SHORT FORM ORDER

INDEX No. 01-24303
CAL. No. 05-02256-MM

SUPREME COURT - STATE OF NEW YORK
POST-NOTE MOTION PART - SUFFOLK COUNTY

PRESENT:

Hon. ROBERT W. DOYLE
Justice of the Supreme Court

MOTION DATE 1/17/06 (013,020)
1/30/06 (014,015,016,017,018)
2/7/06 (019)
2/8/06 (021)
ADJ. DATE 5/9/06
Mot. Seq. # 013 - MD
014 - MG
015 - MG
016 - MD
017 - MG
018 - MD
019 - MD
020 - MG
021 - MD

PATRICIA MYERS, as Executrix of the Estate of ROY MYERS, and PATRICIA MYERS, individually, Plaintiffs, - against - NEIL FERRARA, M.D., SARAH HARGROVE, R.N., STEVEN JAMES FRATELLO, M.D., SANJIV SHARMA, M.D., JOSE ANTONIO, M.D. WILLIAM ONG CHU, M.D., NORTH SHORE UNIVERSITY HOSPITAL AT SYOSSET, LEI GUAN, M.D., SARAH CLIFTON, R.N., TIMOTHY BABSTOCK, R.N., CYNTHIA DIPALO, N.P., PAUL MANCUSO, M.D., JOHN PLATZ, M.D. and ADAM E. SALTMAN, M.D., Defendants.	PEGALIS & ERICKSON, LLC Attorneys for Plaintiff One Hollow Lane, Suite 107 Lake Success, New York 11042 FUREY, KERLEY, WALSH, et al. Attorneys for Deft. Neil Ferrara, M.D. 2174 Jackson Avenue Seaford, New York 11783 FUMUSO, KELLY, DEVERNA, et al. Attorneys for Defts. Chu, Hargrove, Antonio & North Shore Univ. Hosp. 110 Marcus Blvd., Suite 500 Hauppauge, New York 11788 VARDARO & HELWIG, LLP Attorneys for Defendant John Platz, M.D. 732 Smithtown Bypass, Suite 203 Smithtown, New York 11787

Upon the following papers numbered 1 to 153 read on these motions for summary judgment; Notice of Motion/ Order to Show Cause and supporting papers 1 -17; 18 - 28; 29 - 37; 38 - 49; 50 - 60; 61 - 73; 74 - 97; 98 - 110; 111 - 122 ; Notice of Cross Motion and supporting papers_____; Answering Affidavits and supporting papers 123 - 145; Replying Affidavits and supporting papers 146 - 147; 148 - 150; 151 - 153 ; Other ___; (~~and after hearing counsel in support and opposed to the motion~~) it is,

ORDERED that these motions for summary judgment are consolidated for the purposes of this determination; and it is further

ORDERED that this motion (#013) by defendant Sanjiv Sharma, M.D. for an order pursuant to CPLR 3212 granting summary judgment dismissing the complaint as against him is denied; and it is further

ORDERED that this motion (#014) by defendant Timothy Babstock, R.N. for an order pursuant to CPLR 3212 granting summary judgment dismissing the complaint as against him is granted; and it is further

ORDERED that this motion (#015) by defendant Lei Guan, M.D. for an order pursuant to CPLR 3212 granting summary judgment dismissing the complaint as against him is granted; and it is further

ORDERED that this motion (#016) by defendant Sarah Clifton, R.N. for an order pursuant to CPLR 3212 granting summary judgment dismissing the complaint as against her is denied; and it is further

ORDERED that this motion (#017) by defendant Paul Mancuso, M.D. for an order pursuant to CPLR 3212 granting summary judgment dismissing the complaint as against him is granted; and it is further

ORDERED that this motion (#018) by defendant Cynthia DiPalo, N.P. for an order pursuant to CPLR 3212 granting summary judgment dismissing the complaint as against her is denied; and it is further

ORDERED that this motion (#019) by defendant Adam E. Saltman, M.D. for an order pursuant to CPLR 3212 granting summary judgment dismissing the complaint as against him is denied; and it is further

ORDERED that this motion (#020) by defendant Steven James Fratello, M.D. for an order pursuant to CPLR 3212 granting summary judgment dismissing the complaint as against him is granted; and it is further

ORDERED that this motion (#021) by defendant Neil Ferrara, M.D. for an order pursuant to CPLR 3212 granting summary judgment dismissing the complaint as against him is denied.

This is an action to recover damages for the wrongful death of plaintiff's then 59-year-old husband Roy Myers and for medical malpractice based on the alleged negligence of defendants in, among other things, failing to timely diagnose an esophageal perforation and to arrange for an immediate esophagram during his admission at North Shore University Hospital at Syosset, New York (Syosset Hospital) from December 22, 2000 to December 23, 2000 and his subsequent transfer to Stony Brook University Medical Center (Stony Brook Hospital) on December 23, 2000. Plaintiff's decedent remained at Stony Brook Hospital until his death on December 28, 2000.

On December 21, 2000 plaintiffs were eating dinner at a hotel in New York City when a piece of steak meat got stuck in plaintiff's decedent's throat at about 9 p.m., causing plaintiff's decedent to cough and gag. Plaintiff's decedent got up from the table, went out a side door of the dining room unassisted, and plaintiffs went up to their hotel room. At the time, plaintiff's decedent was speaking and breathing and refused to seek medical attention despite gagging and coughing all night. Nothing would pass down his throat when he attempted to drink water and eat a piece of apple, and he had labored breathing. Plaintiffs left the hotel at about 8 a.m. on December 22, 2000 and returned to their home in Syosset by train. At Penn Station, prior to boarding the train, plaintiff's decedent attempted to ingest milk of magnesia as purportedly suggested by a pharmacist but was unable to keep it down.

When plaintiffs arrived home, they went to see plaintiff's physician, who advised plaintiff's decedent to go to the emergency room of Syosset Hospital. Plaintiffs arrived at the emergency room at approximately 2 p.m., and plaintiff's decedent had a chest x-ray taken. At approximately 6 p.m. on December 22, 2000 plaintiff's decedent underwent an endoscopy performed by Neil Ferrara, M.D. (Dr. Ferrara), a gastroenterologist, to remove an impacted piece of meat in his distal esophagus. Although large fragments of the meat were removed, it could not be fully removed. When plaintiff's decedent subsequently had difficulty breathing, Dr. Ferrara sought a consultation by Sanjiv Sharma, M.D. (Dr. Sharma), a pulmonologist. A post-procedure chest x-ray was taken which indicated a mid-left lung infiltrate[1]. Dr. Ferrara believed that intervention by a thoracic surgeon was required, but he could not find a thoracic surgeon within the North Shore Hospital system able to accept a patient. Therefore, he contacted Stony Brook Hospital and spoke with a thoracic surgeon, Adam E. Saltman, M.D. (Dr. Saltman), who accepted transfer of plaintiff's decedent.

Plaintiff's decedent was subsequently transferred to Stony Brook Hospital early in the morning of December 23, 2000. Later that morning, at approximately 11:30 a.m., Dr. Saltman performed a rigid then flexible esophagoscopy on plaintiff's decedent with the assistance of Paul Mancuso, M.D. (Dr. Mancuso). Following the procedure, plaintiff's decedent was released to the recovery room (AICU), then transferred to the cardiac (surgery) telemetry[2] floor. There, plaintiff's decedent imbibed ginger ale and water as permitted by doctor's orders. At about 5 p.m., Sarah Clifton, R.N. (Nurse Clifton) contacted Cynthia DiPalo, N.P. (Nurse DiPalo) to report that plaintiff's decedent had pain and difficulty breathing. Nurse DiPalo informed Dr. Saltman of said symptoms, and he told her to order a chest x-ray. Nurse DiPalo ordered medications for gas and pain, waited to see if the medications would relieve plaintiff's decedent, and then ordered a chest x-ray. Upon notification that the chest x-ray showed pneumothorax, Nurse DiPalo spoke with Dr. Saltman again, who told her to contact cardiothoracic resident, Dr. John Platz (Dr. Platz), for the immediate insertion of a chest tube. That evening, prior to the insertion of the chest tube, plaintiff's decedent had a cardiac arrest, fell into a coma and never regained consciousness. The autopsy

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[1]An infiltrate is a permeation or penetration into the cells in the lung inferred from the appearance of a localized, ill-defined opacity on a chest x-ray (Stedman's Medical Dictionary 896 [27th ed 2000]).

[2]Cardiac telemetry is the transmission of cardiac signals to a receiving location where they are displayed for monitoring (Stedman's Medical Dictionary 1791 [27th ed 2000]).

report indicated cause of death as "complications, including perforation, of meat bolus[3] obstructing esophagus." The autopsy report noted a 2.5 centimeter mucosal laceration in the distal esophagus of which there was an approximately 4 millimeter perforation through the wall of the esophagus into the mediastinum[4].

By her complaint, plaintiff alleges a first cause of action for medical malpractice and wrongful death; a second cause of action for conscious pain and suffering; a third cause of action for lack of informed consent; and a fourth derivative cause of action for loss of services.

Dr. Sharma now moves (#013) for summary judgment dismissing the complaint as against him on the grounds that he did not depart from good and accepted medical practice in his treatment and pulmonary consult of plaintiff's decedent. In support of the motion, Dr. Sharma submits, among other things, the summons and complaint; his answer; the bills of particulars with respect to Dr. Sharma; the consult and orders of Dr. Sharma; plaintiff's decedent's records from Syosset Hospital and Stony Brook Hospital; the deposition transcripts of Dr. Sharma, Dr. Ferrara and plaintiff; and the affidavit dated December 20, 2005 of Ian H. Newmark, M.D.(Dr. Newmark), board certified in pulmonology.

With respect to Dr. Sharma, plaintiff alleged in her amended bill of particulars that he was negligent in, among other things, failing to order an immediate esophagram; failing to obtain an early thoracic evaluation; failing to appreciate and act upon fluctuations in plaintiff's decedent's oxygen saturation; failing to properly interpret the chest x-ray; failing to investigate the source of plaintiff's decedent's lung infiltration; failing to diagnose an esophageal perforation; and failing to communicate the drop in oxygen saturation or concern about possible esophageal perforation to Dr. Saltman.

To make a prima facie showing of entitlement to summary judgment in an action to recover damages for medical malpractice, a defendant hospital or physician must establish through medical records and competent expert affidavits that the defendant did not deviate or depart from accepted medical practice in defendant's treatment of the patient (***Mendez v City of New York***, 295 AD2d 487,744 NYS2d 847 [2d Dept 2002]). To rebut a prima facie showing by the defendant hospital or physician, a plaintiff must demonstrate the existence of a triable issue of fact by submitting an expert's affidavit of merit attesting to a deviation or departure from accepted practice and containing an opinion that the defendant's acts or omissions were a competent-producing cause of the injuries and subsequent death of the patient (*see*, ***Lifshitz v Beth Israel Med. Ctr.-Kings Highway Div.***, 7 AD3d 759, 776 NYS2d 907 [2d Dept 2004]; ***Domaradzki v Glen Cove OB/GYN Assocs.***, 242 AD2d 282, 660 NYS2d 739 [2d Dept 1997]).

Dr. Ferrara testified at his deposition that in 2000 he was board certified in gastroenterology and internal medicine and that he had admitting privileges at Syosset Hospital. Dr. Ferrara had been called for consultation on December 22, 2000 after plaintiff's decedent entered the Syosset Hospital emergency

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[3] A masticated morsel ready to be swallowed (Stedman's Medical Dictionary 222 [27th ed 2000]).

[4] The median partition of the thoracic cavity (Stedman's Medical Dictionary 1076 [27th ed 2000]).

room and noted that plaintiff's decedent had "[r]are intermittent dysphagia[5] for the last six weeks but no GI intervention. No prior upper endoscopy." After examining plaintiff's decedent, Dr. Ferrara had noted as his impression, "[m]eat impaction. Suggest upper endoscopy, removal of meat impaction. Risks, benefits and alternatives explained to the patient." Dr. Ferrara had reviewed the chest x-ray that had been taken while plaintiff's decedent was in the emergency room and had determined that there was nothing significant with respect to the meat impaction and suggested a flexible upper endoscopy because it is the safer, simpler and standard approach to meat impaction. Dr. Ferrara defined the procedure as looking into the esophagus, stomach and duodenum using a flexible upper endoscope. Dr. Ferrara also testified that he informed plaintiff's decedent that he could undergo a rigid upper endoscopy performed by a thoracic surgeon since said procedure was not performed by gastroenterologists. Dr. Ferrara stated that he explicitly informed plaintiff's decedent that a perforation of the esophagus was a possible risk due to, among other things, the fact that the meat bolus had remained there for 24 hours which to some degree weakened the wall of the esophagus.

Following the procedure, Dr. Ferrara recorded in his operative note that "... [l]arge meat bolus impacted in distal esophagus, roughly 40 centimeters. Large pieces of meat were removed with a snare and forceps. Estimated about four centimeters removed, but large meat impaction remains. Impression: Incomplete removal of meat impaction of esophagus. Suggest thoracic surgery consult to consider rigid approach. I spoke with Dr. Saltman, SUNY Stony Brook, who is willing to take the patient in transfer." Dr. Ferrara testified that there was no photographic record of the procedure possibly due to the fact that the photographic machine was not working. According to Dr. Ferrara, after the procedure he consulted with a number of gastroenterologists and thoracic surgeons, who agreed that plaintiff's decedent be transferred to the care of a thoracic surgeon. Then he contacted Dr. Saltman at Stony Brook Hospital, related the same to him and Dr. Saltman agreed to accept plaintiff's decedent.

Dr. Ferrara testified that from the time that the procedure was completed until plaintiff's decedent was transferred, Dr. Ferrara did not do anything to determine whether there was a change in the condition of the esophagus or the position of the meat bolus because it would not have been indicated. Later, at about 10:15 p.m., a nurse contacted Dr. Ferrara, informing him that plaintiff's decedent had an episode of shortness of breath, and Dr. Ferrara contacted Dr. Sharma for a consultation by a pulmonologist. A post-procedure x-ray showed a mid-left infiltrate; based on clinical judgment, Dr. Ferrara believed that the shortness of breath was caused by a small degree of aspiration or atelectasis[6] from intubation and not by a perforation. According to Dr. Ferrara, plaintiff's decedent's condition improved after being placed on oxygen and continued IV fluid, which would not occur if there was a perforation. Dr. Ferrara emphasized that plaintiff's decedent did not have any of the signs and symptoms of a perforated esophagus such as decompensation of the patient, significant changes in vital signs, fever, crepitus (free air under the skin around the

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[5]Dysphagia is difficulty in swallowing (Stedman's Medical Dictionary 554 [27th ed 2000]).

[6]Atelectasis is defined as decreased or absent air in the entire part of a lung with resulting loss of lung volume (Stedman's Medical Dictionary 161 [27th ed 2000]).

mediastinum and neck), pneumothorax, and collapse of a lung, which could be determined by simple bedside examination. Dr. Ferrara pointed out that he gave instructions to send to Stony Brook Hospital the patient copy of the chart, all labs, EKG, chest x-ray films, and his reports and consults.

At his deposition, Dr. Sharma testified that he practiced in internal medicine, pulmonary and critical care at Syosset Hospital. In addition, Dr. Sharma testified that he was called by Dr. Ferrara for a consult after the procedure at about 8:30 p.m. in the evening. Dr. Sharma testified that the chest x-ray taken after the procedure when compared to the one taken prior to the procedure showed a new infiltrate in the lower part of the left lung, which could indicate pneumonia or inflammation of the lung, but showed no pneumothorax (collapse of the lung). Also, the left hemidiaphragm was obscured in the post-procedure x-ray, indicating the possible collapse of the lower left lung, pneumonia or fluid collection in the lower left lung. After the procedure plaintiff's decedent had difficulty breathing and required oxygen. According to Dr. Sharma, from the time he first saw plaintiff's decedent, he wrote in his orders to keep plaintiff's decedent "NPO," meaning that he was not to have any food. Dr. Sharma posited that it was possible for someone to aspirate something into his lungs during an operation and that a patient with an esophageal perforation could complain of difficulty in breathing and chest pain. He listed as differential diagnoses aspiration, esophageal perforation (a hole in the esophagus or food pipe), and mediastinitis (an inflammation of the mediastinum). He testified that he emphasized to Dr. Ferrara the necessity of finding a thoracic surgeon as soon as possible and to consult regarding the performance of a contrast study of the esophagus, also known as an esophagram, as a diagnostic tool to exclude perforation with the supervision of a thoracic surgeon and made sure that a thoracic surgeon was contacted. According to Dr. Sharma, immediate treatment is required for a patient with an esophageal perforation or aspiration pneumonia, and one such treatment is antibiotics, which were prescribed to plaintiff's decedent as soon as possible. Dr. Sharma stated that he wrote that there was a possible esophageal perforation on his consult and his order sheet but that he did not speak to the Stony Brook Hospital surgeons to communicate to them that an esophagram was required to rule out an esophageal perforation. Dr. Sharma indicated that once the transfer to Stony Brook Hospital was arranged, the performance of an esophagram, which had its own concomitant complications, could have delayed the transfer.

Plaintiff testified at her deposition that on the train trip home she noticed that her husband's voice was becoming hoarse. In addition, plaintiff testified that she did not discuss the x-rays that were taken at Syosset Hospital with anyone while her husband was at the hospital. Plaintiff also testified that she left Syosset Hospital prior to her husband's endoscopy procedure on December 22, 2000, that someone from the hospital called her later and informed her that he had been transferred to Stony Brook Hospital and that she next saw her husband at Stony Brook Hospital at approximately 1 p.m. on December 23, 2000. According to plaintiff, after she arrived at Stony Brook Hospital with her sister, she spoke to Dr. Saltman, who told her that during the morning's procedures he had seen a gray pus area the size of the tip of the little finger in plaintiff's decedent's upper abdominal area. She also testified that when she saw plaintiff's decedent, he was complaining of stomach cramps and gas pains and had a little difficulty breathing in the upper chest area. Plaintiff's decedent drank water when plaintiff and her sister arrived at Stony Brook Hospital, and plaintiff's sister removed the oxygen mask from plaintiff's decedent's face because she believed that it was not working.

Plaintiff left Stony Brook Hospital at 4 p.m., and when she called plaintiff's decedent at 6 p.m. from her sister's home in Port Jefferson, he stated that he was not feeling well, and plaintiff learned that plaintiff's decedent would not be released that evening, so plaintiff returned to her home in Syosset. According to plaintiff, after she returned home, a nurse called, asking plaintiff whether she could come back, and plaintiff responded that she could not and did not inquire why the nurse was calling her. Plaintiff next attempted to contact her husband in his room, and there was no answer. A few minutes later plaintiff received another call, informing her that her husband had gone into cardiac arrest. Plaintiff returned to Stony Brook Hospital and learned that her husband was in the Intensive Care Unit and spoke to Dr. Saltman, who told plaintiff that her husband had been found on the floor, there was a code blue, and her husband was in a coma. Plaintiff testified that Dr. Saltman told her that there was a tear in plaintiff's decedent's esophagus, that fluid had entered the lung from the tear and that plaintiff's decedent had basically drowned. Plaintiff's decedent remained in the Intensive Care Unit for five more days and never regained consciousness. Plaintiff stated that she was told that her husband was brain dead and signed a consent form to have the life support machines turned off.

By his affidavit, Dr. Newmark, a board certified pulmonologist, opines within a reasonable degree of medical certainty that Dr. Sharma authored appropriate orders given plaintiff's decedent's signs and symptoms and performed a thorough consultation based on the information provided by Dr. Ferrara, as well as his own observation of plaintiff's decedent. In addition, Dr. Newmark opines that Dr. Sharma's acts of ordering antibiotics, blood cultures, routine blood work on a "STAT" basis and a thoracic surgery consult "ASAP" was appropriate and within the standard of care. Dr. Newmark points out that Dr. Sharma was not involved in the process of transferring plaintiff's decedent and, as a pulmonologist, deferred certain aspects of treatment to physicians specializing in other fields of medicine; that the chart that was transferred to Stony Brook Hospital would have included Dr. Sharma's consult and orders; and that Dr. Sharma did not depart from accepted standards of medical care in his treatment of plaintiff's decedent.

Here, Dr. Sharma made out a prima facie case that he did not deviate or depart from accepted medical practice through submission of the deposition testimony of the physicians involved in plaintiff's decedent's treatment, plaintiff's decedent's medical records, and the affidavit of his expert pulmonologist (*see*, ***Jonassen v Staten Is. Univ. Hosp.***, 22 AD3d 805, 803 NYS2d 700 [2d Dept 2005]; ***Slone v Salzer***, 7AD3d 609, 775 NYS2d 891 [2d Dept 2004]).

Plaintiff opposes Dr. Sharma's motion by submitting a redacted[7] affidavit of her expert, board certified in internal medicine, pulmonary medicine and critical care medicine, who opines that no adequate explanation was provided for the failure to obtain an immediate contrast study at Syosset Hospital during the five hours between the time that Dr. Sharma noted the need for the study and plaintiff's decedent's transfer. According to plaintiff's expert, both Dr. Sharma and Dr. Ferrara were qualified to order the study, and there was no medical reason for the presence of a thoracic surgeon for the

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[7]Plaintiffs may submit an unidentified expert's affidavit provided that the Court may require submission of an unredacted copy for in camera inspection (*see, **Marano v Mercy Hosp.,*** 241 AD2d 48, 670 NYS2d 570 [2d Dept 1998]; ***McCarty v Community Hosp.,*** 203 AD2d 432, 610 NYS2d 588 [2d Dept 1994]).

study's performance. Plaintiff's expert further opines that had the study been performed before the transfer of plaintiff's decedent as the standard of care required, it would have revealed evidence of a perforation of the distal esophagus, plaintiff's decedent would have been treated in a more timely and appropriate manner and his death would have likely been avoided. Plaintiff's expert further opines that the failure to perform the contrast study at Syosset Hospital was a substantial contributing factor in bringing about plaintiff's decedent's untimely death. In addition, plaintiff's expert stated that at a minimum, the standard of care required that Dr. Sharma confirm with Dr. Ferrara that his concerns of perforation were discussed directly with Dr. Saltman. Finally, plaintiff's expert opines that the failure of Dr. Sharma to communicate concerns relating to perforation and the urgent need for an esophagram to Dr. Saltman was a failure of good and accepted care and contributed to the delay in diagnosis and treatment.

In reply, Dr. Sharma contends that his consult note and order indicated that he ordered an esophagram to be performed "STAT" and that there was no reason for him to believe that his orders would not be followed. In addition, Dr. Sharma argues that even if the esophagram was performed prior to plaintiff's decedent's transfer, an immediate thoracic surgery consult was still required, and Dr. Sharma's orders and consult note were among the documents that were to be delivered with plaintiff's decedent to Stony Brook Hospital, which would have revealed to personnel the concern over an esophageal tear and need for an esophagram. Dr. Sharma continues that even if the medical records were not delivered, the ambulance run sheet (Pre-Hospital Care Report) noted that x-rays revealed a possible esophageal tear, which would have informed personnel at Stony Brook Hospital of the concern.

The Court notes that although Dr. Sharma's consultation request (consult note) lists among his opinions that a contrast study of the esophagus be performed "STAT" and NPO IV fluid, his physician order sheet lacks any mention of a contrast study or esophagram. Thus, the record indicates that Dr. Sharma recommended the contrast study but did not order it. The submissions raise complex issues of fact as to how actively involved a physician called in for a consultation by the attending physician must be in the care of a patient, whether to the point of ensuring that his or her recommendations to the attending physician are actually carried out and that his or her opinions with respect to his or her specialty are conveyed to known subsequent treating medical providers or simply providing recommendations and leaving the rest to the discretion of the attending physician. The expert affidavit submitted by plaintiff raises triable issues of fact as to, *inter alia*, whether Dr. Sharma departed from good and accepted medical practice by failing to either order the esophagram himself or to make sure that an esophagram was ordered by the appropriate physician prior to plaintiff's decedent's transfer to Stony Brook Hospital; whether a thoracic surgeon was required to supervise the esophagram; and whether Dr. Sharma departed from good and accepted medical practice by failing to ensure that Dr. Saltman was aware of the concern that plaintiff's decedent might have an esophageal perforation by actually speaking to Dr. Saltman rather than relying on the transfer and subsequent review of medical reports by Stony Brook Hospital personnel; and whether said departures were a substantial factor in causing injury to plaintiff's decedent and his subsequent death (*see*, ***Taylor v Nyack Hosp.***, 18 AD3d 537, 795 NYS2d 317 [2d Dept 2005]; ***Blanar v Dickinson***, 296 AD2d 431, 745 NYS2d 65 [2d Dept 2002]; *see also*, ***Beck v Northside Med.***, 25 AD3d 631, 810 NYS2d 202 [2d Dept 2006]). The conflicts between the respective experts' opinions present credibility issues for the jury to resolve (*see*, ***Magnavita v County of Nassau***, 282 AD2d 658, 723 NYS2d 686 [2d Dept 2001]). Therefore, the motion (#013) by Dr. Sharma for summary judgment dismissing the

complaint as against him is denied.

Timothy Babstock, R.N. now moves (#014) for summary judgment dismissing the complaint as against him on the grounds that there is no evidence that his conduct was a deviation from accepted practice or a proximate cause of injury. Nurse Babstock emphasizes that he was not assigned to plaintiff's decedent's direct care but was a "floater" on plaintiff's decedent's floor at Stony Brook Hospital and found plaintiff's decedent on the floor while walking past his room, called a Code Blue, during the Code his participation was limited to chest compressions, and his last contact involved taking plaintiff's decedent down to the operating room. In support of his motion, Nurse Babstock submits the summons and complaint; the bills of particulars relating to him; the autopsy report; his deposition transcript; and the affidavit dated January 6, 2006 by Abner Perez, a Registered Professional Nurse and Certified Critical Care Nurse.

With respect to Nurse Babstock, plaintiff had alleged in her revised bill of particulars that he was negligent in, among other things, failing to take a proper medical history and conduct a full physical examination; failing to order appropriate diagnostic and radiographic studies and tests; failing to promptly carry out doctor's orders; failing to properly monitor plaintiff's decedent; failing to timely place a chest tube for drainage; allowing plaintiff's decedent to fall to the floor and become cyanotic; and failing to properly resuscitate plaintiff's decedent.

By his affidavit, Nurse Perez points out that Nurse Babstock as a "floater" had no patients assigned to him, by happenstance found plaintiff's decedent on the floor, laid plaintiff's decedent on his back and assessed him, finding him unresponsive Nurse Babstock called a Code Blue then began chest compressions and continued until the physicians arrived in the room and relieved him. Nurse Perez opines within a reasonable degree of nursing certainty that Nurse Babstock did not deviate from accepted standards of nursing practice in the course of his limited treatment and care of plaintiff's decedent and that none of his actions were the proximate cause of his death. Nurse Perez emphasizes that plaintiff's decedent was not Nurse Babstock's patient such that he had no responsibility for nor duty to plaintiff's decedent. Thus, the proffered proof established that Nurse Babstock was not in any way responsible for plaintiff's decedent's alleged injuries or subsequent death (*see*, ***Forray v New York Hosp.***, 101 AD2d 740, 475 NYS2d 57 [1st Dept 1984]). Plaintiff states in her affirmation in opposition that she does not oppose the instant motion. Therefore, the motion (#014) by Nurse Babstock for summary judgment dismissing the complaint as against him is granted.

Lei Guan, M.D. now moves (#015) for summary judgment dismissing the complaint as against him on the grounds that in the morning of December 23, 2000 he was a first-year anesthesiology resident at Stony Brook Hospital, supervised by the nonparty-attending anesthesiologist, Dr. Rampil, during plaintiff's decedent's first surgery, rigid esophagoscopy, and that he did not exercise independent medical judgment in determining the course of anesthesiology for plaintiff's decedent. In support of his motion, Dr. Guan submits the summons and complaint; his answer; his deposition transcript; the affirmation of Mark J. S. Heath, M.D., board certified in anesthesiology; the anesthesiology pre-induction/operating room notes and the affirmation of Thomas Hamilton Gouge, M.D., a board certified surgeon.

A resident who assists a doctor during a medical procedure, and who does not exercise any independent medical judgment, cannot be held liable for malpractice so long as the doctor's directions did not so greatly deviate from normal practice that the resident should be held liable for failing to intervene (***Soto v Andaz***, 8 AD3d 470, 779 NYS2d 104 [2d Dept 2004]).

Dr. Heath opines in his affirmation within a reasonable degree of medical certainty that Dr. Guan did not deviate from accepted standards of medical practice in the treatment and care of plaintiff's decedent; that his actions were not the proximate cause of plaintiff's decedent's death; and that there were no omissions by Dr. Guan that was a proximate cause of plaintiff's decedent's death.

Here, there is no evidence that Dr. Guan exercised independent medical judgment in the treatment of plaintiff's decedent or should have prevented any alleged departures by the other defendants (*see*, ***Velez v Goldenberg***, 29 AD3d 780, 815 NYS2d 205 [2d Dept 2006]). Plaintiff states in her affirmation in opposition that she does not oppose the motion by Dr. Guan. Therefore, the motion (#015) by Dr. Guan for summary judgment dismissing the complaint as against him is granted.

Sarah Clifton, R.N. now moves (#016) for summary judgment dismissing the complaint as against her on the grounds that she was a registered nurse on the cardiac telemetry floor at Stony Brook Hospital in December 2000 who was the charge nurse of plaintiff's decedent and that her conduct was not a deviation from accepted nursing practice nor a proximate cause of injury to plaintiff's decedent. In support of her motion, Nurse Clifton submits the summons and complaint; her answer; her deposition transcript; portions of the deposition transcripts of Dr. Saltman and Dr. Babstock; a list of the dates and times of plaintiff's decedent's chest x-rays at Stony Brook Hospital; the Code Blue/Resuscitation Record and Nurse Clifton's progress note; the affidavit dated January 6, 2006 of Abner Perez, a Registered Professional Nurse and Certified Critical Care Nurse; and the affidavit dated January 9, 2006 of Kristina Burger, a Registered Professional Nurse and a Registered Pediatric Nurse Practitioner[8].

The primary duty of a hospital's nursing staff is to follow the physician's orders unless the orders are clearly contraindicated (***Toth v Community Hosp. at Glen Cove***, 22 NY2d 255, 292 NYS2d 440 [1968]). It is clear that when an attending physician gives direct and explicit orders to hospital staff, nurses are not authorized to unilaterally depart from them, and thus, a hospital is normally protected from tort liability if its staff follows orders (***Georgetti v United Hosp. Med. Ctr.***, 204 AD2d 271, 611 NYS2d 583 [2d Dept1994]).

At her deposition, Nurse Clifton testified that Nurse DiPalo told her that she had ordered a chest x-ray for plaintiff's decedent and Nurse Clifton did not ask her why the chest x-ray was being ordered. In addition, Nurse Clifton testified that the technician who performed the chest x-ray between 6:20 p.m. and 6:30 p.m. told her "that it looked like there was fluid more than or just about halfway up on the right side." Shortly thereafter, Nurse DiPalo called her to tell her that someone was going to insert a chest tube

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[8]Nurse Burger's opinion is limited to Nurse DiPalo and is not relevant to this motion.

in plaintiff's decedent. According to Nurse Clifton, the chest tube was never officially ordered in the chart and generally the cardio-thoracic surgery resident, Dr. Platz, would insert it. Nurse Clifton defined pleural effusion as a collection of fluid around the lung and testified that she understood it to be caused by congestive heart failure or pulmonary edema. She testified that after plaintiff's decedent returned to the room, she asked him to get back into bed, put him on oxygen, replaced his telemetry box, but that she did not tell plaintiff's decedent to stop drinking. According to Nurse Clifton, plaintiff's decedent's breathing was unchanged, still shallow, and his pain level was one out of ten. At about 7:10 p.m., when she was on her way back to plaintiff's decedent's room, after obtaining equipment for the insertion of the chest tube, she heard Nurse Babstock calling for help.

Nurse Perez states in his affidavit that Nurse Clifton read the patient orders, assessed plaintiff's decedent, brought his complaint of pain to the attention of the nurse practitioner and followed issued orders. He opines that she did not deviate from accepted standards of nursing practice in the course of her treatment and care of plaintiff's decedent, that none of her actions were the proximate cause of his death and that there were no omissions on the part of Nurse Clifton which was a proximate cause of plaintiff's decedent's death.

In opposition to the motion, plaintiff submits the redacted affidavit of a Registered Nurse familiar with the standards of nursing care applicable in New York to a post-surgical telemetry floor. Plaintiff's expert opines that the care that Nurse Clifton provided after plaintiff's decedent returned from radiology fell below the applicable standard of care for failing to make sure that plaintiff's decedent was properly monitored and attended until his emergency situation was addressed, based on her knowledge that plaintiff's decedent had shortness of breath, chest pain, effusion in his right chest, and was going to have a chest tube inserted. According to plaintiff's expert, had plaintiff's decedent been placed on the telemetry monitors with the proper settings, which the evidence suggests that Nurse Clifton failed to do, plaintiff's decedent's cardiopulmonary arrest and the physiologic events leading up to it would have been detected and alarms would have sounded at least 10 to 15 minutes before he was discovered on the floor and more likely than not there would have been earlier intervention and resuscitation.

In reply, Nurse Clifton insists that plaintiff's nursing expert affidavit is insufficient since the expert claims no experience or familiarity with the treatment of patients who have undergone esophagoscopies or endoscopies and the affidavit should not be redacted and should list the expert's qualifications inasmuch as the expert is a nurse and not a physician. With respect to the opinions asserted in the affidavit, Nurse Clifton contends that the only claims of deviation are the failure to hook plaintiff's decedent to the telemetry equipment and leaving plaintiff's decedent unattended, which are both baseless because she was never ordered to hook plaintiff's decedent to the telemetry equipment and no causal connection was established between her two- to five-minute absence from the room and plaintiff's decedent's injuries.

Defendant is reminded that it has been the rule that a party may successfully oppose a summary judgment motion without disclosing the names of the party's expert witnesses and that expert witnesses are not limited to physicians (*see*, ***Marano v Mercy Hosp.***, 241 AD2d 48, 670 NYS2d 570 [2d Dept

1998]). In addition, reliance on ***Thomas v Alleyne***, 302 AD2d 36, 752 NYS2d 362 (2d Dept 2002) for the principle that plaintiff's expert must provide qualification details such as the expert's educational institutions, internships, and board certifications is misplaced inasmuch as said case involved and its holdings are limited to the context of disclosure upon demand pursuant to CPLR 3101, not summary judgment pursuant to CPLR 3212.

Here, inasmuch as there are conflicting experts' opinions concerning whether Nurse Clifton should have used independent judgment and acted to hook plaintiff's decedent up to the telemetry equipment as well as waited with plaintiff's decedent based on the new information she obtained from the chest x-ray results rather than leave him alone while she obtained the chest tube equipment, issues of fact are raised as to whether Nurse Clifton departed from accepted standards of medical and nursing care in the care of plaintiff's decedent and her motion (#016) for summary judgment is denied (*see*, ***Connelly v Warner***, 248 AD2d 941, 670 NYS2d 293 [4th Dept 1998]; ***Cranker v Infantino***, 229 AD2d 908, 646 NYS2d 477 [4th Dept 1996]; ***Luthart v Danesh***, 201 AD2d 930, 609 NYS2d 706 [4th Dept 1994]).

Dr. Mancuso now moves (#017) for summary judgment dismissing the complaint as against him on the grounds that he was a third-year general surgery resident rotating on the cardio-thoracic service at Stony Brook Hospital acting under the supervision of the attending surgeon, Dr. Saltman, during plaintiff's decedent's first surgery, rigid endoscopy, and that he was bound by the directives of Dr. Saltman and did not exercise any independent medical judgment. In support of his motion, Dr. Mancuso submits the summons and complaint; his answer; his deposition transcript; Dr. Mancuso's operative note; Dr. Saltman's operative report; a portion of the deposition transcript of Dr. Saltman; the affirmation of Mark J. S. Heath, M.D., board certified in anesthesiology; the anesthesiology pre-induction/operating room notes; and the affirmation of Thomas Hamilton Gouge, M.D., a board certified surgeon.

Dr. Gouge opines in his affirmation within a reasonable degree of medical certainty that Dr. Mancuso did not deviate from accepted standards of medical practice in his limited role in the treatment and care of plaintiff's decedent. In addition, Dr. Gouge indicates that at no point either during or after surgery did Dr. Mancuso exercise any independent medical judgment and that he properly followed Dr. Saltman's instructions after surgery by ordering a chest x-ray to rule out a perforation. According to Dr. Gouge, there was no deviation from normal practice either in the surgery performed by Dr. Saltman or in his post-operative orders that would have required Dr. Mancuso to intervene or question treatment. Dr. Gouge concludes that Dr. Mancuso's actions were not the proximate cause of plaintiff's decedent's death; that there were no omissions by Dr. Mancuso which proximately caused plaintiff's decedent's death; and that plaintiff's decedent's inordinate delay in seeking medical attention exacerbated his condition and contributed to his death.

Here, there is no evidence that Dr. Mancuso exercised independent medical judgment in the treatment of plaintiff's decedent or should have prevented any alleged departures by the other defendants (*see*, ***Velez v Goldenberg***, *supra*). Plaintiff states in her affirmation in opposition that she does not oppose the instant motion. Therefore, the motion (#017) by Dr. Mancuso for summary judgment dismissing the complaint as against him is granted.

Nurse DiPalo now moves (#018) for summary judgment dismissing the complaint as against her on the grounds that she did not deviate from accepted standards of nursing practice in her care of plaintiff's decedent by performing an appropriate physical assessment that his difficulty in breathing was secondary to pain, appropriately ordering pain medication and a chest x-ray, and discussing her plan and assessment with the attending physician, Dr. Saltman. In support of the motion, Nurse DiPalo submits the summons and complaint; her answer; her deposition transcript; portions of plaintiff's and Dr. Saltman's deposition transcripts; Nurse DiPalo's progress notes; the radiology request form for the second x-ray; the report of the second x-ray; the affidavit dated January 9, 2006 of Kristina Burger, a Registered Professional Nurse and a Registered Pediatric Nurse Practitioner; and the affidavit dated January 6, 2006 of Abner Perez, a Registered Professional Nurse and Certified Critical Care Nurse.

At her deposition, Nurse DiPalo testified that on December 23, 2000 she was the sole nurse practitioner assigned to the inpatient cardiac (surgery) telemetry floor of Stony Brook Hospital and she had the authority to write medications, consults and orders for radiology, but she did not have the authority to order the insertion of a chest tube. In addition, Nurse DiPalo testified that in the afternoon Nurse Clifton informed her by telephone that plaintiff's decedent had returned from the operating room after a rigid esophagoscopy and that he was "a little gassy" and was walking around but she was not told that he had abdominal pain. She had never cared for a patient who had undergone said procedure. According to Nurse DiPalo, Nurse Clifton, the nurse who had the patient, reported to her. Nurse DiPalo also testified that she had been unaware that a chest x-ray had been ordered earlier in the day by Nurse Kathleen Lopez and that prior to ordering the second chest x-ray, she reviewed plaintiff's decedent's transfer orders from the recovery room to the telemetry floor but was unaware of a hospital chart from Syosset Hospital or an ambulance run sheet or a pre-hospital report. At about 5 p.m. Nurse DiPalo ordered medications for gas and pain. Nurse DiPalo noted that she was called to plaintiff's decedent's bedside secondary to his having pain and difficulty breathing secondary to pain and wrote, as an assessment and plan, pain medication, oxygen, check pulse, and follow up with chest x-ray, because she was concerned about plaintiff's decedent having difficulty breathing. At said time she conveyed to Dr. Saltman that plaintiff's decedent was having difficulty breathing and that she was ordering a chest x-ray, and Dr. Saltman responded "good" and told her that Dr. Platz, the covering resident, should look at it. Nurse DiPalo testified that she ordered a "STAT" chest x-ray at 5:55 p.m. after waiting to see whether the gas and pain medication gave relief; she was notified by radiology that plaintiff's decedent had pneumothorax and hemothorax, blood in the lung cavity; and that she conveyed this information to Dr. Saltman, who stated that plaintiff's decedent needed an immediate chest tube and told Nurse DiPalo to page Dr. Platz to insert the chest tube and show him the x-ray. According to Nurse DiPalo, no more than 15 minutes later she saw Dr. Platz and relayed that Dr. Saltman wanted the chest tube inserted, and Dr. Platz told her that he was busy, to prepare plaintiff's decedent for the insertion of the chest tube, to get the x-ray report, and to page him when everything was ready. Nurse DiPalo did not remember discussing Dr. Platz's response with Dr. Saltman, nor did she contact any other physicians in the service for insertion of the chest tube. She contacted Nurse Clifton to assemble the materials for insertion of the chest tube. When Nurse DiPalo returned to plaintiff's decedent's room with the x-ray report, she found that a Code Blue had been called.

Nurse Burger opines in her affidavit within a reasonable degree of nursing certainty that Nurse DiPalo did not deviate from accepted standards of nursing practice in her care of plaintiff's decedent inasmuch as her assessment that plaintiff's decedent's difficulty in breathing was secondary to pain was appropriate since pain can cause shallow respiration; she followed appropriate procedure by attempting to alleviate gassy pain through medication; she ordered a chest x-ray "STAT" and actively sought the results from the radiology department; and informed the attending physician, Dr. Saltman, of her plan and assessment prior to ordering the x-ray and the results following the x-ray.

In opposition to the motion, plaintiff's experts in cardio-thoracic surgery and nursing opine that it was a clear and fatal departure from the standard of medical and nursing care for Nurse DiPalo as a nurse practitioner managing the cardiac post-surgical telemetry floor to delay ordering the chest x-ray from 5 p.m., when it is noted that she informed Dr. Saltman of the plan to order the chest x-ray based on plaintiff's decedent's chest pain and shortness of breath, until 5:55 p.m. when she actually ordered the chest x-ray, purportedly so as to wait and see if the pain and gas medications were providing relief. According to plaintiff's expert physician, a chest x-ray performed one hour earlier would have shown hydropneumothorax; Dr. Saltman's plan for insertion of a chest tube would have been executed at least one hour earlier; and the entire sequence of cardiopulmonary arrest, cyanosis, brain damage and death would have been avoided. In addition, plaintiff's experts opine that Nurse DiPalo departed from the standard of care by failing to effectively communicate to Dr. Platz the urgency of a chest tube insertion and by failing to immediately relay to Dr. Saltman the inability of Dr. Platz to immediately perform the insertion and that these departures caused additional delay in providing proper treatment to plaintiff's decedent. Plaintiff's experts also point out that the hospital records fail to indicate that plaintiff's decedent was monitored by telemetry equipment, contrary to Nurse Clifton's deposition testimony, and opine that it was a departure from the standard of care by Nurse DiPalo and Nurse Clifton and all of the other care givers to fail to ensure that plaintiff's decedent was monitored or monitored at the proper parameters, particularly after he complained of chest pain and shortness of breath, and to fail to have anyone attending to plaintiff's decedent, especially once it was known that he had hydropneumothorax. Plaintiff's experts emphasize that had plaintiff's decedent been placed on the telemetry monitors with the proper settings, plaintiff's decedent's cardiopulmonary arrest and the physiologic events leading up to it would have been detected and alarms would have sounded at least 10 to 15 minutes before he was discovered on the floor. Thus, plaintiff's experts raised issues of fact as to whether Nurse DiPalo departed from accepted standards of medical and nursing care in the care of plaintiff's decedent such that her motion (#018) for summary judgment is denied (*see*, ***Connelly v Warner***, *supra*; ***Cranker v Infantino***, *supra*; ***Luthart v Danesh***, *supra*).

Dr. Saltman now moves (#019) for summary judgment dismissing the complaint as against him on the grounds that there was no act or omission on his part that would constitute a deviation from the standard of care for cardio-thoracic surgery in this state and that plaintiff cannot demonstrate causation since it is unclear when plaintiff's decedent's esophagus was perforated. In support of his motion, Dr. Saltman submits the expert affirmation dated January 11, 2006 of Alfred T. Culliford, M.D., board certified in cardio-thoracic surgery; the summons and complaint; his answer; the bills of particulars with respect to Dr. Saltman; the deposition transcripts of plaintiff, Dr. Ferrara, Dr. Fratello, Sarah Hargrove,

R.N., Dr. Sharma, Jose Antonio, M.D., Nurses Clifton, Babcock and DiPalo, Dr. Mancuso, Dr. Platz, Dr. Saltman, Punit C. Aghera, M.D.; plaintiff's decedent's records from Syosset Hospital and Stony Brook Hospital; and plaintiff's decedent's autopsy report.

By her amended bill of particulars, plaintiff alleges that Dr. Saltman was negligent in, among other things, failing to read the ambulance run sheet and records sent with the patient from Syosset Hospital to Stony Brook Hospital; failing to be aware of the documented concern over esophageal perforation; failing to provide for proper monitoring of plaintiff's decedent after his return from the radiology department; permitting plaintiff's decedent to take food and drink by mouth after the esophagoscopy; and failing to diagnose esophageal perforation.

At his deposition, Dr. Saltman testified that he first learned of plaintiff's decedent in the evening of December 22, 2000, when he received a call from Dr. Ferrara at Syosset Hospital explaining that plaintiff's decedent had a piece of steak impacted in his esophagus, that he had attempted unsuccessfully to remove the meat with a flexible endoscope and needed the help of a thoracic surgeon but had been unable to obtain a thoracic surgical consultation in his local system. In addition, Dr. Saltman testified that prior to plaintiff's decedent's transfer, Dr. Ferrara called again two hours later to inform that plaintiff's decedent had suffered an episode of desaturation, that his oxygen levels had fallen and had recovered with some support, and Dr. Saltman believed that plaintiff's decedent might have had a small episode of aspiration. Dr. Saltman did not have any discussions with Dr. Sharma. Dr. Saltman testified that during those two conversations, Dr. Ferrara did not mention any concern about esophageal perforation or tear or the possibility of performing an esophagram. According to Dr. Saltman, when plaintiff's decedent arrived at Stony Brook Hospital, he recorded the admitting history of a 59-year-old man with hypertension and food impaction in the esophagus and noted an unremarkable physical examination with a chest x-ray and laboratory values pending. Dr. Saltman scheduled a rigid esophagoscopy and performed it at 11:30 a.m. on December 23, 2000. He did not review any medical documentation that came with plaintiff's decedent from Syosset Hospital and did not see the ambulance run sheet (Pre-Hospital Care Report), indicating that x-rays revealed possible esophageal tear. Dr. Saltman recalled seeing an x-ray prior to the procedure which he noted to be normal, but he was not sure whether the x-ray had been performed at Stony Brook Hospital or at Syosset Hospital.

According to Dr. Saltman, whether plaintiff's decedent had suffered a microaspiration or a tear or any other possible differential diagnoses, the treatment was nevertheless the same, an esophagoscopy. Dr. Saltman explained that the rigid esophagoscope enabled a surgeon to inspect and operate on the esophagus. Dr. Saltman testified that during the rigid esophagoscopy procedure he did not observe any meat impaction but that he did find a small piece of extra tissue measuring one or two millimeters from which he took a biopsy using small biopsy foreceps. When he next used the flexible esophagoscope, Dr. Saltman observed edematous (swollen) mucosa, normal in color, about four centimeters closer to plaintiff's decedent's mouth as compared to the small piece of extra tissue. He explained that during an esosphagoscopy as part of a general examination, he would check for tears or perforations because they were one of the risks of the procedure. Dr. Saltman's assessment after the procedure was that plaintiff's decedent was in remarkably good shape, that his esophagus was entirely normal, and that the impacted

food had not caused any harm to plaintiff's decedent. After the completion of the procedure, a chest x-ray was ordered to rule out any early signs of a perforation such as pneumothorax, and if the chest x-ray was unremarkable, plaintiff's decedent would be allowed to take clear liquids. Dr. Saltman saw plaintiff's decedent once in the AICU approximately half an hour to an hour after the procedure at 1:30 or 2 p.m., and plaintiff's decedent looked well. Dr. Saltman was unaware of any abdominal gas complaints and then saw the chest x-ray.

Plaintiff's decedent was transferred to the cardiac (surgery) telemetry at 16 South at 1:55 p.m. at the direction of the anesthesiologist. Dr. Saltman did not order that plaintiff's decedent be hooked up to the telemetry equipment. Prior to leaving the hospital at 4 or 4:30 p.m., Dr. Saltman did not go to see plaintiff's decedent and was arriving at his home, when he received a call from Nurse DiPalo informing that plaintiff's decedent was having chest pain and shortness of breath. Dr. Saltman responded that he was worried that plaintiff's decedent had an esophageal perforation and told Nurse DiPalo that she should order a chest x-ray, and that he was going in to see an emergency consult so she should call Dr. Platz to put in a chest tube if required. Dr. Saltman did not recall that Nurse DiPalo told him that the difficulty in breathing was secondary to pain. During her next telephone call, Nurse DiPalo told Dr. Saltman that the chest x-ray showed hydropneumothorax and that Dr. Platz had refused to put the chest tube in. According to Dr. Saltman, he told Nurse DiPalo that if Dr. Platz continued to refuse to put the chest tube in, he would put it in himself. In addition, Dr. Saltman testified that he did not approve Nurse DiPalo's action of waiting an hour and a half after her conversation with Dr. Saltman for the medication to work before ordering the chest x-ray. The chest x-ray was performed about 15 minutes before the code was called, and Dr. Saltman's impression was that plaintiff's decedent must not have been breathing for several minutes when he was found on the floor. Dr. Saltman explained his operative note that plaintiff's decedent's right chest was opened and a large amount of clear fluid, including ginger ale, consistent with his oral intake, was removed and that his working diagnosis at the time was esophageal perforation. In addition, Dr. Saltman noted pus in the lower area of the right chest consistent with a longer-standing infection. Dr. Saltman's impression concerning the source of the lacerations in plaintiff's decedent's lung was that they were "due to the urgency with which the thoracotomy was performed."

Dr. Platz testified at his deposition that he was a fourth-year surgical resident at Stony Brook Hospital in December 2000 and that he was only covering plaintiff's decedent's floor with respect to code-type situations. In addition, Dr. Platz testified that he first saw Nurse DiPalo near the elevator on the fourth floor, radiology department, and she informed him that she was ordering a chest x-ray for a patient and later Nurse DiPalo paged him to tell him that there was a patient with an effusion who needed a chest tube. Dr. Platz's impression was that it was something that needed to be done but was not particularly urgent since Nurse DiPalo did not give specific details. According to Dr. Platz, he told Nurse DiPalo to call the attending covering cardiac surgery and to arrange for the chest tube to be inserted and that if she was unable to accomplish this, he would help her, but he made it clear that as part of his call assignment he was not covering the 16th floor except for code-type situations. Dr. Platz explained that at the time he was proceeding to care for a trauma patient in the Emergency Department who needed a chest tube for pneumothorax, as well as another patient who had abdominal pain. Then, Dr. Platz received another page from Nurse DiPalo, and Dr. Platz told her that he would come upstairs to insert the chest tube, allowing

for the time to enable Nurse DiPalo to get the materials together for the insertion of the chest tube and to explain to the patient what was going to occur, which would be about 15 minutes. After speaking to Nurse DiPalo, Dr. Platz continued to care for the patients in the Emergency Department, and approximately 20 minutes later a code was called for the 16th floor.

Dr. Culliford explains in his expert affirmation that an esophageal perforation can occur in several cases, including intense coughing and retching or from an object puncturing or lacerating the inside of the esophagus, and that it is not always easy to diagnose. He lists the symptoms as including pain, vomiting, rapid breathing, desaturation, temperature, and a high white blood cell count, as well as a pleural effusion (liquid in the chest cavity), pneumothorax/pneumomediastinum (air in the chest cavity), or both (ie. hydropneumothorax). Dr. Culliford points out that plaintiff's decedent began to experience an unusual swallowing problem (ie. dysphasia) six weeks prior to the steak dinner but never consulted a physician about the problem so its etiology was never discovered. Dr. Culliford opines within a reasonable degree of medical certainty that Dr. Saltman acted within the standard of care by declining to conduct pre-operative testing other than the review of the chest x-ray and performing the rigid esophagoscopy. Dr. Culliford continues that since Dr. Ferrara did not mention the possibility of esophageal perforation and there were indications of possible infiltrate in the lungs, slight desaturation, and shortness of breath, it was reasonable for Dr. Saltman to suspect that plaintiff's decedent was suffering from aspiration and that even if Dr. Saltman had suspected a possible esophageal perforation, the procedure would have been the same, a rigid esophagoscopy. According to Dr. Culliford, Dr. Saltman's rigid esophagoscopy was well within the standard of care for cardio-thoracic surgery in New York in that it was careful, thorough and cautious. Dr. Culliford goes on to explain that even if Dr. Saltman missed a perforation or misconstrued one of the esophageal defects as not being a perforation, it would not necessarily be a deviation from the standard of care inasmuch as a small perforation can be missed during the procedure due to its size because the inside of the esophagus has many folds and redundancies. Dr. Culliford further opines within a reasonable degree of medical certainty that Dr. Saltman properly interpreted plaintiff's decedent's signs and symptoms after the rigid esophagoscopy and properly evaluated plaintiff's decedent as not suffering from an esophageal perforation at that time. In support, he points to evidence that plaintiff's decedent voiced no complaints to Dr. Saltman after the procedure, that neither Dr. Saltman nor the radiologist saw any signs of perforation during the wet read of the post-procedure chest x-ray, and complaints of gassy pain and burping would not have indicated perforation because Dr. Saltman had introduced air into plaintiff's decedent's esophagus to better observe the inner wall. He adds that while plaintiff's decedent may already have had an esophageal perforation at that time of his post-operative examination, it was unusually subtle without demonstrating any significant symptomology. Dr. Culliford notes that there is no specific point in time that it can be said within a reasonable degree of medical certainty that the perforation definitely occurred and that since pus was found in plaintiff's decedent's right lung during Dr. Saltman's surgery after the code blue, it is his opinion within a reasonable degree of medical certainty that the perforation was not acute, that is, it probably had existed for at least 12 to 24 hours. In conclusion, Dr. Culliford opines within a reasonable degree of medical certainty that all the claims against Dr. Saltman lack merit since his actions at all times were appropriate and in accordance with accepted medical and cardio-thoracic standards of care. Here, Dr. Saltman demonstrated through, *inter alia*, medical records, deposition testimony, and the affirmation of his expert witness his prima facie entitlement to judgment as

a matter of law, thereby shifting the burden to the plaintiff to raise a triable issue of fact in opposition to the motion (*see*, ***Bowman v Chasky***, ___ AD3d ___, 817 NYS2d 153 [2d Dept 2006]).

In opposition, plaintiff's expert in cardio-thoracic surgery opines by affidavit that the standard of care required that Dr. Saltman inquire of Dr. Ferrara the details of plaintiff's decedent's desaturation, what studies had been done, if there had been any consultations, what diagnoses had been rendered and what plans, if any, were implemented to address the issue. According to plaintiff's expert, had Dr. Saltman done so, he would have learned that Dr. Sharma suspected an esophageal perforation and wanted a "STAT" contrast study or esophagram performed. In addition, plaintiff's expert opines that it was a further departure from the standard of care for Dr. Saltman to fail to review the documents and materials, including the ambulance run sheet, that were sent with plaintiff's decedent from Syosset Hospital to Stony Brook Hospital, which would have revealed concern over a possible esophageal tear. In any event, according to plaintiff's expert, once Dr. Saltman learned of plaintiff's decedent's desaturation, he should have included esophageal perforation in his differential diagnosis without reference to any other information and the standard of care required Dr. Saltman to perform a contrast study or esophagram to search for the perforation either prior to or immediately after the rigid esophagoscopy as well as a detailed visual search with endoscopic instruments. Plaintiff's expert opines that had the esophagram been performed early, the esophageal tear would most likely have been diagnosed early, plaintiff's decedent would have been kept "NPO," with no oral intake, and his death would have been avoided. Plaintiff's expert adds that at the time Dr. Saltman told Nurse DiPalo to order a chest x-ray in response to plaintiff's decedent's chest pain and shortness of breath, the standard of care required Dr. Saltman to also order that plaintiff's decedent be monitored in telemetry. According to plaintiff's expert, it was a clear departure from the standard of care to fail to monitor plaintiff's decedent in telemetry after Dr. Saltman learned of the x-ray results of fluid and air in the right chest. Plaintiff's expert points out that had plaintiff's decedent been monitored by telemetry, his cardiopulmonary arrest and the physiologic events leading up to it would have been detected and alarms would have sounded at least 10 to 15 minutes, the time that it takes to become cyanotic, before he was found on the floor and there would have been earlier intervention and resuscitation and more likely than not plaintiff's decedent would have survived the resuscitation with no residual or permanent harm. Thus, plaintiff raised a triable issues of fact through her expert's affidavit warranting denial of Dr. Saltman's motion (#019) for summary judgment (*see*, ***Wiands v Albany Med. Ctr.***, 29 AD3d 982, 816 NYS2d 162 [2d Dept 2006]).

Defendant Steven James Fratello, M.D. (Dr. Fratello) now moves (#020) for summary judgment dismissing the complaint as against him on the grounds that there is no evidence that he departed from accepted standards of medical practice in his anesthesiological treatment of plaintiff's decedent and that such a departure proximately caused injury to plaintiff's decedent. Dr. Fratello asserts that he merely administered the general anesthesia during the endoscopy procedure at Syosset Hospital and suggested that plaintiff's decedent's oxygen be increased and that a pulmonologist evaluate plaintiff's decedent when plaintiff's decedent had post-operative respiratory problems. In support of his motion, Dr. Fratello submits, among other things, the summons and complaint; his answer; the bill of particulars with respect to Dr. Fratello; his affidavit dated January 5, 2006; the affidavit dated November 3, 2005 of his expert board certified anesthesiologist, Mordecai Bluth, M.D.; a portion of plaintiff's decedent's Syosset

Hospital records; his deposition transcript; and portions of the deposition transcripts of Drs. Ferrara and Saltman.

Dr. Bluth details Dr. Fratello's involvement in plaintiff's decedent's care at Syosset Hospital and concludes that to a reasonable degree of medical certainty, Dr. Fratello appropriately and timely recognized, responded to and documented plaintiff's decedent's pre-operative and post-operative condition and opines that plaintiff's decedent's esophageal perforation was not caused or exacerbated by any act or omission by Dr. Fratello.

Here, Dr. Fratello demonstrated the absence of any issue of fact and established his entitlement to judgment as a matter of law based on his expert's affidavit, plaintiff's decedent's Syosset Hospital records, and the deposition transcripts (*see*, ***DiMitri v Monsouri***, 302 AD2d 420, 754 NYS2d 674 [2d Dept 2003]). Plaintiff indicates in her opposition papers that she is not opposing Dr. Fratello's motion. Therefore, the motion (#020) for summary judgment dismissing the complaint as against Dr. Fratello is granted.

Dr. Ferrara now moves (#021) for summary judgment dismissing the complaint as against him on the grounds that plaintiff's decedent had no perforation at any time that he was under Dr. Ferrara's care at Syosset Hospital and that Dr. Ferrara appropriately referred plaintiff's decedent to a thoracic surgeon at a tertiary care facility. In support of his motion, Dr. Ferrara submits, among other things, the summons and complaint; his answer; the bill of particulars with respect to Dr. Ferrara; his deposition transcript; the physician's Certificate of Transfer and Transfer Check-Out List; and the affidavit dated January 11, 2006 of his expert board certified in internal medicine and gastroenterology, Milton L. Levine, M.D. Plaintiff's allegations of negligence as against Dr. Ferrara listed in her bill of particulars are similar to those alleged with respect to Dr. Sharma.

By his affidavit, Dr. Levine opines that the treatment rendered by Dr. Ferrara was at all times appropriate and that to a reasonable degree of medical certainty there was no deviation from good and accepted medical practice by Dr. Ferrara. Dr. Levine points out that there was no evidence of a perforation during the procedures at Syosset Hospital or Stony Brook Hospital and that during the procedure at Syosset Hospital, plaintiff's decedent was intubated to guard against significant aspiration. In addition, Dr. Levine opines that Dr. Ferrara appropriately referred plaintiff's decedent to a thoracic surgeon, Dr. Saltman, at a tertiary care facility due to his concern that the food bolus was not completely removed. Here, Dr. Ferrara satisfied his prima facie burden of demonstrating his entitlement to judgment as a matter of law by the submission of an expert's affidavit setting forth that Dr. Ferrara followed acceptable procedure and that no causal link existed between any act or omission by him and plaintiff's decedent's subsequent death (*see*, ***Wallenquest v Brookhaven Mem. Hosp. Med. Ctr.***, 28 AD3d 538, 813 NYS2d 484 [2d Dept 2006]).

In opposition to the motion, plaintiff's experts in internal medicine, pulmonary medicine and critical care medicine and in cardio-thoracic surgery opine in their affidavits that plaintiff's decedent sustained the perforation in his distal esophagus at Syosset Hospital, probably during the flexible

endoscopic procedure performed by Dr. Ferrara inasmuch as such a perforation is generally a known complication of such an endoscopic procedure. Plaintiff's expert in cardio-thoracic surgery points to two other factors supporting this opinion, the observation by Drs. Saltman and Mancuso during their initial procedures of swelling and erythema at the distal esophagus at the area where the tears were later located and the presence of long-standing pus in the right lower chest cavity. Plaintiff's expert in internal medicine, pulmonary medicine and critical care medicine adds that it was departure from the standard of care to ignore the advice of his consultant Dr. Sharma of the possibility of an esophageal perforation and to fail to take immediate and affirmative steps to rule out perforation by arranging plaintiff's decedent to undergo a contrast study during the five hours he waited prior to being transferred to Stony Brook Hospital. Plaintiff's experts also opine that it was a clear departure from the standard of care for Dr. Ferrara to fail to communicate to the receiving care givers at Stony Brook Hospital the suspicion that plaintiff's decedent may have had a torn esophagus. According to plaintiff's experts, these failures contributed to the delay in plaintiff's decedent's diagnosis and treatment and were substantial contributing factors giving rise to plaintiff's decedent's injuries and death.

In reply, Dr. Ferrara contends that all the information concerning possible esophageal tear and the recommendation of an esophagram were in the records to be transferred to Stony Brook Hospital where an esophagram could have been performed since plaintiff's decedent was transferred in stable condition.

Plaintiff's expert affidavits raised triable issues of fact as to, among other things, whether Dr. Ferrara deviated from acceptable medical practice by failing to communicate the possibility of an esophageal tear and the need for an esophagram to Dr. Saltman and whether such departures proximately caused plaintiff's decedent's injuries (*see*, *id.*). Therefore, the motion (#021) by Dr. Ferrara for summary judgment dismissing the complaint as against him is denied.

Accordingly, the motions (#014,#015,#017,#020) for summary judgment are granted and the complaint is dismissed as against Nurse Babstock, Dr. Guan, Dr. Mancuso, and Dr. Fratello. The motions (#016, #018,#019, #021) for summary judgment are denied and the action is severed and continued against the remaining defendants.

Dated: AUG 23 2006

J.S.C.

____ **FINAL DISPOSITION** __X__ **NON-FINAL DISPOSITION**

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