 721 (2d

Dept. 2013); *Gillespie v New York Hosp. Queens*, 96 A.D.3d 901, 902 (2d Dept. 2012); *Semel v Guzman*, 84 AD3d 1054, 1055-56 (2d Dept. 2011). The plaintiff opposing a defendant physician's motion for summary judgment must only submit evidentiary facts or materials to rebut the defendant's prima facie showing. *Stukas*, at 24. "When a defendant in a medical malpractice action demonstrates the absence of any material issues of fact with respect to at least one of those elements, summary judgment dismissing the action should eventuate unless the plaintiff raises a triable issue of fact in opposition" *Schwartz v Partridge*, 179 AD3d 963, 964 (2d Dept 2020) (internal citations omitted).

Dr. Galloway's Motion

After reviewing the facts and exhibits, there exist triable issues of fact regarding the care the decedent received from Dr. Galloway. "Summary judgment may not be awarded in a medical malpractice action where the parties adduce conflicting opinions of medical experts." *McKenzie v. Clarke*, 77 A.D.3d 637, 638 (2d Dept. 2010); *see Adjetey v. New York City Health & Hosps. Corp.*, 63 A.D.3d 865 (2d Dept. 2009). There are conflicting expert opinions in this case regarding the decedent's treatment by Dr. Galloway and whether there was a departure from the standards of care. Dr. Galloway's expert opines that there was no departure from the standard of care concerning Dr. Galloway's conduct. The plaintiffs' expert opines the opposite, claiming Dr. Galloway deviated from the standard of care by prematurely discharging the decedent and failing to properly treat the low WBC count. The plaintiffs' expert opines that the deviations from the standard of care resulted in the development of ARDS which became a substantial contributing factor in the decedent's death. Meanwhile, the defendants' expert states that

the complications encountered by the decedent postoperatively are known risks of cardiac surgery. Thus, there exist questions of fact regarding the decedent's treatment he received from defendant Dr. Galloway and his motion for summary judgment must be denied.

Dr. Lee's Motion

After reviewing the facts and exhibits, there exists no triable issues of fact concerning the care the decedent received from Dr. Lee. The plaintiffs' opposition does not mention the care provided by then-resident, Dr. Lee, under Dr. Galloway's supervision. The defendants' expert testified that, "Dr. Lee's limited involvement in the intraoperative care was not directly or proximately related to the postoperative complications as those complications, while tangentially related to the surgery, were not preventable." There exist no questions of fact regarding the decedent's treatment he received from defendant Dr. Lee, and his motion for summary judgment must be granted.

Dr. Brosnahan's Motion

After reviewing the facts and exhibits, there exists no triable issues of fact concerning the care the decedent received from Dr. Brosnahan. The plaintiffs' opposition does not mention the care of Dr. Brosnahan, provided on May 12 and 13. The defendants' expert opined that, "Dr. Brosnahan was not involved in [the decedent's] MICU care until after ECMO was started and did not initiate new care." The decedent's condition did not warrant her to change or start new treatment during her two days of care and she properly continued the treatment orders of the other attending physicians. There exist no questions

of triable fact regarding the decedent's treatment he received from defendant Dr. Brosnahan, and her motion for summary judgment must be granted.

NYU Langone Health System's Motion

After reviewing the facts and exhibits, there exists no triable issues of fact concerning the care the decedent received from NYU Langone Health System. In Exhibit N, the Director of Insurance for NYU Langone Health System, Michael Browdy, explained in an affidavit that NYU Langone Health System is a not-for-profit domestic corporation that does not provide healthcare services. He wrote, "[t]he Health System employs personnel who provide support services to various campuses (including Information Technology (IT), Finances, Real Estate Development & Facilities (RED&F), Legal, Development, Communications)." The System does not provide any healthcare services, and NYU Langone Health System did not employ any of the clinicians or caregivers who provided care to the decedent. NYU Langone Health System did not treat the decedent. Browdy concluded, "based on my review of the NYU Langone Health System employment database, the Health System does not and did not employ or supervise the care of Defendants, Aubrey Galloway, M.D., Timothy Lee, M.D., and Shari Barnett Brosnahan, M.D., or any of the healthcare providers who may have rendered treatment to plaintiffs' decedent." Thus, with no opposition to this affidavit, there exist no questions of fact regarding the decedent's treatment he received from defendant NYU Langone Health System, and its motion for summary judgment must be granted.

NYU School of Medicine's Motion

After reviewing the facts and exhibits, there exist triable issues of fact regarding the care the decedent received from NYU School of Medicine. There are conflicting expert opinions in this case regarding the decedent's treatment by Dr. Galloway, an employee of NYU School of Medicine, and whether there was a departure from the standards of care. The defendants' expert stated that there was no departure from the standard of care concerning Dr. Galloway or NYU School of Medicine's conduct. The plaintiffs' experts say the opposite, claiming NYU School of Medicine via vicarious liability, deviated from the standard of care when Dr. Galloway failed to properly assess the low WBC count resulting in the decedent's death. The plaintiffs' Affirmation in Opposition does not mention direct negligence or vicarious liability on behalf of NYU School of Medicine. However, because there are questions of fact regarding Dr. Galloway's conduct, there exists questions of fact regarding the vicarious liability of NYU School of Medicine, and its motion for summary judgment must be denied.

As to the lack of informed consent claims, the plaintiffs do not mention them in their Affirmation in Opposition, and therefore the claims must be dismissed.

In conclusion, Dr. Galloway and NYU School of Medicine's motions for summary judgment are denied, and Dr. Lee, Dr. Brosnahan, and NYU Langone Health System's motions for summary judgment are granted.

The caption shall be amended as follows:

VALERI V. PROKOPENKO as the Administrator of The Estate of VALERIY PROKOPENKO, deceased and ELENA PROKOPENKO,

Plaintiff(s),

-against-

AUBREY CLAUDIUS GALLOWAY, M.D., and NYU SCHOOL OF MEDICINE,

Defendant(s).

The parties shall appear for a conference in MMTRP via Microsoft Teams on July 24, 2024 at 10:15.

This constitutes the decision and order of the Court.

KINGS COUNTY CLERK FILED 2024 APR 12 A 10:21

ENTER,

JSC

HON. ELLEN M. SPODEK