

Lloyd v St. Vincent's Manhattan Hosp.

2009 NY Slip Op 31638(U)

July 20, 2009

Supreme Court, New York County

Docket Number: 124120/02

Judge: Alice Schlesinger

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SUPREME COURT OF THE STATE OF NEW YORK — NEW YORK COUNTY

IA PART 16
PART

PRESENT: ALICE SCHLESINGER

Index Number : 124120/2002

LLOYD, ROBIN

vs

ST. VINCENTS MANHATTAN

Sequence Number : 010

VACATE

INDEX NO. _____

MOTION DATE _____

MOTION SEQ. NO. _____

MOTION CAL. NO. _____

The following papers, numbered 1 to _____ motion to/for _____

Notice of Motion/ Order to Show Cause — Affidavits — Exhibits ...

Answering Affidavits — Exhibits _____

Replying Affidavits _____

PAPERS NUMBERED

Cross-Motion: Yes No

Upon the foregoing papers, it is ordered that this motion

MOTION/CASE IS RESPECTFULLY REFERRED TO JUSTICE
FOR THE FOLLOWING REASON(S):

**MOTION IS DECIDED IN ACCORDANCE WITH
ACCOMPANYING MEMORANDUM DECISION.**

FILED

JUL 23 2009

COUNTY CLERK'S OFFICE
NEW YORK

Dated: JUL 20 2009

Alice Schlesinger
ALICE SCHLESINGER J.S.C.

Check one: FINAL DISPOSITION NON-FINAL DISPOSITION

Check if appropriate: DO NOT POST

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NEW YORK

-----X
ROBIN LLOYD, as Executor of the Estate of
ELIZA L. MOORE,

Plaintiff,

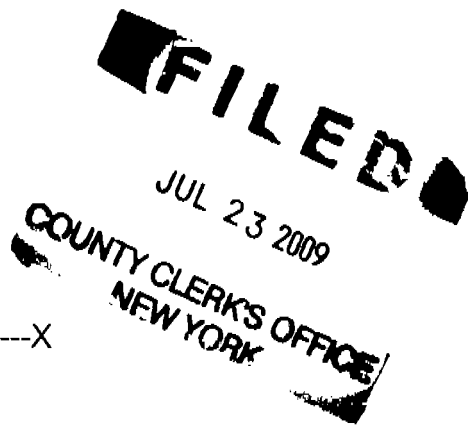
-against-

Index No. 124120/02
Motion Seq No. 010

ST. VINCENT'S MANHATTAN HOSPITAL, a
division of SAINT VINCENT'S CATHOLIC
MEDICAL CENTERS OF NEW YORK a/k/a
ST. VINCENT'S MEDICAL CENTER OF NEW
YORK, K.D. MOORE, M.D., AHMED A.
RAWANDUZY, M.D., and MANHATTAN
NEUROSURGICAL ASSOCIATES, P.C.,

Defendants

-----X
SCHLESINGER, J.:



Between March 2 and March 20, 2009, the action *Robin Lloyd, as Executor of the Estate of Eliza L. Moore against St. Vincent's Manhattan Hospital, KD Moore, M.D., Ahmed A. Rawanduzy, M.D. and Manhattan Neurosurgical Associates, P.C.* was tried before this Court and a jury. It was an action sounding in medical malpractice. What set things in motion, however, was a serious accident on Houston Street in Manhattan that had occurred on Saturday, May 6, 2000 around eleven o'clock in the morning.

Ms. Moore, a pedestrian, perhaps a jogger, was crossing the street with the light when she was hit and thrown to the ground by a passing car. The major injury was to her head. She was unconscious from the the moment of impact and through the time EMS took her to the nearest Trauma I Center, St. Vincent's Hospital.

While at St. Vincent's, from approximately 11:30 a.m. on May 6 through the following evening May 7, no surgical or other intervention occurred. Some time in the early

evening of May 7, a neurosurgeon, Dr. Jamshid Ghajar, associated with Cornell Medical Center, arrived at St. Vincent's to see the patient. He had been called by a representative of Ms. Moore's family.

After examining the patient, reviewing her chart, and consulting with her family, Dr. Ghajar recommended surgical intervention. He wanted to remove a large hematoma in the skull which had been placing a great deal of pressure on the brain, causing it to herniate. The family agreed.

Thus, what this case was about was should there have been surgical intervention by the defendants, St. Vincent's and Dr. Ahmed Rawanduzy, much earlier during Ms. Moore's first hospitalization. Dr. Kraig Moore, the chief resident at St. Vincent's, together with Dr. Ahmed A. Rawanduzy, the attending on call that weekend, decided that surgical intervention was not indicated and would have made no significant difference in Ms. Moore's outcome. Their opinion was that Ms. Moore was essentially brain dead and that no meaningful recovery could occur.

As indicated earlier, Dr. Ghajar, who did perform surgery late on Sunday night the 7th of May, and who did testify at trial as the only liability expert for the plaintiff, believed very strongly otherwise. He felt there was some brain stem function from the time of the accident and continuing. And though he believed that Ms. Moore's condition deteriorated as time went by due to the continuing pressure on the brain, he still believed some benefit would come from intervention.

On the questions relating to liability, the jury found in favor of the plaintiff and against both defendants, St. Vincent's via the actions of Dr. Moore, and Dr. Rawanduzy as the attending neurosurgeon. The jury interrogatories separately addressed both defendants

on both days, May 6th and May 7th. The jury went on to apportion liability 50/50 between the two categories of defendants. The total amount of damages awarded was \$8 million for past pain and suffering and \$1.25 million for past medical expenses.¹

The day before the trial concluded, a high/low settlement between plaintiff and St. Vincent's in the amount of \$5 million and \$500,000, was placed on the record. Therefore, after the verdict was returned, judgment in favor of the plaintiff against Dr. Moore and St. Vincent's in the amount of \$4,625,000 was entered.

Before the Court now is a motion brought on behalf of Dr. Rawanduzy to set aside the jury verdict against him and to award him judgment as a matter of law. Alternatively, he asks for a new trial, arguing that the verdict was against the weight of the evidence and that because of certain evidentiary rulings, he was deprived of a fair trial. He also argues that the apportionment made no sense, and that damages were excessive.

I believe that the evidentiary rulings I made were proper, particularly one sustaining plaintiff's objection to a videotape of Ms. Moore which the defense wished to introduce. I also believe Dr. Rawanduzy's testimony was not unduly restricted in light of his failure to recollect the events in question. However, more significantly, I do find in defendant's favor on his first argument. In other words, after carefully reviewing relevant portions of the trial testimony, particularly that of Drs. Ghajar and Moore in their entirety, I do believe that liability against Dr. Rawanduzy regarding the events of both May 6 and 7, 2000 has not been proven and as a matter of law cannot be allowed to stand.

¹Ms. Moore had died about one year before the trial. She had lived in a minimally conscious state until that time.

Each day must be discussed separately. May 6 is, of course, the crucial day, since no one really disputed Dr. Ghajar's emphatic opinion that if surgical intervention were to be done at all, the time to do it was as soon as possible after the initial insult to the brain.

It is also not seriously disputed that Dr. Rawanduzy did not come to the hospital on the 6th. Rather, the defense position was that his role on that day was to receive information from the chief resident, Dr. Moore, make all necessary inquiries, and decide whether surgery was indicated. Therefore, two determinations were relevant: first, whether reliance on the information provided by the resident was sufficient, or conversely whether it was necessary for Dr. Rawanduzy to actually come to St. Vincent's and examine the patient himself before deciding on a course of action; and two, what information did the resident actually convey to the attending physician about Ms. Moore's condition and whether that information was sufficient to enable a decision on this life and death issue to be made.

As to the first determination, Dr. Ghajar testified without challenge from anyone that 1) it would not be a departure for an attending to rely on information given to him by a resident or house officer (pp 949-50 of the trial transcript), and 2) that "if the resident says there are no brain stem functions, the person is in a coma, they're fixed and dilated, the person had no brain stem reflexes, there's no indication for an operation" (p 1100).

Therefore, what is critical here is the information that Dr. Moore communicated to Dr. Rawanduzy. His testimony, both on direct examination by plaintiff's counsel who called him to testify as an adverse witness and then on cross-examination by counsel for Rawanduzy, was that Ms. Moore had no meaningful brain stem function.

Dr. Moore first had contact with this patient between 2:00 and 2:30 p.m. on May 6. He saw and examined her after she had undergone a CAT scan of her brain. He wrote in the record that she had severe TBI (traumatic brain injury) not amenable to surgical intervention in view of both pupils being dilated and fixed (p 577). He was asked (line 16) "No brain stem function, is that correct?" He answered "correct".

On page 579, he stated in answer to a question (line 18) that "the damage she had sustained was irreversible". These observations were made at approximately 2:30 p.m., around the time Dr. Moore spoke by telephone to Dr. Rawanduzy. The testimony continued (p 602, lines 11-14, 17-21) as to what was said by Dr. Moore in this conversation.

Q. Did you tell Dr. Rawanduzy on Saturday, when you spoke to him that there was no brain stem reflexes?

A. I told him exactly that there was no brain reflexes and she was herniated by clinical exam, as well as by CT scan (sic) (obviously "scan" is meant).

Q. And he concurred with your decision not to do surgery?

A. Correct. Well it was his decision but I concurred.

Q. He made the decision not to do surgery?

A. He's the attending.

Later on cross, where counsel was able to lead Dr. Moore, the following testimony was given at page 713, lines 13-25:

Q. When you called Dr. Rawanduzy, did you tell him your findings including the fact that the pupils were fixed and dilated and the patient was comatose and not totally non-responsive from the moment of the traumatic brain injury, the pedestrian accident?²

A. That is correct.

² The question only makes sense in the context of the other questions if the word "not" is omitted.

Q. Did you tell Dr. Rawanduzy that you had performed the cold water caloric that you mentioned, by putting the cold water in the patient's ear?

A. Yes, I did.

Q. And if the patient's eyes didn't respond, is that what happened here?

A. Exactly.

On page 715, lines 6-9, 12-18, the testimony continued as follows:

Q. And it was your opinion that there was a subdural hematoma and what else was present on CAT scan that was significant to your determination that the brain stem was irreversibly compromised?

Q. Significant enough on your findings of CAT scan that you related to Dr. Rawanduzy in the call at 2:30 on Saturday afternoon.

A. That she had a subdural hematoma with shift. She had contusion in her right temporal lobe, and she had massive general swelling as well as obliteration or nonexistent basal cisterns.

On page 717, line 14, through page 718, line 2:

Q. Why, in this case, did you believe it wasn't appropriate to remove the subdural hematoma?

A. Because the herniating process was complete. She had fixed dilated pupils. She had no brain stem reflexes. Herniation was clearly visible by the CAT scan, and by the time I saw her at 2:00, 2:15, it was three hours after the herniating process was started. There was no organ in the body that can survive lack of blood flow for three hours, definitely not the brain.

Q. Were these findings that you just told Her Honor and the Jury about, where those findings, in substance, related by you by (sic) Dr. Rawanduzy over the telephone that Saturday afternoon?

A. Yes, they were.

There followed an exchange about Dr. Rawanduzy's response, which Dr. Moore did not precisely recall. However, he then testified that he had worked closely for 4 years with Dr. Rawanduzy at Westchester Medical Center where he regularly presented the condition

of patients to him. Finally on page 726, lines 9-26, Dr. Moore concluded his cross-examination with the following testimony:

Q. Your conclusion that you told Her Honor and the Jury about, that Ms. Moore's brain was irreversibly damaged and surgery would not afford any meaningful recovery for cognitive or any meaningful recovery, was that a conclusion that you reached before you spoke to Dr. Rawanduzy on your careful examination of this patient, the fixed and dilated pupils? ... (Colloquy omitted).

Q. In other words, your conclusion that you told the jury, was that based on your examination of the patient, your experience in dealing with brain damaged patients and review of the CAT scans? Was that the foundation of your conclusion?

A. Yes, it was.

Q. And was that the conclusion that you discussed with Dr. Rawanduzy at about 2:30 Saturday afternoon?

A. Yes it was.

While it was the plaintiff's position that it was Dr. Rawanduzy who actually made the decision not to surgically intervene, a decision Dr. Ghajar said was wrong and a departure from accepted neurosurgical practice, that opinion is ultimately irrelevant as to whether Dr. Rawanduzy can be held responsible in light of Dr. Ghajar's testimony that the attending could reasonably rely on the information received from the resident Dr. Moore. The same Dr. Ghajar testified that if the resident Moore had communicated clearly to the attending that the patient had no brain stem reflex (and the testimony clearly was that he did), then the attending had a right to decide that surgery was not the proper course.

In opposition, counsel for plaintiff essentially argues two things vis-a-vis the events of May 6. First he relies on the note(s) Dr. Moore wrote around the time he called Dr. Rawanduzy to report on Ms. Moore's condition. Reference was made to these notes

(exhibit 8, the hospital records) wherein Dr. Moore wrote there was a "trace corneal reaction" and that the patient had sluggish pupils. Additionally, counsel pointed out that while Dr. Moore testified that he did not have a specific recollection of what he had discussed with Dr. Rawanduzy, he said he had "absolutely" related everything he had written in his note (p 673).

Therefore, the argument is made that since this additional information presumably was conveyed to Dr. Rawanduzy, and since Dr. Ghajar testified that some corneal reaction is a sign of brain stem function, that information was sufficient for Dr. Rawanduzy to inquire further and/or come to the hospital to ascertain the situation for himself. If he had done the latter, he would have also noted that Ms. Moore was breathing over the respirator, another sign of brain stem function.

However, this reed is simply too slim to hold the attending physician here liable. First, Dr. Moore himself dismisses the significance of this finding and says "for me a trace means I may or may not have seen it for me" (p 570). More importantly, this one noted reaction, while perhaps communicated to the attending, is completely outweighed quantitatively and qualitatively by the thrust of Dr. Moore's complete testimony (self-serving though it may have been) that Ms. Moore had no meaningful brain stem function and that it was he who communicated this conclusion to Dr. Rawanduzy.

The other argument is based on Dr. Moore's alleged unreliability. Here it is urged that Dr. Rawanduzy should not have relied solely on the resident's findings and opinions. But all that counsel points to in support of this argument is conduct by Dr. Moore which occurred after Ms. Moore's hospitalization, such as his leaving the neurosurgery program about a month later. There was nothing to show before the events of May 6 that the two

doctors here enjoyed something other than a several-year, mutually respectful period of working together.

As to the events of May 7, it should be noted at the outset that Dr. Ghajar's testimony emphasized repeatedly that May 7 was far less important than May 6 as to the implications for a meaningful recovery for Ms. Moore. In seeking judgment for his client, moving counsel relies on Dr. Ghajar's statement that he could not really say that surgical intervention by Dr. Rawanduzy earlier in the day on May 7, earlier than his own surgery later that night, would have made a significant difference in the outcome. The following exchange is specifically alluded to in Dr. Ghajar's redirect testimony on page 1138, line 23:

- Q. On May 7 Do you have an opinion with regard to May 7 whether the decision not to intervene surgically caused further damage or was a substantial factor in causing further damage to Ms. Moore?

At p 1139, line 3 through p 1140, line 10:

- A. No, I can't say that. I would really focus on May 6. By May 7, me operating at night, or the attending operating in the afternoon, I think we're fine slicing at that point. I couldn't foresee any real difference in the outcome. The major difference in outcome would have been operating early. If she had been operated in the first few hours, if she came in, my opinion is that she would have made a substantially better outcome than what she had.

- Q. You mentioned on Tuesday, not to repeat it, that that would have included the capacity to communicate better than she could.

- A. Her injuries were on the right side, language and comprehension on the left side. No evidence of severe damage on the left side. The right temporal lobe was the problem and, frankly, in the surgeons world, the right temporal lobe is a minor player. What really did her in was having this big clot, blood clot sitting and pushing her brain over and squashing her brain stem over this period of time. The earlier it's taken out the better chance of a good outcome. This is supported by a lot of evidence. General surgeons always track us by saying, did you take out a subdural within four hours, not that it's four hours as some kind of magic limit, but what

they're trying to do, and the evidence does support this, the earlier you take it out, especially somebody whose pupils are getting bigger and unreactive, the sooner you take it out the better the outcome for the patient. The better chance for a good outcome. I think that's what we're focusing on. Whether or not the next day the attending came in and operated in the afternoon would make a big difference as opposed to me operating later, I really can't say. At that point, the horse is out of the barn.

It is this exchange that moving counsel argues removes the factual and legal predicate for a "yes" answer to question 4(b) of the jury interrogatories which read:

Was that departure (Dr. Rawanduzy's concluding that surgery was not warranted for Ms. Moore on May 7, 2000) a substantial factor in causing Eliza Moore injury, in other words, depriving Eliza Moore of an opportunity for a better recovery?

Plaintiff's response vis-a-vis May 7th is similar to this Court's comments when counsel for Dr. Rawanduzy moved to dismiss the action at the close of the plaintiff's case. The argument was made that Dr. Ghajar consistently testified that Ms. Moore's condition continued to deteriorate as more time went by. For example, he stated the following (p 1153, lines 4-11):

Time is of the essence because her examination went from doing this, which was better than doing this, so her motor examination changed and it is obvious as time was getting on she was getting worse and worst (sic). It wasn't sudden.

You can't say at some point one hour is better than another, but certainly operating early would have made a significant difference in her outcome.

This was counsel's last question to Dr. Ghajar on redirect. Was it enough to have met plaintiff's prima facie burden vis-a-vis Dr. Rawanduzy on the 7th? I stated during argument on the motion that Dr. Ghajar had clearly opined that the injury continued and

was progressive, acknowledging his unwillingness or inability to actually quantify that injury. I allowed the case to go forward.

However, upon reflection and review of the transcript and several of the cases cited by the moving defendant, I now believe that the evidence on causation regarding Dr. Rawanduzy's failure to surgically intervene on May 7 is simply insufficient to support a verdict or insufficient to sustain plaintiff's burden in proving that this failure to intervene on May 7 deprived Eliza Moore of an opportunity for a better recovery.

For example, in a Third Department case cited by the moving defendant, *Giambona v. Stein*, 265 AD2d 775 (1999), a CPLR §4401 motion was granted soon after a trial had commenced based on the insufficiency of the videotaped testimony of plaintiff's sole expert. That case involved an alleged failure by the dermatologist defendant Dr. Stein to diagnose Hodgkin's disease. Dr. Stein had allegedly failed to follow up on abnormal blood test results which he had received. The expert, however, was unable to say – he testified it was "impossible to determine" – when plaintiff's disease was diagnosable. Further, when asked whether the diagnosis could have been made during the 7 ½ months that the defendant had been treating the plaintiff, he responded, "I'll have to say not necessarily."

Dr. Ghajar's testimony is similarly inconclusive. He honestly could not say that intervention on May 7 by Dr. Rawanduzy earlier in the day would have changed the result. The best he could say was it may have. That is not enough.

This Court does not take lightly the decision I have reached on this motion. Effectively nullifying a jury's decision by granting a motion made pursuant to CPLR §4404(a) is not done easily, nor should it be. However, I am compelled to find, based on the above discussion, that regarding both departures alleged against Dr. Rawanduzy there

is simply no valid line of reasoning and permissible inferences which could possibly lead rational people to the conclusion reached by this jury on the basis of the evidence presented at trial. See *Cohen v. Hallmark Cards, Inc.*, 45 NY2d 493 (1978).

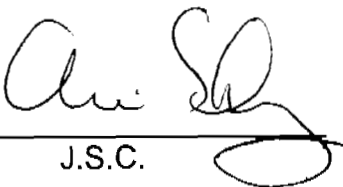
Accordingly, it is hereby

ORDERED that the defendant's motion is granted pursuant to §4404(a), the jury verdict against Dr. Ahmed A. Rawanduzy is set aside, and judgment in his favor is granted as a matter of law. The Clerk is directed to enter judgment accordingly.

This constitutes the decision and order of this Court.

Dated: July 20, 2009

JUL 20 2009



J.S.C.

ALICE SCHLESINGER

FILED
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