[* 1]

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

PRESENT: Joan B. Lobis Justice

PART 86

Gary Richard Miller Et Al.

-v-

Arnold Markowitz, M.D., Et Al.

INDEX NO. 102825/08

MOTION DATE 12/7/10

MOTION SEQ. NO. 3

MOTION CAL. NO.

The following papers, numbered 1 to _____ were read on this motion to/for Summary judgment

	PAPERS NUMBERED
Notice of Motion/ Order to Show Cause — Affidavits — Exhibits ...	1-19
Answering Affidavits — Exhibits	20-21
Replying Affidavits	22

Cross-Motion: ☐ Yes ☒ No

Upon the foregoing papers, it is ordered that this motion

MOTION DECIDED IN ACCORDANCE WITH ACCOMPANYING DECISION AND ORDER

FILED

FEB 24 2011

NEW YORK
COUNTY CLERK'S OFFICE

Dated: 2/18/11

J.S.C.

Check one: ☐ FINAL DISPOSITION ☑ NON-FINAL DISPOSITION

Check if appropriate: ☐ DO NOT POST ☐ REFERENCE

☐ SUBMIT ORDER/ JUDG. ☐ SETTLE ORDER/ JUDG.

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

[* 2]

SUPREME COURT OF THE STATE OF NEW YORK
NEW YORK COUNTY: IAS PART 6

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GARY RICHARD MILLER, as Executor of the Last Will and Testament of ELISABETH SINDELLI, Deceased,

Plaintiff,

- against -

ARNOLD MARKOWITZ, M.D., PAUL DALECKI, M.D. and MEMORIAL HOSPITAL FOR CANCER & ALLIED DISEASES,

Defendants.

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Index No.: 102825/08

Decision and Order

JOAN B. LOBIS, J.S.C.

Defendants Arnold Markowitz, M.D., Paul Dalecki, M.D., and Memorial Hospital for Cancer and Allied Diseases (the "Hospital") move, by order to show cause, pursuant to C.P.L.R. Rule 3212, for an order dismissing this action. On December 3, 2010, after the motion was marked fully submitted, but prior to oral argument, the parties entered into a stipulation of discontinuance as to Dr. Markowitz. For the reasons set forth below, the motion by the remaining defendants is denied.

This action, sounding in medical malpractice and lack of informed consent, arises out of the death of Elisabeth Sindelli approximately forty minutes after undergoing an esophagogastroduodenoscopy ("EGD") on June 5, 2007. Ms. Sindelli consulted with Dr. Markowitz, a gastroenterologist, at the Hospital on June 1, 2007, complaining of epigastric burning, dyspepsia, and abdominal pain. According to the medical records, Dr. Markowitz suspected gastritis or peptic ulcer disease and ordered an urgent EGD. That same day, Ms. Sindelli underwent an "Endoscopy Nursing Patient Assessment." According to the assessment, Ms. Sindelli, inter alia,

denied a history of hypertension, high cholesterol, vascular disease, or any cardiac condition. She denied experiencing shortness of breath while climbing stairs, chest pains, or fainting in the six weeks prior to the assessment. Although not noted in the assessment, Ms. Sindelli was seen by a cardiologist in December 2006; however, the physician ruled out ischemic heart disease and cardiac abnormality.

On June 5, 2007, Ms. Sindelli returned to Hospital for the EGD. She consulted with Dr. Dalecki, an anaesthesiologist at the Hospital, and Mark Greaves, M.D., a gastroenterology fellow. The doctors noted that she had no history of cardiac problems. Dr. Greaves obtained Ms. Sindelli's signature on a consent form. According to Dr. Markowitz's EBT testimony, obtain consent from the patient involves a "discussion of the procedure and the risks." According to the medical records, Dr. Dalecki discussed the risks and benefits of the anesthesia, although such risks and benefits are not specificed. He also reviewed her cardiac history.

Prior to undergoing the EGD, Ms. Sindelli vomited in the waiting area. Nevertheless, the procedure went forward as planned. According to the examination before trial ("EBT") testimony of Nurse Laura Ardzzone, Ms. Sindelli was sedated with general anesthesia at approximately 4:08 p.m. and Nurse Ardzzone intubated her about sixty seconds later. According to the medical records, Dr. Markowitz commenced the EGD at 4:11 p.m. and ended it at 4:19 p.m. By the end of the procedure, Ms. Sindelli was spontaneously ventilating and arousable. Nurse Ardzzone testified that she extubated Ms. Sindelli at "roughly 4:30 p.m." in the operative room and promptly transported her to the post-anthesia care unit ("PACU"). The medical records reflect that at 4:30 p.m., Ms. Sindelli "was transferred to the recovery room in stable condition." Nurse

Ardzzone testified that while she transfers patients from the operating room to the PACU, a distance of approximately 20 to 25 feet, it is her customary practice to place her hand over the patient's "mouth to make sure [the patient is] exchanging air[.]" Nurse Ardzzone further maintained that Ms. Sindelli was exchanging air, because anything otherwise would have been noted in the records.

Once in the PACU, Nurse Ardzzone attached Ms. Sindelli to monitors and noted that her heart rate was bradycardic (slower than normal). Ms. Sindelli also "appeared a little pale." As a result, Nurse Ardzzone called "code blue" at 4:33 p.m. According to the medical records, Ms. Sindelli was intubated at 4:36 p.m. Nurse Tricia Madden testified at her EBT that the medical records indicate that the placement auscultation was negative, meaning that Nurse Ardzzone could not hear breathing sounds. Approximately forty one (41) days after her EBT, on the errata sheet, Nurse Madden corrected her testimony with regard to the negative auscultation note. She writes that where the EBT transcript reads, "Negative placement auscultation," it should say, "It is difficult to determine from the photocopy of the CPR record whether the symbol I recorded is a '+' or a '- ' sign, but when I consider the other entries on that record [and] others in the chart, it is clear that good placement of the endotracheal tube was achieved." Ultimately, resuscitation efforts were unsuccessful and Ms. Sindelli was pronounced dead at 5:00 p.m. The autopsy revealed that Ms. Sindelli had atherosclerotic cardiovascular disease.

Plaintiff commenced this action as executor of the last will and testament of Ms. Sindelli by filing a summons and verified complaint on or about February 20, 2008. Against Dr. Dalecki and the Hospital, plaintiff alleges, inter alia, that defendants failed to obtain proper clearance, including cardiac clearance, for general anesthesia; failed to obtain Ms. Sindelli's

informed consent; prematurely extubated Ms. Sindelli; failed to timely "resuscitate and oxygenate" Ms. Sindelli; and failed to properly monitor Ms. Sindelli during the unsuccessful resuscitation. Plaintiff further alleges against the Hospital that it failed to obtain a proper medical history prior to the EGD. Plaintiff alleges that these departures led to Ms. Sindelli's cardiac arrest and death.

A defendant moving for summary judgment in a medical malpractice action must make a prima facie showing of entitlement to judgment as a matter of law by showing "that in treating the plaintiff there was no departure from good and accepted medical practice or that any departure was not the proximate cause of the injuries alleged." Roques v. Nobel, 73 A.D.3d 204, 206 (1st Dep't 2010) (citations omitted). To satisfy the burden, a defendant in a medical malpractice action must present expert opinion testimony that is supported by the facts in the record and addresses the essential allegations in the bill of particulars. Id. If the movant makes a prima facie showing, the burden shifts to the party opposing the motion "to produce evidentiary proof in admissible form sufficient to establish the existence of material issues of fact which require a trial of the action." Alvarez v. Prospect Hosp., 68 N.Y.2d 320, 324 (1986) (citation omitted). Specifically, in a medical malpractice action, a plaintiff opposing a summary judgment motion

> must demonstrate that the defendant did in fact commit malpractice and that the malpractice was the proximate cause of the plaintiff's injuries. . . . In order to meet the required burden, the plaintiff must submit an affidavit from a medical doctor attesting that the defendant departed from accepted medical practice and that the departure was the proximate cause of the injuries alleged.

Roques, 73 A.D.3d at 207 (internal citations omitted). A defendant moving for summary judgment on a lack of informed consent claim must demonstrate that the plaintiff was indisputably informed of the foreseeable risks, benefits, and alternatives of the treatment rendered, and "that a reasonably

prudent patient would not have declined to undergo the [procedure] if he or she had been informed of the potential complications[.]" Koi Hou Chan v. Yeung, 66 A.D.3d 642, 643 (2d Dep't 2009); see also Public Health Law § 2805-d(1).

Defendants rely on the expert testimony of three physicians. The first affirmation is submitted by David Greenwald, M.D., who is board certified in internal medicine and gastroenterology. Dr. Greenwald's opinion concerns plaintiff's claims with regard to the performance of the EGD by Dr. Markowitz. As noted previously, plaintiff has discontinued the case against Dr. Markowitz. To the extent that claims regarding the EGD can be imputed upon the Hospital, the affirmation will be briefly discussed. Dr. Greenwald asserts that Dr. Markowitz properly cleared Ms. Sindelli for the EGD and that it is not within the standard of care to obtain a cardiology consult for a patient like Ms. Sindelli who presents without a history of cardiac problems. Dr. Greenwald further maintains that, in his review of the medical records, Ms. Sindelli's consent for the EGD was properly obtained.

In the second affirmation, Michael Urban, M.D., a board certified anesthesiologist, sets forth that Ms. Sindelli's records revealed a benign cardiac history and she was therefore not at risk for cardiac failure. Dr. Urban further asserts that Ms. Sindelli presented for the "minor surgery" as a healthy patient, notwithstanding her stomach issues. Therefore, there was no need for her to undergo preoperative testing. Dr. Urban opines that Ms. Sindelli was properly sedated and all the anesthesia cleared her bloodstream before, and played no part in, her cardiac arrest at 4:33 p.m.

With regard to the extubation, Dr. Urban asserts that it was proper for Dr. Dalecki

to delegate the extubation to Nurse Ardzzone as she was qualified and capable to handle the extubation. Dr. Urban further asserts that once Ms. Sindelli was breathing spontaneously and became arousable, and the last of the sedation wore off, Ms. Sindelli was ready for extubation. Dr. Urban maintains that Ms. Sindelli was properly extubated a 4:30 p.m. and her cardiac arrest at 4:33 p.m. had nothing to do with her oxygen levels. He asserts that "hypoxemia sufficient to cause an arrest could not have occurred in the brief interval between the extubation of the patient at 4:30 p.m. and her arrest at 4:33 p.m." Dr. Urban admits that it is not clear from the records if Ms. Sindelli was successfully intubated following her arrest. Nevertheless, he asserts that Nurse Madden's clarification of EBT testimony makes it clear that the intubation was successful. Dr. Urban further asserts that the resuscitation efforts, which included cardiopulmonary resuscitation ("CPR"), the administration of various medications, and the use of a defibrillator, were appropriate. With regard to plaintiff's lack of informed consent claim, Dr. Urban submits that Dr. Dalecki appropriately advised Ms. Sindelli of the risks and benefits of general anesthesia.

The third expert, Michael W. Cleman, M.D., who is board certified in internal medicine with a subspeciality certification in cardiovascular disease, sets forth that there is no evidence in Ms. Sindelli's medical records that she had any cardiac disease or condition. Dr. Cleman sets forth that the autopsy does not demonstrate any evidence of myocardial infarction or thrombosis. He opines that Ms. Sindelli likely died of an "unexpected, unpredictable, and unavoidable" cardiac arrythimia.

In opposition, plaintiff presents an affidavit from Isaac Azar, M.D., a board certified anesthesiologist. Dr. Azar sets forth that under the standard of care, Ms. Sindelli should not have

been extubated until she was "wide awake and gagging on the breathing tube." The medical records indicate that Ms. Sindelli was not wide awake at the time of extubation; rather, she was arousable. According to Dr. Azar, Nurse Ardzzone's EBT testimony, which set forth that she likely placed her hand over Ms. Sindelli's mouth to assess breathing, further indicates that Ms. Sindelli was not wide awake. Dr. Azar asserts that an awake patient will manifest breathing by "the coordinated movements of the chest and abdomen," so there is no need to check for breathing in the manner used by Nurse Ardzzone.

Dr. Azar notes that the EGD ended at 4:19 p.m. and records reflect that, at that point, Ms. Sindelli was breathing spontaneously. Dr. Azar notes that Nurse Ardzzone testified that she had no concern that gastric acid would enter the trachea after the EGD. Therefore, although admitting that the medical records do not indicate the exact time of the extubation, Dr. Azar opines that Nurse Ardzzone removed the breathing tube at 4:19 p.m. Dr. Azar asserts that the extubation of Ms. Sindelli at 4:19 p.m., before she was wide awake, caused gastric juice to enter Ms. Sindelli's trachea and bronchial tree, as her "protective airway reflex" was not yet back. Dr. Azar asserts that the aspiration of the gastric juice caused an "intense contraction of circular involuntary muscles around the bronchi." The contraction disrupted the flow of oxygen to the lungs and heart. Dr. Azar asserts that the fourteen minutes of compromised respiration was sufficiently long enough to result in a substantial loss of oxygen and eventual cardiac arrest, especially since Ms. Sindelli's coronary artery disease was already reducing the flow of oxygen to her heart. Ultimately, Dr. Azar opines, the premature extubation was a deviation from the standard of care that caused Ms. Sindelli's death.

Dr. Azar maintains that the resuscitation efforts were inadequate. Noting that

"placement auscultation" was said to be negative, Dr. Azar sets forth that after the calling code blue, Nurse Ardzzone failed to place the breathing tube into Ms. Sindelli's trachea. Dr. Azar asserts that the failure to properly intubate Ms. Sindelli after her cardiac arrest was a deviation from the standard of care and contributed to Ms. Sindelli's death. Dr. Azar further asserts that while performing CPR, staff at the Hospital should have tested Ms. Sindelli's blood gases in order to measure her electrolytes and acid-base balance. He sets forth that because "[i]t is possible that during CPR [Ms. Sindelli] had gross abnormalities in potassium blood level and acidity of the blood," the CPR failed. Dr. Azar asserts that the failure to test the blood gases was a deviation from the standard of care and contributed to Ms. Sindelli's death.

In reply, the Hospital and Dr. Dalecki point out that plaintiff failed to address their assertion that Ms. Sindelli's consent was obtained for the procedure and the anesthesia. They also argue that the facts on which plaintiff's expert relies are not found in the record.

The Hospital and Dr. Dalecki have demonstrated a prima facie entitlement to summary judgment on plaintiff's claim sounding in lack of informed consent with their experts' testimony that Ms. Sindelli was sufficiently advised of the risks and benefits of general anthesia and the EGD. Since plaintiff does not contest the assertion that Ms. Sindelli's informed consent was obtained, the claim sounding in lack of informed consent is dismissed.

The Hospital and Dr. Dalecki have also demonstrated a prima facie entitlement to summary judgment on plaintiff's claims sounding in medical malpractice. They have demonstrated, through competent expert testimony, that Ms. Sindelli's surgical course was normal; that she was

extubated at the appropriate time; that the resuscitation efforts were proper; and that her death was caused by a sudden, unexpected, and unpreventable arrythimia. Nevertheless, plaintiff's expert has pointed to acts of malpractice, including premature extubation, that he argues caused Ms. Sindelli's death. In light of the experts' conflicting opinions, summary judgment on the claims sounding in medical malpractice claim must be denied. See Cruz v. St. Barnabas Hosp., 50 A.D.3d 382 (1st Dep't 2008). Defendants' argument in the reply concerning the factual inferences drawn by plaintiff's expert turn on the credibility of evidence and "[i]t is not the court's function on a motion for summary judgment to assess credibility." Ferrante v. American Lung Ass'n., 90 N.Y.2d 623, 631 (1997) (citations omitted); see also Frye v. Montefiore Med. Ctr., 70 A.D.3d 15, 25 (1st Dep't 2009). Accordingly, it is hereby

ORDERED that the branch of the motion seeking summary judgment as to the claim for failure to obtain informed consent is granted and the causes of action for lack of informed consent is severed and dismissed as to all defendants; and it is further

ORDERED that the branch of the motions seeking summary judgment as to the causes of action sounding in medical malpractice is denied, and the remainder of the action shall continue; and it is further

ORDERED that the parties shall appear for a pre-trial conference on April 5, 2011 at 9:30 a.m.

Dated: February, 17 2011

FILED

JOAN B. LOBIS, J.S.C.

FEB 24 2011