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SHORT FORM ORDER

INDEX No. 07-40362
CAL. No. 11-00717MM

COPY

SUPREME COURT - STATE OF NEW YORK
I.A.S. PART 43 - SUFFOLK COUNTY

PRESENT:

Hon. ARTHUR G. PITTS
Justice of the Supreme Court

MOTION DATE 7-28-11 (#001)
MOTION DATE 8-18-11 (#002)
MOTION DATE 8-26-11 (#003), (#004),(#005),(#006)
ADJ. DATE: 12-1-11
Mot. Seq. # 001 - MG # 004 - MG
002 - MotD # 005 - MG
003 - MG # 006 - MG

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SYLVIA COTTO, as Executrix of the Estate of MARIA LUNA-DIAZ, and SYLVIA COTTO, Individually,

Plaintiffs,

- against -

MANAL HEGAZY, M.D., BRADLEY D. COHEN, M.D., TERRY PALATT, M.D., CHARLES A. LaROSA, M.D., LAURENCE A. ENGELBERG, M.D., DAVID FARR, M.D., DAVID REICH, M.D., THOMAS M. PALLAN, M.D., GOOD SAMARITAN HOSPITAL, SOUTH BAY CARDIOVASCULAR ASSOCIATES, P.C., SUFFOLK HEART GROUP, LLP, THE LONG ISLAND LUNG CENTER, LLP, and ISLAND SURGICAL & VASCULAR GROUP, P.C.,

Defendants.

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Upon the following papers numbered 1 to 94 read on this motion and cross motions for summary judgment; Notice of Motion/ Order to Show Cause and supporting papers (001)1 - 17; Notice of Cross Motion and supporting papers (002) 18-32, (003) 33-53, (004) 54-62, (005) 63-66, (006) 67-78; Answering Affidavits and supporting papers 79-91; Replying Affidavits and supporting papers 92-94; Other __; (~~and after hearing counsel in support and opposed to the motion~~) it is,

ORDERED that motion (001) by the defendants, David Reich, M.D. and South Bay Cardiovascular Associates, P.C., pursuant to CPLR 3212 for summary judgment dismissing the complaint, is granted and the complaint as asserted against them is dismissed; and it is further

ORDERED that motion (002) by the defendants, Manal Hegazy, M.D., Bradley D. Cohen, M.D., Terry Palatt, M.D., Charles A. LaRosa, M.D., and Island Surgical and Vascular Group, P.C., pursuant to CPLR 3212 for summary judgment dismissing the complaint, is granted to the extent that the complaint is dismissed as asserted against Bradley D. Cohen, M.D., Terry Palatt, M.D., and Charles A. LaRosa, M.D., and is denied as to Manal Hegazy, M.D. and Island Surgical and Vascular Group, P.C.; and it is further

ORDERED that motion (003) by the defendants, David Farr, M.D. and The Suffolk Heart Center, pursuant to CPLR 3212 for summary judgment dismissing the complaint, is granted and the complaint is dismissed as asserted against them; and it is further

ORDERED that motion (004) by the defendant, Thomas M. Pallan, M.D., pursuant to CPLR 3212 for summary judgment dismissing the complaint, is granted and the complaint is dismissed as asserted against him; and it is further

ORDERED that motion (005) by the plaintiffs, Sylvia Cotto as Executrix of the Estate of Maria Luna-Diaz, deceased, and Sylvia Cotto, Individually, for an order precluding any remaining defendants not granted summary judgment from claiming the limited liability benefits pursuant to CPLR Article 16, is granted; and it is further

ORDERED that motion (006) by the defendants, Laurence A. Engelberg, M.D. and the Long Island Lung Center, pursuant to CPLR 3212 for summary judgment dismissing the complaint, is granted and the complaint as asserted against them is dismissed.

In this action for medical malpractice and lack of informed consent on behalf of the plaintiff's decedent Maria Luna-Diaz, and derivatively on behalf of Sylvia Cotto, it is alleged that the defendants negligently departed from good and accepted standards of care during their treatment of the plaintiff's decedent. The decedent was admitted to Good Samaritan Hospital from January 30, 2006 through February 2, 2006, where she was treated by the defendants. It is alleged that the defendants failed to prevent and to timely diagnose and treat the decedent for deep vein thrombosis (DVT), causing the plaintiff to suffer massive bilateral pulmonary emboli; that they failed to timely place an internal pacemaker and negligently inserted an intracardiac needle; and that they caused and permitted the decedent to suffer respiratory/cardiac arrest and die on February 2, 2006. Sylvia Cotto was granted Letters Testamentary for the Estate of the decedent on August 22, 2007 from the Supreme Court of Puerto Rico.

The moving defendants seek dismissal of the complaint as asserted against each of them on the basis they were not negligent in their care and treatment of the plaintiff's decedent. It is noted that the plaintiff has submitted papers in opposition to the motion submitted by the defendant Manal Hegazy, M.D. but sets forth that there is no opposition as to the remaining movants. The plaintiff cross moves, seeking an order wherein, if, the complaint is dismissed against any of the defendants, that the remaining defendants are precluded from asserting limited liability as to those dismissed defendants pursuant to CPLR Article 16.

The proponent of a summary judgment motion must make a prima facie showing of entitlement to judgment as a matter of law, tendering sufficient evidence to eliminate any material issues of fact from the case. To grant summary judgment it must clearly appear that no material and triable issue of fact is presented (***Friends of Animals v Associated Fur Mfrs.,*** 46 NY2d 1065, 416 NYS2d 790 [1979]; ***Sillman v Twentieth Century-Fox Film Corporation***, 3 NY2d 395, 165 NYS2d 498 [1957]). The movant has the initial burden of proving entitlement to summary judgment (***Winegrad v N.Y.U. Medical Center***, 64 NY2d 851, 487 NYS2d 316 [1985]). Failure to make such a showing requires denial of the motion, regardless of the sufficiency of the opposing papers (***Winegrad v N.Y.U. Medical Center***, *supra*). Once such proof has been offered, the burden then shifts to the opposing party, who, in order to defeat the motion for summary judgment, must proffer evidence in admissible form...and must "show facts sufficient to require a trial of any issue of fact" (CPLR 3212[b]; ***Zuckerman v City of New York***, 49 NY2d 557, 427 NYS2d 595 [1980]). The opposing party must assemble, lay bare and reveal his proof in order to establish that the matters set forth in his pleadings are real and capable of being established (***Castro v Liberty Bus Co.,*** 79 AD2d 1014, 435 NYS2d 340 [1981]).

The requisite elements of proof in a medical malpractice action are (1) a deviation or departure from accepted practice, and (2) evidence that such departure was a proximate cause of injury or damage (***Holton v Sprain Brook Manor Nursing Home***, 253 AD2d 852, 678 NYS2d 503[1998], *app denied* 92 NY2d 818, 685 NYS2d 420). To prove a prima facie case of medical malpractice, a plaintiff must establish that defendant's negligence was a substantial factor in producing the alleged injury (*see,* ***Derdiarian v Felix Contracting Corp.***, 51 NY2d 308, 434 NYS2d 166 [1980]; ***Prete v Rafla-Demetrious,*** 221 AD2d 674, 638 NYS2d 700 [1996]) Except as to matters within the ordinary experience and knowledge of laymen, expert medical opinion is necessary to prove a deviation or departure from accepted standards of medical care and that such departure was a proximate cause of the plaintiff's injury (*see,* ***Fiore v Galang***, 64 NY2d 999, 489 NYS2d 47 [1985]; ***Lyons v McCauley,*** 252 AD2d 516, 517, 675 NYS2d 375 [1998], *app denied* 92 NY2d 814, 681 NYS2d 475; ***Bloom v City of New York,*** 202 AD2d 465, 465, 609 NYS2d 45 [1994]).

To rebut a prima facie showing of entitlement to an order granting summary judgment by the defendant, the 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 of the plaintiff (*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]).

In support of motion (001), the defendants, David Reich, M.D. and South Bay Cardiovascular Associates, P.C., have submitted, inter alia, an attorney's affidavit, copies of the summons and complaint, the answers served by Dr. Reich and South Bay Cardiovascular Associates, P.C. and the plaintiff's verified bill of particulars and amended verified bill of particulars as to Dr. Reich; the affidavit of Dr. Reich, and the transcript of the examination before trial of Dr. Reich. The plaintiff has not opposed the defendants' application.

David Reich, M.D. testified to the extent that he is licensed to practice medicine in New York State and is board certified in internal medicine, cardiovascular disease, and interventional cardiology. The plaintiff's decedent, Maria Luna-Diaz, came under his care on February 2, 2006, at Good Samaritan Hospital when he was paged emergently to the angiography suite as the decedent was having a cardiac arrest. The plaintiff's decedent was undergoing a catheter thrombectomy for pulmonary emboli and went into shock. He learned that a pacemaker had been placed and that she had been intubated prior to his arrival. She had low blood pressure and was in dire straits. He decided that she needed an intra-aortic balloon pump which he placed into the descending thoracic aorta from the groin. He described the intra-aortic balloon pump as an endovascular device to aid in the maintenance of blood

pressure, and cardiac function and output. His decision to place the pump was based upon her cardiac output being very low despite her heart rate, accounting for shock and hypotension. He stated that he felt that this was the best thing for the patient in addition to administering medication. He encountered no complications in inserting the balloon pump, and stated the patient's blood pressure increased, but he did not know if her cardiac output improved. He stated that because the decedent had a critical care team and a cardiology consultant on the case, he had no other involvement in her care and treatment after he inserted the balloon pump.

In his supporting affidavit, Dr. Reich avers that in rendering care and treatment to the plaintiff's decedent, he did not perform, or assist in performing, a suction thrombectomy; he had no involvement in intubating the patient; he was not involved in resuscitative measures or in preventing or trying to prevent respiratory arrest; and that he timely responded to the code immediately upon being requested to do so. He continued that he did not participate in any of the decedent's care and treatment prior to being requested to assist in the angiocath suite, and by the time he was called to the scene, the decedent had already suffered massive bilateral pulmonary emboli. Angiojet catheter thrombectomy had already been performed, and thereafter plaintiff suffered a cardiopulmonary arrest for which a code was called. As she was in dire straits, he placed the intraaortic balloon pump to aid in maintaining her blood pressure and cardiac function and output to help her survive. Dr. Reich opines with a reasonable degree of medical certainty that he did not depart from any standards of care relative to his profession or specialty in inserting the balloon pump, or in the care and treatment rendered relative thereto. He continued that he was able to resurrect the decedent even though only for several hours, after which time she died in the intensive care unit. He further opines that there is nothing that he did or did not do which caused her injury or contributed to or caused her death, and that there is nothing which he would have done differently or additionally to save her life.

Based upon the foregoing, it is determined that Dr. Reich and South Bay Cardiology Associates, P.C. have demonstrated prima facie entitlement to summary judgment dismissing the complaint as asserted against them. The plaintiff has not opposed this motion and has thus failed to raise factual issue to preclude summary judgment from being granted to these defendants.

Accordingly, motion (001) is granted and the complaint is dismissed with prejudice as asserted against Dr. Reich and South Bay Cardiology Associates, P.C.

In support of motion (002), the defendants, Manal Hegazy, M.D., Bradley D. Cohen, M.D., Terry Palatt, M.D., Charles A. LaRosa, M.D., and Island Surgical and Vascular Group, P.C., have submitted, inter alia, an attorney's affirmation; copies of the summons and complaint, the answer served on their behalf, various discovery demands, and the separate verified bill of particulars and amended verified bills of particulars served by plaintiff; uncertified copies of the decedent's medical records; transcripts of the examinations before trial of Manal Hegazy, M.D dated July 21, 2009, Terry Palatt, M.D. dated December 10, 2009, Charles LaRosa, M.D. dated October 15, 2009, all in admissible form; and the affirmation of the moving defendants' expert, Thomas H. Gouge, M.D.

Manal Hegazy, M.D. testified that she is licensed to practice medicine in New York State, is board certified in surgery, and is a partner in Island Surgery and Vascular Group. She testified as to the care and treatment she rendered to the decedent from when she first saw her on January 20, 2006. The decedent had been referred from Good Samaritan Hospital emergency department concerning a ventral hernia. Because the decedent spoke Spanish, she communicated through the decedent's son-in-law who accompanied her. She obtained a history which revealed the decedent had a hysterectomy and five previous hernia repairs. She ascertained that she was experiencing constipation and intermittent obstruction. Dr. Hegazy stated the decedent wanted the condition repaired. When she performed a physical examination, she could feel the mesh previously inserted during prior repairs. Dr. Hegazy

stated that she discussed the options, and whether there would be a laparoscopic or open procedure. Thereafter, Dr. Blanco provided medical clearance for surgery. Surgery was performed on January 30, 2006. Dr. Hegazy described the procedure performed and stated it was necessary to perform a small bowel resection in order to remove the embedded mesh. She monitored the decedent for a time after surgery.

Dr. Hegazy continued that she examined the decedent the following day on January 31, 2006, and that the decedent offered no complaints. She ordered the decedent to ambulate and to continue use of the venodynes, or compressive or sequential TEDS, which were in place when she saw her. The decedent ambulated on that date. When she saw the decedent on February 1, 2006, she was walking with her family and was not wearing the venodynes as they were removed for ambulating. Dr. Hegazy stated she was off duty on February 2, 2006, and her partner, Dr. Palatt, saw the decedent and called to inform her that the decedent died. She stated that they believed the decedent had suffered pulmonary emboli caused by deep vein thrombosis, based upon the CAT scan of the chest which showed clots.

Terry Palatt, M.D. testified to the extent that he is a physician licensed to practice medicine in New York State, is board certified in general surgery and cardiothoracic surgery, and is a partner at Island Surgery and Vascular Group. He did not have an independent recollection of the decedent and review of the medical records did not refresh his recollection. He testified that he first met the decedent on February 2, 2006 at 8 a.m. when he was called to see her on an emergency basis as she was experiencing shortness of breath. She had already been seen by Dr. Farr, a cardiologist, and Dr. Engelberg, a pulmonologist. The CAT scan, which he reviewed himself, showed pulmonary emboli consisting of a significant amount of clot in both the main pulmonary artery and the right and left proximal branches of the pulmonary artery. He conducted a physical examination, and wrote an entry into her chart. He testified that he agreed with Dr. Engelberg who recommended Angiojet thrombectomy and IVC filter.

Dr. Palatt testified that the decedent's condition was critical when he saw her, and that the pulmonary emboli were occluding a large portion of her pulmonary blood flow, and if nothing were done, she would die. He felt the Angiojet should be performed as soon as possible. He described the Angioget as a procedure to break up clots with a jetting of saline or blood through a catheter to dissolve the clot, a procedure performed by an interventional radiologist, who, in this case, was Dr. Pallan. He stated that because she had recent surgery, she was not a candidate to be administered thrombolytics to dissolve the blood clots. He next saw the decedent in the angiography suite after she coded while Dr Pallan was in attendance. Dr. Pallan's note, Dr. Palatt stated, indicated that a full code was instituted, and that Dr. Palatt, Dr. Farr, and Dr. Reich, and respiratory responded. Dr. Palatt testified that he arrived at the end of the code when Dr. Reich was inserting the balloon pump. Dr. Palatt testified that he had no involvement with placing the pacemakers, or their verification or position. He stated he ordered necessary medications and tried to maintain acid/base balance and blood pressure, and continued with a slow code. As the attending physician, he stayed with her and followed her into ICU. He stated he knew she was going to die, and that he tried to keep her alive until the family could see her in the ICU. Thereafter, he pronounced her dead.

Charles LaRosa, M.D. testified to the extent that he is a physician licensed to practice medicine in New York State, is board certified in general surgery with qualifications in vascular surgery, and is a partner with Island Surgery and Vascular Group. He had no independent recollection of Maria Luna-Diaz. Reviewing the hospital record refreshed his recollection of his involvement in her care on February 2, 2006. He had a vague recollection of being asked by Dr. Palatt, who informed him of her condition, to attend her in the angiography suite as the plan was to proceed with a pulmonary artery thrombectomy for pulmonary emboli diagnosed via a CT scan ordered by Dr. Farr, a cardiologist on staff at Good Samaritan Hospital. He described a pulmonary emboli as the passage of debris, whether it be a clot, air or other material, into the pulmonary arteries. Depending upon the severity, it would present with some difficulty breathing, probably some chest pain, and in severe cases, some degree of hypotension or decrease in blood pressure.

Dr. LaRosa continued that Dr. Pallan, an interventional radiologist, was to perform the pulmonary artery thrombectomy. Dr. Reich placed the intra-aortic balloon pump. Dr. Engelberg of pulmonary medicine, and Dr. Farr of cardiology, were present. Dr. LaRosa testified that his involvement with the patient was establishing her airway when her oxygen saturation dropped to 69 percent at 10:55 a.m., establishing central venous access at 11:20 a.m. to administer IV fluids and medications, supervising the code with administration of advanced cardiac life support, performing pericardiocentesis after Dr. Reich inserted the intra-aortic balloon pump, placing a temporary pacemaker wire at 11:56 a.m., being on standby to provide opinion to Dr. Pallan as he was proceeding with the thrombectomy, and giving chest compressions while Dr. Pallan was proceeding with the thrombectomy. Dr. LaRosa testified that the pericardiocentesis was performed when the patient remained in a pulseless electrical activity state. He stated that if there was a pneumopericardium with air in the heart sac, or possibly blood in the heart sac, that it could have inhibited cardiac contractility. Removal of the air or blood might allow her to resume a cardiac output. He did not remember whose decision it was to do the pericardio-centesis, but he was in agreement with its performance, and was among the best qualified to proceed with it. However, only pericardial fluid was returned. The pacemaker was inserted to stimulate adequate electrical activity within what appeared to be a stunned myocardium in an effort to increase cardiac output, but it was not successful. He translated in Spanish for Dr. Pallan to obtain consent for the thrombectomy and to advise the decedent what was being done. He did not recall the risks or alternatives provided.

Thomas H. Gouge, M.D., the expert for the moving defendants in this motion, affirms that he is a physician licensed to practice medicine in New York State and is board certified in surgery. He set forth the records and materials reviewed in reaching his opinion, and opines with a reasonable degree of medical certainty that the care and treatment rendered by Dr. Hegazy, Dr. Palatt, Dr. LaRosa, Dr. Cohen, and Island Surgical and Vascular Group, P.C. to the plaintiff's decedent during her admission to Good Samaritan Hospital was within the standard of care and did not proximately cause any of the injuries or death, as alleged by the plaintiff in the bills of particulars. Dr. Gouge stated that the decedent was a sixty-eight year old female who underwent hernia surgery on January 30, 2006. Thereafter, the decedent developed pulmonary emboli which eventually led to the decedent's death on February 2, 2006. Her past medical history was significant for a colon resection, colostomy, colostomy reversal, and a hysterectomy.

Dr. Gouge continued that Ms. Luna-Diaz was first seen as a patient on January 17, 2006, in the emergency department of Good Samaritan Hospital with complaints of pain in her abdomen and right side of her back. She was to have hernia surgery performed in Puerto Rico, but had no one to care for her, so she came to New York for the surgery. She was seen and examined in the emergency room by Dr. Hegazy, who was offered no complaints of lower extremity pain or tenderness, and who found that the plaintiff's decedent was non-tender to palpation of the extremities, and that distal pulses were normal. Dr. Hegazy explained to the plaintiff's decedent that she would attempt the hernia repair surgery laparoscopically but due to scar tissue from the multiple prior surgeries, she might have to convert to open surgery. Pre-surgical labs and a chest x-ray were conducted on January 25, 2006. Dr. Blanco provided medical clearance for the surgery. Upon the plaintiff's decedent's admission to Good Samaritan Hospital on January 30, 2006, Dr. Hegazy explained the risks, benefits, and alternatives with the patient and her family, and consent was obtained. Thereafter, Dr. Hegazy, assisted by Dr. Cohen, performed a laparoscopic lysis of adhesions, an exploratory laparotomy, and a small bowel resection, without complications. Following surgery, Dr. Cohen was no longer involved in her care and treatment.

Dr. Gouge continued that postoperatively, Dr. Hegazy saw the plaintiff's decedent on January 31, and February 1, 2006, at which time she was stable and doing well. It was ordered that she ambulate. Dr. Hegazy had no further contact with the decedent after February 1, 2006 as she was off on February 2, 2006. Her colleagues, Dr. Palatt and Dr. LaRosa, saw the decedent for her on February 2, 2006. Dr. Gouge notes that on February 2, 2006, at 7 a.m., the decedent was placed on a non-rebreather mask, and Dr. Farr, the cardiologist was in attendance. A

CT scan with contrast was ordered, and it was determined that the decedent had large bilateral pulmonary emboli. She was placed on Heparin, and it was decided that she would benefit from an Angiojet evacuation (suction thrombectomy). Dr. Pallan of radiology was consulted at 8 a.m. and was asked to perform the procedure. However, another patient was having a procedure in the interventional radiology suite, so the decedent's procedure could not begin until 10:30 a.m. During the procedure, the decedent required intubation which was performed by Dr. LaRosa while Dr. Pallan continued with the Angiojet evacuation. Dr. LaRosa placed a central venous catheter for IV access and a temporary pacing wire, and also performed a pericardiocentesis. Dr. Reich placed an intra-aortic balloon pump. The decedent was coded from 11:30 a.m. until 1:25 p.m. when she was transferred to the ICU. Dr. Gouge states that despite all supportive care, the decedent expired at 3:18 p.m. Dr. Gouge stated that the autopsy report indicates that the final clinical anatomic diagnosis was bilateral pulmonary emboli, however, at the time of death, there was no longer any residual pulmonary emboli seen as the procedure had been successfully performed.

Dr. Gouge opines with a reasonable degree of medical certainty that the moving defendants' care and treatment was at all times within accepted standards of care from which they did not depart, and that none of the alleged acts or omissions by the defendants proximately caused or contributed to the injuries or death of the decedent. The medical clearance by Dr. Blanco was appropriately done. Informed consent was properly given based upon Dr. Hegazy's testimony. The surgery performed by Dr. Hegazy, assisted by Dr. Cohen, was indicated for a ventral hernia which was easily reducible. It was necessary to perform the open surgical procedure due to the amount of scar tissue found, and also for removal of the old mesh used in the prior unsuccessful repairs as the mesh embedded in the small bowel requiring removal of a section of small bowel. At the time of the decedent's presentation to Dr. Hegazy pre-operatively, she did not have any signs or symptoms of a deep vein thrombois (DVT) or venous thromboemboli. During surgery and post-operatively, venodynes were used to help prevent DVT. Dr. Cohen rendered no care or treatment other than assisting with the surgery which was appropriately performed.

Dr. Gouge states that Dr. Palatt's first contact with the decedent did not occur until February 2, 2006 after the CT scan revealed large bilateral pulmonary emboli, which Dr. Farr and Dr. Engelberg discussed with Dr Palatt and concurred with a recommendation for an Angiojet evacuation and IVC filter. Dr. Palatt noted that the decedent was not a candidate for thrombolytics since she had just recently had major abdominal surgery and thrombolytics could cause her to hemorrhage. Dr. Gouge opines that Dr. Pallat did not delay in seeing or responding to the decedent and appropriately performed the consultation with cardiology and pulmonary medicine, and provided appropriate assistance and supportive care during the code. When the decedent was transferred to ICU, Dr. Pallat monitored her on the ventilator, provided medications, checked labs, and transfused two units of packed cells. He continued that the decedent was not a candidate for any surgery whereby the pulmonary arteries would be opened as she would have had to be placed on cardiopulmonary bypass, which, under the circumstances, would have created even more significant stress.

Dr. Gouge opines that Dr. LaRosa did not have any contact with the decedent until February 2, 2006 when he was called to the interventional radiology suite to assist during the Angiojet procedure being performed by Dr. Pallan. Dr. LaRosa properly translated Dr. Pallan's informed consent to the decedent and her family. He appropriately established the decedent's airway, central venous access to administer IV fluids and medication, appropriately placed a temporary pacemaker wire to re-start the decedent's heart, performed a pericardiocentesis to try to resume cardiac output, and subsequently supervised the code.

Based upon the foregoing, it is determined that the moving defendants have established prima facie entitlement to summary judgment dismissing the complaint asserted against them.

The plaintiff opposes only that part of the motion which seeks summary judgment dismissing the complaint as asserted against Dr. Manal Hegazy. In opposing that part of the motion asserted on behalf of Dr. Hegazy, the plaintiff has submitted, inter alia, an attorney's affirmation; a physician's expert affirmation; medical literature; transcripts of the examinations before trial of Sylvia Cotto and Ivan Cotto, and of Dr. Farr and Dr. Engelberg. The deposition transcripts of Dr. Farr and Dr. Engelberg are not in admissible form pursuant to CPLR 3212 to be considered on a motion for summary judgment as they are neither signed nor certified (*see*, ***Martinez v 123-16 Liberty Ave. Realty Corp.***, 47 AD3d 901, 850 NYS2d 201 [2d Dept 2008]; ***McDonald v Maus***, 38 AD3d 727, 832 NYS2d 291 [2d Dept 2007]; ***Pina v Flik Intl. Corp.***, 25 AD3d 772, 808 NYS2d 752 [2d Dept 2006]), are not accompanied by proof of service pursuant to CPLR 3116, and thus, are not considered. The medical literature provided by the plaintiff is not in admissible form to be considered in opposition to the defendant's motion. The deposition transcripts of Sylvia Cotto and Ivan Cotto are illegible as the print is too small to read. The transcripts fail to comport with CPLR 2101 (a) with reference to font size, and thus, the transcripts are not considered.

The plaintiff's expert affirms that he is a physician duly licensed to practice medicine in New York State and is board certified in general surgery. He indicates that his clinical medical experience includes the diagnosis and treatment of patients with pulmonary embolism, as well as the prevention of pulmonary embolism in surgical candidates, including those with risk factors such as age over 65 and the need for invasive surgery. The plaintiff's expert sets forth the materials and records reviewed and opines with a reasonable degree of medical certainty that the standard of care in January and February 2006 required anticoagulation, in the form of Heparin or Lovenox, in surgical patients with certain risk factors, including obesity, being over age 65, and undergoing major abdominal surgery. The plaintiff's expert states such patients are at high risk for deep vein thrombosis and pulmonary embolism.

The plaintiff's expert continued that the decedent should have received anticoagulant medications no later than January 31, 2006, the day after her surgery, but that she did not receive any until February 2, 2006, which delay is a departure from standards of care, including those guidelines established by the American College of Chest Physicians. Such guidelines require anticoagulation in patients with such aforementioned risk factors, no later than the day following the surgery. He continued, however, that next-day anticoagulation would not be required, or would be contraindicated, in the presence of bleeding, and that the medical records do not reflect any evidence of bleeding on January 31, 2006, the morning after surgery. The plaintiff's expert opines that the failure of Dr. Hegazy to order anticoagulants either peri-operatively or the next day post-operatively, increased the likelihood of her suffering a deep venous thrombosis and/or pulmonary embolus and deprived her of an opportunity to avoid this complication.

The plaintiff's expert opines that the failure to provide the anticoagulant medication was a substantial factor in causing her unnecessary and avoidable death. He continues that anticoagulants prevent abnormal intravascular clot formation and would thereby have prevented the deep venous thrombosis that resulted in the fatal pulmonary emboli, which could have been avoided had anticoagulants been administered in a manner required by the standards of care. He further added that the guidelines do not change based upon the patient not demonstrating signs or symptoms of a deep vein thrombosus or venous thromboemboli. Here, the expert opines, there were no contraindications to the administration of anticoagulants.

Based upon the foregoing, it is determined that the plaintiff has raised factual issues precluding summary judgment concerning whether or not the standard of care required Dr. Hegazy to administer anticoagulant therapy to the decedent post-operatively or peri-operatively, and whether Dr. Hegazy exercised proper judgment in determining that the decedent did not require anticoagulant therapy.

Accordingly, summary judgment is granted to defendants, Bradley D. Cohen, M.D., Terry Palatt, M.D., and Charles A. LaRosa, M.D., and the complaint is dismissed with prejudice as asserted against them. Summary judgment is denied as to Manal Hegazy, M.D. and Island Surgical and Vascular Group, P.C.

In support of motion (003), the defendants, David Farr, M.D. and The Suffolk Heart Center, have submitted, inter alia, an attorney's affirmation; copies of the summons and complaint, answers and demands, and plaintiff's verified bill of particulars; a copy of the unsigned and uncertified transcript of the examination before trial of Sylvia Cotto dated May 4, 2009; the unsigned but certified copy of the transcript of the examination before trial of Ivan Cotto dated January 10, 2011, David Reich, M.D. dated August 4, 2010, Thomas M. Pallan, M.D. dated October 12, 2010, Manal Hegazy dated July 21, 2009, Emilia Theodate, R.N. dated December 2, 2010; the signed transcripts of the examinations before trial of Terry Palatt, M.D. dated December 10, 2009, Charles LaRosa, M.D. dated October 15, 2009, David Farr, M.D. dated June 3, 2010, Laurence A. Engelberg, M.D dated April 8, 2010, and Terri Piezzo dated October 22, 2010; an uncertified copy of the plaintiff's hospital record; and the affirmation of Frank T. Pollaro, M.D.

Dr. Farr testified that he is a physician licensed to practice medicine in New York State and is board certified in internal medicine and cardiovascular disease and founded the Suffolk Heart Center. He first became involved in the plaintiff's decedent's care and treatment at Good Samaritan Hospital in the morning of February 2, 2006, when one of the nurses asked him to see her as she was not doing well. He saw the decedent within minutes of being asked and reviewed her chart. He ascertained, among other things, that it was her third post-operative day following ventral hernia repair. When he examined her, he ascertained that her blood pressure was 150/90 and that her heart rate was rapid at 130. There was no evidence of bleeding, her distal pulses were full, she had no Homans sign, and no thrombophlebitis. His differential diagnosis, or the most likely cause of her aliment was that of acute pulmonary embolism with hypoxemia. Among other things, he ordered a Spiral CT scan and an echocardiogram to determine if there were any pulmonary emboli and to check the pressure in the right heart chambers.

Dr. Farr described an acute pulmonary embolism as a condition wherein the patient has developed a thrombus in the pulmonary arteries, which is an emergency situation. Its primary treatment is anticoagulation, so he ordered Heparin at 7 a.m., and it was administered at 7:15 a.m. At 7:42 a.m., the Spiral CT Scan was conducted. He learned that it was positive for pulmonary emboli during conversation with Dr. Engelberg, a pulmonologist whom he asked to see the patient as her primary problem was pulmonary. Dr. Engelberg took over the case. He then learned of the plan to treat the pulmonary emboli with a procedure called a thrombectomy, which was started about 10:25 a.m. in the radiology department. He was not present at the beginning of the procedure, but went in "long after it had begun" to observe as he had never seen that procedure before. The radiologist, Dr. Pallan, had inserted a catheter in the decedent's pulmonary area and attempts were being made to remove the thrombus from the pulmonary arteries. Dr. Farr testified that he was there as an observer only and had no hands on involvement with her care and treatment during the procedure, and that he was not present when she went into cardiac arrest. He later learned that the procedure was unsuccessful and that she succumbed to the pulmonary embolism.

Frank T. Pollaro, M.D., the moving defendants' expert, affirms that he is licensed to practice medicine in New York State and is board certified in cardiovascular disease with subcertification in nuclear cardiology and echocardiography. He stated the records and materials he reviewed and set forth his opinion within a reasonable degree of medical certainty that at all times Dr. Farr acted appropriately and did not depart from the accepted standards of medical and cardiovascular practice his care and treatment of the decedent. Dr. Pallaro stated that when Dr. Farr was asked to see the plaintiff's decedent, that he responded within minutes, and elicited a history of the patient. He set forth that Dr. Farr appropriately conducted a physical examination of the decedent, documented his findings, and correctly formulated a differential diagnosis that the patient was suffering from acute pulmonary

emboli wherein she developed thrombi or blood clots in the pulmonary arteries, with hypoxemia or deficient oxygenation of the blood, which he states, is a life threatening condition.

Dr. Pallaro continues that Dr. Farr ordered a Spiral CT Scan which demonstrated bilateral pulmonary emboli, which necessitated the initial treatment with anticoagulation therapy, for which Dr. Farr ordered Heparin which was administered at 7:15 a.m., followed by a Heparin drip, which is the standard protocol. Dr. Farr also ordered an echocardiogram to assess the function of her heart and the pressure in the right heart chambers, and further ordered blood work. Dr. Farr then spoke with Dr. Engelberg, and transferred the decedent's care to him, because Dr. Engelberg was a pulmonologist, and her primary problem was pulmonary embolism. Dr. Pallaro states that pulmonary emboli is a pulmonary rather than a cardiac diagnosis. Dr. Pallaro opines that this transfer of care to Dr. Engelberg was a reasonable and appropriate decision and was within the relevant standard of care. Thereafter, and subsequent to learning the results of the CT scan, Dr. Farr was no longer involved in the decision on how to treat the pulmonary embolism. Dr. Pallaro continues that Dr. Farr did not participate in the thrombectomy procedure performed by Dr. Pallan.

Based upon the foregoing, it is determined that Dr. Farr and Suffolk Heart Group have established prima facie entitlement to summary judgment dismissing the complaint as asserted against them. The plaintiff has not opposed the application and therefore, has not raised a factual issue to preclude summary judgment being granted.

Accordingly, motion (003) is granted and the complaint as asserted against Dr. Farr and Suffolk Heart Group is dismissed with prejudice.

In support of motion (004), the defendant, Thomas M. Pallan, M.D., has submitted an attorney's affirmation; the expert affirmation of Jacob Cynamon, M.D.; plaintiff's verified bill of particulars; a copy of the unsigned but certified transcript of the examination before trial of Thomas M. Pallan, M.D. dated October 12, 2010; and an uncertified copy of the decedent's medical records which is not in admissible form pursuant to CPLR 3212. It is noted that the moving defendant has not submitted copies of the pleadings in support of the application, as required pursuant to CPLR 3212, but the same are found in searching the record.

Dr. Pallan testified to the effect that he is licensed to practice medicine in New York State and is board eligible, but is not board certified in radiology, although he attempted to become certified on several occasions. He completed a fellowship in interventional radiology. On February 2, 2006, he arrived at Good Samaritan Hospital Radiology Department and was shown a CT scan of the decedent's chest which he reviewed with several other radiologists, and observed an extremely large bilateral pulmonary emboli. He received a telephone call from Dr. Larry Engelberg, a pulmonologist, who already diagnosed a pulmonary embolus, and asked him what could be done to get rid of it. He advised Dr. Engelberg that the usual protocol is to administer thromboemoblytic therapy, which at the time was TPA (tissue plasminogenic activator) through a peripheral vein, which would break down any blood clots pretty much anywhere in the body. He continued that it sometimes has a dramatic effect in term of being able to lyse a clot that is in the chest. Dr. Engelberg advised him that they could not administer TPA as the patient had just had surgery and the treatment would lead to massive abdominal bleeding. They agreed that TPA was not an option. Dr. Engelberg then asked him if there was any way that the clot could be sucked out, and he advised that he could, as he had performed the Angiojet suction thrombectomy procedure in the past. He considered it an emergent procedure. He stated that Dr. Palatt, the chief of thoracic surgery, also wanted this procedure done.

Dr. Pallan continued that, at the time, Dr. Anker was in the middle of an involved interventional radiology procedure, with a patient under anesthesia on the table in the room which he needed to perform the suction thrombectomty. Appropriate persons were advised of the emergent need for the room, and they had to wait until

completion of Dr. Anker's case. Thereafter, the procedure room had to be cleaned and readied before commencing the procedure. There was no other room in the hospital where this procedure could have been performed. The decedent was Heparinized in ICU, and transferred to the radiology department where successful Angiojet suction thrombectomy was performed wherein the patient's pulmonary arteries were essentially evacuated of clots early in the procedure. During the procedure, however, he stated, the patient became asystolic and a full code was instituted by him and the doctors present, Dr. LaRosa, Dr. Pallan, Dr. Palatt, Dr. Reich, and Dr. Farr. She was intubated and aortic balloon and pacemakers were started. She was returned to the ICU with an oxygen saturation of 95 percent. No filter (IVC) was placed as there was a pacemaker wire in place via the right femoral vein.

Jacob Cynamon, M.D., the moving defendant's expert, affirms that he is a physician licensed to practice medicine in New York State and is board certified in diagnostic radiology with added qualifications in vascular and interventional radiology. He set forth the records and materials he reviewed and opines with a reasonable degree of medical certainty that the care and treatment rendered by Thomas Pallan, M.D. was within the standard of care that existed at that time and did not proximately cause any of the injuries or death as alleged by the plaintiffs. He continued to set forth her past medical history, and stated that on February 2, 2006, at about 8 a.m., it was determined by Dr. Pallan and Dr. Engelberg that the decedent would benefit from an percutaneous thrombectomy to remove the bilateral pulmonary emboli. An IVC filter was discussed to protect against further emolization. Administration of intravenous tissue plasminogen activator (ITA) was ruled out due to the risk of massive abdominal bleeding due to the recent abdominal surgery. Because there was another procedure being performed in the interventional radiology suite, the Angiojet suction thrombectomy procedure, which Dr. Pallan and Dr. Engelberg agreed needed to be performed, was not commenced until approximately 10:30 a.m. In the interim, the plaintiff's decedent remained in a tenuous but relatively stable condition

Dr. Cynamon continued that during the procedure, the plaintiff's decedent went into cardiac arrest at 11:30 a.m. Dr. Cynamon stated that the pulmonary emboli had been successfully performed and that the care and treatment rendered by Dr. Pallan was at all times within the accepted standards of care, and that none of the acts or omissions alleged by the plaintiff proximately caused or contributed to the death of the decedent. Dr. Cynamon set forth the basis for his opinion. He opines that intravenous tissue plasminogen activator was appropriately ruled out due to the risk of hemorrhage post-operatively; that Dr. Pallan did not delay in performing the percutaneous thrombectomy; that Dr. Pallan assessed this to be an emergent procedure and correctly waited for the interventional radiology suite to be quickly prepared before commencing the procedure; and that performing the procedure in a room not designed for interventional procedures would fall below the standard of care. He adds that Dr. Pallan correctly performed the procedure after receiving proper informed consent from the decedent and her family through an interpreter, Dr. LaRosa, and that he rapidly removed the clot, and correctly ordered the resuscitation of the decedent when she coded during the procedure. Dr. Cynamon concludes that the decedent's alleged injuries and death are not related to the care and treatment provided by Dr. Pallan who did not depart from good and accepted standards of practice,

Based upon the foregoing, it is determined that Dr. Pallan has demonstrated prima facie entitlement to summary judgment dismissing that part of the complaint asserted against him. The plaintiffs do not oppose this motion and have failed to raise a factual issue to preclude summary judgment from being granted.

Accordingly, motion (004) is granted and the complaint as asserted against Dr. Pallan is dismissed with prejudice.

In support of motion (006), the defendants, Laurence A. Engelberg, M.D. and the Long Island Lung Center, have submitted, inter alia, an attorney's affirmation; copies of the summons and complaint, defendants' answers,

plaintiff's verified and amended verified bill of particulars; the expert affirmation by Melvin Holden, M.D.; uncertified copies of the plaintiffs' medical records; and signed transcripts of the examination before trial of Laurence A. Engelberg, M.D. dated April 8, 2010, and Thomas Pallan, M.D. dated October 12, 2010.

Laurence A. Engelberg, M.D. testified to the effect that he is a physician licensed to practice in New York State and practices in the field of pulmonary medicine and critical care. He is board certified in sleep medicine, internal medicine, and pulmonary medicine. He first became involved in the decedent's care and treatment at 8:00 a.m. on February 2, 2006 when he received a call to see her for a massive pulmonary embolism. He learned that she was post-operative. He reviewed a CT scan film and observed that she had massive bilateral pulmonary emboli. He then examined her and determined that she needed to have the clots removed as they were life threatening. At about 9:03 a.m., he spoke with Dr. Pallan, from interventional radiology, to have an Angiojet extraction of the emboli and to place an inferior vena cava filter. He also spoke to Dr. Palatt about the possibility of using thrombolytic therapy as an alternative, however, it was determined that her surgery was too extensive to use thrombolytic therapy due to the possibility of excessive bleeding internally which they would not be able to control or assess. The ultimate decision to perform the procedure was made by Dr. Pallan. He had the expectation that Dr. Pallan would perform the procedure as soon as he could do it. Dr. Engelberg testified that thereafter, he had no further involvement in the decedent's care and treatment.

Melvin Holden, M.D., the moving defendant's expert, affirmed that he is a physician licensed to practice medicine in New York State and is board certified in pulmonary disease. He set forth the records and materials he reviewed, and opines with a reasonable degree of medical certainty that Dr. Laurence Engelberg did not depart from good and accepted standards of medical care and treatment and did not proximately cause the injuries or death of the decedent as claimed by the plaintiff. He set forth the decedent's medical history and course of care and treatment during the decedent's hospitalization and events surrounding her death. He stated that because the decedent had extensive abdominal surgery and was newly post-operative, she was not a candidate for thrombolytics upon her diagnosis of massive bilateral pulmonary emboli. The only viable treatment available was Angiojet evacuation of the emboli.

Dr. Holden continued that Dr. Engelberg served as a pulmonary consult in this case and recommended the only viable treatment available to the decedent. He saw the decedent in a timely manner, immediately dictated his note, and properly consulted with other physicians involved in the decedent's case. It is Dr. Holden's opinion that Dr. Engelberg and The Long Island Lung Center, LLP provided appropriate assistance and supportive care, that they did not participate in the Angiojet procedure or the resuscitation of the patient, and did not see the patient at any time following the procedure when she was transferred to the ICU. Dr. Holden continued that the records clearly indicate that the decedent was properly cared for and treated by these defendants, that the decedent's injuries and death are unrelated to the care and treatment provided by them, and that any action or inaction by Dr. Engelberg, or The Long Island Lung Center, LLP, did not contribute to or proximately cause the injuries and death suffered by the plaintiff's decedent.

Based upon the foregoing, Dr. Engelberg and The Long Island Lung Center, LLP have demonstrated prima facie entitlement to summary judgment dismissing the complaint. The plaintiff has not opposed this motion and therefore, has failed to raise a factual issue to preclude summary judgment.

Accordingly, motion (006) is granted and the complaint is dismissed with prejudice as asserted against Dr. Engelberg and The Long Island Lung Center, LLP.

In motion (005), the plaintiff seeks an order precluding those defendants remaining in this action from asserting the limited liability protection afforded by Article 16 against the defendants who have been granted summary judgment dismissing the complaint against them. In that none of the defendants have opposed any of the motions or submitted expert affirmations asserting liability against one another, and the plaintiff has opposed only the motion by Dr. Hegazy. M.D., the defendants, Dr. Manal Hegazy and Island Surgical and Vascular Group, P.C., are hereby precluded from asserting the limited liability protection afforded by Article 16 as to any other co-defendant at the time of trial (*see,* ***Dembitzer v Broadwall Management Corp,*** 2005 NY Slip Op 50303U, 6 Misc 3d 1035A, 800 NYS2d 345, 2005NY Misc LEXIS 420; citing ***Hanna v Ford Motor Co.***, 252 AD2d 478, 479, 675 NYS2d 125 [2d Dept [1998]). Here, it would be cold comfort to the defendants against whom summary judgment has been granted, and to the plaintiff, if the remaining defendants were permitted to assert the limited liability protection afforded by Article 16. Dr. Hegazy and Island Surgical and Vascular Group, P.C. had the opportunity to do so at the time of these summary judgment motions and failed to do so. Thus, they are precluded from doing so at the time of trial.

Accordingly, motion (005) is granted.

Dated: February 2, 2012

J.S.C.

____ FINAL DISPOSITION __X__ NON-FINAL DISPOSITION