Macias v Ferzli
2012 NY Slip Op 33812(U)
November 1, 2012
Supreme Court, Kings County
Docket Number: 500000/06
Judge: Marsha L. Steinhardt

At an IAS Term, Part 15 of the Supreme Court of the State of New York, held in and for the County of Kings, at the Courthouse, at Civic Center, Brooklyn, New York, on the 3rd day of October, 2012.

PRESENT:

HON. MARSHA L. STEINHARDT,
Justice

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MILTON MACIAS and GLADYS RIVERA, as Co-Administrators of the Estate of JACQUELINE ANDRADE, for the Benefit of her Infant Sons, MILLER AND ERICKSON,

Plaintiffs,

-against-

GEORGE FERZLI, M.D., GEORGE FERZLI, M.D., P.C., ARMANDO CASTRO, M.D., PETER GERARD BAUER, M.D., PAMELA BOWEN, M.D., "MARY" NALBANDIAN, M.D., EVELYN ANSA, M.D., "JOHN" MURALI, M.D., HUSAN RIMAWI, M.D., GHAZALI CHAUDRY, M.D., and LUTHERAN MEDICAL CENTER,

Defendants.

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DECISION AND ORDER

Index No. 500000/06

Mot. Seq. #14, 15, 16

The following papers numbered 1 to 21 read herein:	Papers Numbered
Notice of Motion/Order to Show Cause/ Petition/Cross Motion and Affidavits (Affirmations) Annexed	1-3, 4-6, 7-9
Plaintiffs' Opposing Affidavits (Affirmations)	10-11
Defendants' Reply Affidavits (Affirmations)	12, 13, 14-15
Plaintiffs' Supplemental Opposing Affidavits (Affirmations)	16-17
Defendants' Supplemental Reply Affidavits (Affirmations)	18, 19-20, 21

[1] The caption is conformed in accordance with the Court's order, dated January 12, 2012.

Defendants ARMANDO CASTRO, M.D., GEORGE FERZLI, M.D., GEORGE FERZLI, M.D., P.C., PETER GERARD BAUER, M.D., "MARY" NALBANDIAN, M.D., KANNAN MURALIKRISHNAN, M.D. (incorrectly sued herein as "JOHN" MURALI, M.D.), and LUTHERAN MEDICAL CENTER move or cross-move for summary judgment.[2] Plaintiffs oppose, except with respect to "MARY" NALBANDIAN, M.D.

Now upon the foregoing papers and after oral argument and due deliberation had thereon, the cross motion of the defendants ARMANDO CASTRO, M.D., GEORGE FERZLI, M.D., and GEORGE FERZLI, M.D., P.C. (sequence No. 16); the branch of the amended motion of the defendants PETER GERARD BAUER, M.D. and "MARY" NALBANDIAN, M.D. (sequence No. 15); and the motion of the defendants KANNAN MURALIKRISHNAN M.D., incorrectly sued herein as "JOHN" MURALI, M.D., and LUTHERAN MEDICAL CENTER (sequence No. 14); are each granted in every respect. The action is severed and continued against the remaining defendants Pamela Bowen, M.D., Husan Rimawi, M.D., and Ghazali Chaudry, M.D.

Background

This is an action sounding in medical malpractice and lack of informed consent wherein plaintiffs claim that the moving defendants failed to obtain the decedent's informed consent to surgery, performed unnecessary surgery (more specifically, removal of a gastric

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[2] The action against the moving defendants "JUN" LI, M.D. and ALLEN COOPERSMITH, M.D. was dismissed by order of the Court, dated January 12, 2012, as these defendants were never served or brought into this action, and the Clerk was directed to strike their names from the caption.

band), failed to monitor her vital signs post-operatively, prematurely discharged her from the recovery room to the Labor & Delivery service, caused or permitted her to suffer an aspiration and respiratory distress, failed timely and properly to treat her oxygen deficiency, and caused her death as well as the death of her then 22-week-old fetus. The action against defendant Evelyn Ansa, M.D. was discontinued by stipulation of the parties. As noted, the action against the moving defendants "JUN" LI, M.D. and ALLEN COOPERSMITH, M.D. was dismissed by order of the Court, dated January 12, 2012. Defendants Pamela Bowen, M.D., Husan Rimawi, M.D., and Ghazali Chaudry, M.D. have not appeared in this action, but plaintiffs have sought no default judgment against them.

Plaintiffs' decedent Jacqueline Andrade (the patient) was a 32-year-old Ecuadorian-born nursing aide who resided with her boyfriend and two children in Brooklyn. She was 5'1" tall and weighed about 255 pounds at the time when the events giving rise to this action occurred. Although morbidly obese, she apparently had no other major health problems. Her heart and lungs were within the normal limits, and she had no diabetes. She abused no drugs or alcohol. She delivered her first child (a boy) via a C-section. She delivered her second child (also a boy) via a normal spontaneous vaginal delivery.

In October 2002, eighteen months prior to the events at issue in this action, she underwent a laparoscopic gastric band placement by Dr. Ferzli at Victory Memorial Hospital. A gastric band is a long-term surgical obesity treatment in which an inflatable silicone band is placed in a ring around the upper stomach, creating an upper stomach pouch to limit the

amount of food that can be consumed. The band is connected by tubing to an access port that is placed in a muscle layer beneath the skin. The tightness of the band regulates the opening of the upper stomach pouch. The degree to which food intake is restricted is changed by a percutaneous addition or removal of saline from the band through the access port from time to time in the months and years after placement of the band (Castro Tr at 13-14). When it is initially placed, the port contains no saline so as to make the band maximally unrestrictive.

One week post-surgery, the patient followed up with Dr. Ferzli in his office to remove sutures. She was a "no show" for all three follow-up appointments. She never had any subsequent surgery to reposition the gastric band or its port. She never had a band adjustment (a percutaneous injection of the gastric band with saline through the port). There is no claim in this action concerning Dr. Ferzli's initial implantation of the gastric band.

In February 2004, the patient became pregnant with her third child. Her estimated date of delivery was for the end of October 2004. Pregnancy did not require removal of a gastric band.

In March 2004, the patient, then five weeks' pregnant, presented to the physicians' office of George Ferzli, M.D., P.C. She was seen by Dr. Castro, who was then employed as a fellow in laparoscopic surgery by the physicians' office and was practicing at Lutheran Medical Center (Castro Tr at 11-12, 37-38). She stated to Dr. Castro that she had difficulty when she was eating fast and that she had lost no weight since her gastric band surgery

16 months prior. Dr. Castro advised the patient against removal of a gastric band because general anesthesia was dangerous to a fetus in the first trimester.

On June 7, 2004, the patient returned to the physicians' office where Dr. Ferzli examined her. His physicians' office note indicated that his evaluation of the patient revealed no abnormalities and that he desired the patient to continue through her pregnancy without removing her gastric band. Although the patient considered to have the gastric band removed, Dr. Ferzli advised her to carry on with her pregnancy and to revisit the status of her gastric band after she delivered her baby. He scheduled a return visit in three weeks. At his pretrial deposition, he testified (at page 112) that removal of a gastric band was "not something we want to jump into . . . for any reason unless [it is] an emergency and in general, we should continue with the band [for] as long as possible . . ."

June 8-9, 2004 (Initial Visit to the Emergency Department; Overnight Stay; Discharge)

On June 8, 2004, at 5:31 P.M., the patient, then weighing about 255 pounds, presented to the Emergency Department at Lutheran Medical Center (LMC), complaining of pain in the area where she had her gastric band surgery, and also complaining of pain on swallowing. She was evaluated in the Labor and Delivery (L&D) service. Surgical consult was obtained from Dr. Chaudry, then a laparoscopic surgery fellow in the physicians' office of Dr. Ferzli, but Dr. Chaudry recommended no CT scan or other imaging studies. The patient was kept overnight in the L&D service where she received IV fluids, and, at night, an injection of Demerol (an opiate). She awoke at 7 A.M. and vomited once. Her diagnosis at 3 P.M. on

June 9 was intrauterine pregnancy and nausea/vomiting. According to an untimed nursing note, her pain was unlikely to be pregnancy-related. She was discharged home on June 9 with instructions to see a surgeon as soon as possible to evaluate the condition of her gastric band. At discharge, she was provided with a referral form indicating that she had vomited for the preceding four days, that she had lost 15 pounds in the preceding four weeks, and that she needed her abdominal pain evaluated.

June 10, 2004 (Return to the Emergency Department; Admission to LMC)

On June 10, at 8:40 A.M., the patient returned to the Emergency Department at LMC, with complaints of nausea/vomiting and constipation for the preceding four-five days. She explained that she had not experienced morning sickness during either her current pregnancy or her two prior pregnancies. She stated that she ate only a small amount of food, but that since the prior Sunday, June 6, 2004,[3] she had been unable to hold down any food, was retching "streaks with bloody sputum," and could feel her gastric band, which until then had not bothered her. The initial plans of the Emergency Department staff were to schedule a surgery consultation and to provide IV hydration. She was admitted to the L&D service by an obstetrician, the defendant Husan Rimawi, M.D., with complaints of constipation, vomiting, tenderness, and epigastric pain in the area of her gastric band. According to the physicians' orders section in her hospital records, the patient was immediately placed on the

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[3] June 10, 2004 was a Thursday. By the court's calculation, the prior Sunday fell on June 6, 2004. It is well-settled that courts will "notice that a particular date falls on a particular day of the week" (Jerome Prince, Richardson on Evidence § 2-204 [Farrell 11th ed 1995]).

NPO (nothing by mouth) status. The daily nursing antepartum assessment records indicated that the patient was NPO for the entire day of June 10. At 11:15 A.M., she was given Pepcid (an antacid) intravenously and a Tylenol suppository rectally. A standing order was issued for Pepcid intravenously twice a day at 10 A.M. and 10 P.M., for June 10 through 16. At 1:45 P.M., she received her Demerol (an opiate) and Phenergan (an antiemetic). At 9 P.M., she received another dose of Demerol and Phenergan. Demerol and Phenergan were repeated at 11:35 P.M. and 11:40 P.M., respectively.

June 11-14, 2004 (Patient's Monitoring; Search for the Root Cause; Upper Endoscopy)

On June 11, the patient vomited in the morning. At 10:35 A.M., an ultrasound study of the patient's abdomen indicated that her pancreas was within the normal limits and that her gallbladder showed no definite evidence of gallstones. A consulting nutritionist recommended that if the patient stopped vomiting, she should be given some soft/bland/low-fat food in six small meals, but that if she continued vomiting, she should receive total parenteral nutrition. At 10:20 A.M., she received Toradol (an anti-inflammatory). At 9 P.M., she received her Demerol and Phenergan. The daily nursing antepartum assessment records indicated that the patient was NPO for the entire day.

On June 12, the patient continued NPO, according to the fluid balance records for that day. On June 13, a 2 A.M. nursing noted indicated that the patient vomited about 30 cubic centimeters (or 1 fluid ounce). At 10:30 A.M., she was administered a stool softener suppository, but she still produced no bowel movement. A 4 P.M. note by an obstetrical

resident indicated that the patient was unable to tolerate a clear liquid diet and that she complained of nausea, epigastric pain, and backache. She was continued on Pepcid. A 5 P.M. nursing note stated that she still complained of nausea and vomiting. She remained NPO, according to the fluid balance records for that date.

On June 14, an untimed nursing note reiterated that the patient was to be kept NPO. An untimed perinatology note stated that the patient had vomited all throughout the prior day (June 13), was not tolerating any diet, and produced no bowel movement for the preceding six days. A 1:20 A.M. note reflected that she was complaining of epigastric pain. At that time, her oxygen saturation was 99% on ambient air. Some time during the day, the patient was examined by the defendant Dr. Muralikrishnan (an obstetrical resident), who recommended a surgical consultation. At 9 A.M., an upper endoscopy was ordered to rule out a potential gastric obstruction and to measure the size of her gastric opening. The patient was then examined by Dr. Castro, who summarized his examination of the patient in the following untimed note:

> "Surgical attending. [The patient] still with persistent nausea/vomiting even with clears [*i.e.*, with a clear liquid diet] . . . Will consult Dr. Rivito for EGD [upper endoscopy]. May require nasogastric tube. *Patient wishes to have lap band removed if nausea/vomiting persists*" (emphasis added).

Dr. Castro, in his pretrial testimony (at pages 50-51 of his deposition), listed four potential causes of why, in his view, the patient continued to suffer from nausea/vomiting:

> "[1] Her being pregnant, it could have been she was having hyper emesis [vomiting] from pregnancy or [2] that she was

> having dys[phagia] [difficulty swallowing] or [3] issues relating to the amount or the speed with which she took in fluids or solids that may have led to the nausea and vomiting . . .
>
> . . . [4] It could have been an issue with the band itself."

A 10 A.M. to 12 P.M. note indicated that the patient was complaining of lower flank back discomfort and a mild shortness of breath. At 1:10 P.M., she received Maalox (an antacid). A 3:45 P.M. nursing note stated, "NPO status reinforced." An untimed note from Dr. Rivito, the performing endoscopist, stated, "endoscopy with [a] *pediatric scope*[;] status post lap banding with narrowing of proximal body of her stomach. No difficulties in going into atrium and duodenum" (emphasis added). Dr. Rivito's typewritten report of his upper endoscopy on the patient summarized his impressions and his recommendation, as follows:

> Impressions:
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> "1. The esophagus appeared normal.
> 2. Narrowing in the proximal body consistent with banding.
> 3. *Large amount of fluid in the body proximal to the banding.*
> 4. The duodenum appeared normal."
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> Recommendation:
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> "*Consider removing banding if vomiting persists*" (emphasis added).

A 6:10 P.M. note indicated that the results of the patient's upper endoscopy were reported to Dr. Ferzli. This note continued, "Dr. Ferzli to come and evaluate [the] patient in the morning and counsel her re tube feeding or removing the band. As per Dr. Ferzli, [the] patient could have [a] clear liquid diet." An untimed entry in the physicians' orders section of the hospital records stated, "clear liquid diet (no jello)." A 6:30 p.m. nursing note indicated that the "patient tolerated clear liquid diet with no jello . . . No hemoptysis [blood

in sputum] noted . . ." According to the fluid balance records, the patient received 120 cubic centimeters (or about four fluid ounces) of tea at 6-7 P.M., plus 80 cubic centimeters (or about 2.7 fluid ounces) of water at 9-10 P.M. on that day. At 9 P.M., the patient received her Demerol, plus Vistaril (an antiemetic). At 11 P.M., she received another dose of Vistaril.

June 15, 2004 (the Day Before Surgery; Patient's Consent)

On June 15, a 7 A.M. nursing note stated that the patient was spitting up a large amount of sputum. A 7 A.M. physician's note stated that the patient had a clear diet, vomited only once (as per a nurse, it was mostly "sputum like"), but experienced no bowel movement for the preceding seven days. According to the physician's note, Dr. Ferzli was to evaluate the patient and counsel her regarding "tube feeding versus removal of the gastric band."

It was Dr. Castro, rather than Dr. Ferzli, who reviewed the results of the patient's upper endoscopy and examined her. According to Dr. Castro's pretrial testimony (at pages 57-58 of his deposition), at the time of his examination of the patient, he had ruled out all of the four potential causes of her continued nausea/vomiting:

> "[1] [T]he hyper emesis I would refer to the OB [obstetrics] service, and in reviewing the chart it seemed that she didn't have that with her previous pregnancies, nor was it usual for this pregnancy. So that was not likely the cause. [2-3] Relating to her . . . dys[phagia] . . . [i]n recalling that she had previously mentioned in my [March 2004] visit in the office that she ate too much and she was having difficulty with that, obviously at this point, she wasn't really eating food, . . . she was only having liquids, or . . . that's the only issue she was having, the nausea and vomiting with it, would be unlikely that that was the cause. [4] The result of the EGD [upper endoscopy] indicated there wasn't an obstruction. They were able to pass the tube or scope

> easily, so the likelihood of it being an obstruction caused by the band itself was highly unlikely."

At his pretrial deposition (at page 58), Dr. Castro admitted that he did not know the exact cause of the patient's continued nausea/vomiting, but decided that removal of the gastric band was appropriate as the last resort because the patient wanted it removed. As he explained (at page 58 of his pretrial deposition):

> "[I]t was difficult for me to understand why she would be having it [nausea/vomiting] at all, but *the fact of the matter is that she was having it, and she was uncomfortable with it and she wanted her lap band [i.e., gastric band] removed*" (emphasis added).

An untimed note by Dr. Castro reflecting his examination and recommendation to the patient on June 15 stated:

> "Surgery attending for Dr. Ferzli. Patient not tolerating liquid diet, with persistent nausea/vomiting. *Explained to patient options of placement feeding tube for nutritional support versus removal of lap band. Risks/benefits/alternatives to removal of band [were] discussed with patient (including feeding tube), including* bleeding, infection, intestinal injury, *death*, loss of pregnancy. *Patient understands and wishes to have [the] lap band removed*" (emphasis added).

While the patient desired to have her gastric band removed, Dr. Castro and his colleagues, Drs. Ferzli and Chaudry, preferred a feeding tube, which was less invasive and would have given her the required nutritional support (Castro Tr at 62-63). Dr. Castro testified (at pages 63-64 of his pretrial deposition) that he recommended a feeding tube to the patient. Yet, the patient was "very adamant about wanting the band removed" and rejected

Dr. Castro's recommendation (Castro Tr at 64, 71-72, 83, 90). Dr. Castro explained (at page 65 of his pretrial deposition) that he followed the patient's preference and performed surgery because "she had something foreign in her GI tract . . . that we would want to exclude completely. We tried to exclude it functionally by getting an EGD [upper endoscopy]. The only way to exclude it without question would be to remove it altogether." Dr. Castro concluded (at page 66 of his pretrial deposition) that, in hindsight, "the band wasn't causing the obstruction." He quantified (at pages 67 and 69 of his pretrial deposition) at 50-50 the probability that either surgery or a feeding tube could resolve the patient's nausea/vomiting. Although both surgery and a feeding tube had an equal probability of success, Dr. Castro left the ultimate decision to the patient, explaining (at pages 75-76, 84 of his pretrial deposition) that he owed no obligation to her *not* to pursue a course of treatment whose risks outweighed its benefits, unless such course of treatment subjected her to any "undue harm," which was not the case with surgery. In accordance with her wishes, she was scheduled for surgery the following day (Castro Tr at 80). In Dr. Castro's words, "we needed to offer her something," even if that offer ultimately "may or may not have done anything to relieve her symptoms" (Castro Tr at 78). The three surgeons (Drs. Castro, Ferzli, and Chaudry) "were all in agreement if this is the way the patient wanted to proceed, that's the way [they] would proceed," subject to the "operating room availability and timing and surgeon availability that someone in the[ir] group would perform the [band] removal" (Castro Tr at 88-89).

An 11:22 A.M. note on June 15 stated that the patient's physical examination revealed tenderness in the left upper quadrant of her stomach. At 1 P.M., she received Maalox. At 2 P.M., the patient had an oral intake, which was "fair" (50-74%), according to the daily nursing antepartum assessment records. The fluid balance records reflected that the patient received 150 cubic centimeters (about 5 fluid ounces) of soup at 5-6 P.M. and an additional 50 cubic centimeters (about 1.7 fluid ounces) of soup at 8-9 P.M. on that day. A 2:20 P.M. nursing note stated that the patient had no nausea/vomiting. A 4:25 P.M. pre-anesthesia examination noted no anesthetic complication. Some time in the evening, the patient had another oral intake, which was also "fair," according to the daily nursing antepartum assessment records. In anticipation of the next day's surgery, the patient was placed NPO starting at midnight. At 9:30 P.M., she received her Demerol and Vistaril.

June 16, 2004 (Surgery; Recovery Room; Discharge to the L&D Service; Patient's Sudden Deterioration)

On June 16, a 3:30 A.M. nursing note stated that the patient had complained of slight nausea. She was spitting up white "fluid" (phlegm). The patient complained of discomfort in the left upper quadrant of her stomach. An untimed perinatology note stated that the patient was having mild to moderate abdominal pain and was positive for vomiting. According to the physicians' orders section of the hospital records, the patient received her Demerol and Vistaril at 2:45 A.M. A 9 A.M. nursing note indicated that the patient was not vomiting. According to the vital sign records, the patient's blood pressure, as measured at midnight, at 4 A.M., and at 8 A.M. ranged from 91/60 to 108/67.

A 9 A.M. nursing note stated that the patient understood the nature of surgery and reaffirmed her consent. Between 9:45 A.M. and 10:45 A.M., Dr. Castro, with the assistance of Dr. Chaudry as surgeon and Dr. Bauer as anesthesiologist, removed the gastric band. Dr. Castro's operative report designated the patient's pre- and post-operative diagnoses as a "gastric obstruction." According to Dr. Castro's operative report and his pretrial deposition testimony, surgery was uneventful. The operative anesthesia record by Dr. Bauer stated that the patient underwent 1½ hours of anesthesia from 9:30 A.M. to 11 A.M. An untimed pre-anesthesia note by Dr. Bauer indicated that the patient had a rating of III (a severe systemic disease, such as a morbid obesity) under the guidelines of the American Society of Anesthesiologists. At the conclusion of the patient's surgery at 10:45 A.M., Dr. Bauer administered Anzemet (an antiemetic) and Toradol (an anti-inflammatory). An operating room check for her gag reflex was positive; no retching, vomiting, or obstruction was noted. A 10:45 A.M. nursing note stated, "as per surgery, [the] patient could have [a] clear liquid diet for [a] couple of days. Could be discharged home in A.M. if no complications are [identified]. Patient has [an] appointment with surgery next Wednesday [*i.e.*, one week after surgery]. Patient to be given Pepcid by mouth upon discharge." The plaintiff was extubated in the operating room and transferred to the recovery room in stable condition.

A recovery room nursing note stated that the patient was admitted to the recovery room at 11 A.M. and discharged to the L&D service at 12:30 P.M. An 11:00 A.M. recovery room admission note by Dr. Bauer stated that, upon her admission to the recovery room, her

oxygen saturation was 100%. During her 1½-hour stay in the recovery room, she was on supplemental oxygen delivered by nasal cannula at 3 liters per minute. Her first reading of oxygen saturation at 11 A.M. was 96%. Her last reading of oxygen saturation at 12:15 P.M. was 95%. Her oxygen supplementation was turned off at 1 P.M. It appears that her oxygen saturation was not measured between 1 P.M. and 3:19 P.M. In the additional comments section of the recovery room nursing note, the nurse then on duty (Nurse Melissa Weber) indicated that the patient was not complaining of pain and had not experienced nausea/vomiting. In the same section of her recovery room note, the nurse indicated that the patient was "tolerating ice chips," thus suggesting that the nurse provided her with ice chips. In an untimed recovery room discharge note, nonparty anesthesiologist Dr. Coopersmith approved the release of the patient to the L&D service. It does not appear from Dr. Coopersmith's note that the patient was provided supplemental oxygen upon her discharge from the recovery room to the L&D service.[4]

The patient was admitted to the L&D service at 1 P.M. At 1:30 P.M., she was given Pepcid intravenously. At 3 P.M., she received her Demerol and Phenergan. A 3:20 P.M. "late entry" nursing note indicated that the patient complained of difficulty breathing.[5] Defendant Dr. Muralikrishnan (an obstetrical resident), nonparty Dr. Li (an anesthesiologist), and an

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[4] According to Dr. Bauer (at pages 74-75 of his deposition), he did not recall whether the patient was receiving oxygen by nasal cannula when he arrived at her bedside at about 3:30 P.M.

[5] The assertion in ¶ 19 of plaintiffs' expert affirmation that a late entry nursing note made it clear that by 3:20 P.M. the patient was "continuing" to have difficulty breathing is without factual support. The note does not use the word "continuing" and does not suggest the existence of any respiratory difficulty before 3:20 P.M.

unidentified surgeon were then at the patient's bedside. According to this nursing note, the patient's oxygen saturation was 80-82%.[6] In fact, the patient's oxygen saturation, as measured at 3:19 P.M., was 73.3%. Arterial blood-gas levels were obtained at 3:19 P.M., reporting that the patient's Po_2 was at 38.7 mmHg (normal 80-100), which suggested oxygen deficiency. Dr. Bauer was summoned, arriving at the patient's bedside in a "couple of minutes" at about 3:30 P.M. (Bauer Tr at 72, 80). At about 3:30 P.M., administration of oxygen by non-rebreather mask at ten liters per minute, as directed by Dr. Bauer, was in progress. An additional untimed nursing note stated that the patient's blood pressure was critically low at 74/32. Despite the administration of oxygen at 100% by non-rebreather mask, the patient remained in respiratory distress, although her blood pressure did rise slightly to 95/50. Per Dr. Bauer's instructions, the patient then received Albuterol (a bronchodilator) by nebulizer, but her oxygen saturation failed to improve. A few minutes later, Dr. Bauer intubated the patient and connected her endotracheal tube to an Ambu-bag. Dr. Bauer and other personnel manually squeezed the Ambu-bag for at least one hour to keep the patient breathing (Bauer Tr at 96). At some point, Dr. Bauer transported her to the surgical Intensive Care Unit (ICU), with the assistance of, among others, the defendant Dr. Mary Nalbandian. The patient arrived at the ICU at or after 4:35 P.M., according to a note by the defendant Dr. Pamela Bowen. The patient was placed on a ventilator at 5 P.M. Dr. Bauer remained at the patient's bedside at the ICU until 5:15 P.M.

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[6] "An oxygen saturation level below 90% is not normal, and a level below 88% is 'bad.' A level of 70% is indicative of hypoxemia, which shows that the blood has a low level of oxygen, and indicates a danger of respiratory distress" (*Cregan v Sachs*, 65 AD3d 101, 105 [1st Dept 2009]).

A 4:35 P.M. ICU/critical care medicine note by Dr. Pamela Bowen stated in the assessment/plan portion of her note, "respiratory failure/shock. Full ventilator support . . . Cannot rule out thromboembolitic disease, though likely ARDS [acute respiratory distress syndrome] etiology. [Question mark] aspiration." Dr. Pamela Bowen ordered a spiral CT scan to rule out pulmonary embolism. This scan was performed two days later on June 18.

A 5 P.M. ICU nursing note stated that the patient was received from the L&D service intubated, accompanied by an anesthesiologist, and Ambu-bagged at 100% of Fio_2 (concentration of oxygen in the inspired air). The note further stated that when the patient was connected to a cardiac monitor, she became restless. Her facial area was cyanotic. A 5 P.M. surgical attending note stated that, despite the ventilator settings of the positive end-expiratory pressure at 15 and Fio_2 at 100%, the patient's oxygen saturation was only 92%. According to the critical care clinical records, the patient's oxygen saturation fluctuated between 81% and 93% during her first hour on the ventilator at 5 P.M.-6 P.M. According to the same records, her blood pressure was abnormally low at 80/31 at 5:45 P.M. and at 76/23 at 6 P.M., necessitating repeated injections of ephedrine. A 7 P.M. ICU nursing note documented the patient's blood pressure at 74/32. According to the ICU nursing note, when the patient failed to respond to a challenge of two liters of fluid via a nasogastric tube, she was started on Levophed (a vasopressor) to boost her blood pressure. She also was placed on Heparin (an anticoagulant) to prevent any clotting that could result from her immobility.

At 4:41 P.M., a chest X ray found pulmonary congestion and possible early infiltration of the patient's right lower lobe. At 6 P.M., a chest X ray revealed that her lungs contained

"mild pulmonary venous congestion, small left pleural effusion and right and mid and lower lobe infiltrates with air bronchogram." At 9:49 P.M., a repeat chest X ray stated, "[t]here is interval increased in the pulmonary venous congestion and the small bilateral pleural effusion as compared to the [6 P.M.] exam . . ." Arterial blood-gas levels at 7:44 P.M. and 11:23 P.M. were outside the normal range in each of the categories of Pco_2, Po_2, and Hco_3, indicative of her ongoing respiratory distress, despite her oxygen saturation of 93.6-99.5%.

June 17-29, 2004 (Continuing Deterioration; Death)

On June 17, the patient's blood pressure was still low at 97/48, despite prior administration of Levophed. She was continued on Propofol for sedation and on Heparin for anticoagulation. Her extremities were positive for edema (swelling). The assessment/plan were respiratory failure, acute respiratory distress syndrome secondary to aspiration versus pulmonary embolism. A 2:20 P.M. note stated, "Assessment/Plan: respiratory failure, respiratory distress syndrome. Pulmonary embolism was less likely, but could not be excluded."

On June 18, a 2 A.M. nursing note stated, "suctioned off minimal to moderate amounts of blood tinged secretions." The patient remained on Levophed to maintain her blood pressure, which was then between 90/50 and 93/49. A report of a spiral CT scan with infusion stated that the radiologist could not determine whether the patient had (or did not have) pulmonary embolism because of the suboptimal techniques used, and recommended that the patient undergo another spiral CT scan with proper techniques or, in the alternative,

a lung ventilation/perfusion scan. No CT scan or a ventilation/perfusion scan was subsequently performed to rule out pulmonary embolism. Rather, the treating physicians interpreted the CT scan results as a conclusive finding of no pulmonary embolism. Specifically, a 1:45 P.M. surgical attending note stated that a spiral CT scan, in a preliminary report, found no evidence of central pulmonary embolism. Nevertheless, this CT scan disclosed that the patient suffered from bilateral air space disease with ground glass opacities. An undated pulmonary attending note diagnosed the patient with acute respiratory distress syndrome/respiration pneumonia.

Between June 19 and 28, the patient continued on mechanical ventilation. By June 22, she suffered a barotrauma with bilateral pneumothorax (collapsed lungs), which required the placement of chest tubes. After further complications, the patient died at LMC in the late evening of June 28. Her unborn child died with her. An autopsy report by the Office of the Chief Medical Examiner described the manner of her death as a "therapeutic complication."

The Standard of Review

"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" (*Winegrad v New York Univ. Med. Ctr.*, 64 NY2d 851, 853 [1985]). "Failure to make a prima facie showing requires denial of the motion, regardless of the sufficiency of the opposing papers" (*id.*). Once the proponent's burden is

met, the burden shifts to the opposing party to establish the existence of a material issue of fact (*see Alvarez v Prospect Hosp.*, 68 NY2d 320, 324 [1986]).

To establish the liability of a physician for medical malpractice, "a plaintiff must prove that the physician . . . departed from accepted community standards of practice, and that such departure was a proximate cause of the plaintiff's injuries" (*Stukas v Streiter*, 83 AD3d 18, 23 [2d Dept 2011]). A defendant physician seeking summary judgment must make "a prima facie showing that there was no departure from good and accepted medical practice or that the plaintiff was not injured thereby" (*id.* at 24). To defeat summary judgment, "the nonmoving party need only raise a triable issue of fact with respect to the element of the cause of action or theory of nonliability that is the subject of the moving party's prima facie showing" (*id.*). "General allegations that are conclusory and unsupported by competent evidence tending to establish the essential elements of medical malpractice are insufficient to defeat a defendant's motion for summary judgment" (*Savage v Quinn*, 91 AD3d 748, 749 [2d Dept 2012]). A plaintiff's expert must address all of the pivotal facts relied upon by the defendant's expert in order to establish the existence of a material issue of fact (*see Dimitri v Monsouri*, 302 AD2d 420, 421 [2d Dept 2003]).

The Defendant Surgeons –
Dr. Castro, Dr. Ferzli, and George Ferzli, M.D., P.C.

Dr. Castro, the operating surgeon, his employer, George Ferzli, M.D., P.C., and the employer's owner, Dr. Ferzli (collectively, the defendant surgeons), cross-move for summary judgment dismissing all claims insofar as asserted against them. In support of their cross motion, these defendants submit, among other things, the hospital records, the office records

of George Ferzli, M.D., P.C., and pretrial deposition testimony of Dr. Castro and Dr. Ferzli.

In support of their cross motion, the defendant surgeons submit expert affirmations of Dan Reiner, M.D., a New York state licensed physician who is board certified in surgery and surgical critical care. Dr. Reiner opines, to a reasonable degree of medical certainty, that the defendant surgeons acted in accordance with good and accepted surgical practice in obtaining the patient's consent, in performing surgery, and in providing post-operative care and treatment, and that the same was not a substantial factor in her injuries and death. With respect to the issue of the patient's consent and the need for surgery, Dr. Reiner asserts (in ¶ 10 of his opening affirmation) that, although the patient's upper endoscopy was within normal limits, "it is always an option for the patient to request and obtain removal of the lap band if other measures to reduce nausea and vomiting are unsuccessful." Dr. Reiner maintains (in ¶ 11 of his opening affirmation) that "[s]uch was the case for [the patient]," and "she requested, and consented to, laparoscopic removal of the lap band."

Next, Dr. Reiner opines that the defendant surgeons should be absolved from any responsibility regarding for the patient's post-operative care. "It is the responsibility of the recovery room team to determine when a patient is sufficiently recovered from anesthesia for discharge from the recovery room," Dr. Reiner opines (in ¶ 11 of his opening affirmation), and "[t]his facet of patient care is not the responsibility of the surgical team or surgeon." In this connection, Dr. Reiner distinguishes between a "surgical" and a "medical" event. According to Dr. Reiner (in ¶ 12 of his opening affirmation), "the record does not indicate

that [the patient] subsequently suffered some type of *surgical* related event. Quite to the contrary, she suffered some type of *medical* event – namely some type of respiratory dysfunction which resulted in respiratory distress" (emphasis added). Dr. Reiner points out (in ¶ 14 of his opening affirmation) that the medical examiner's record suggests that the patient "sustained some type of respiratory event after the surgery after the patient was no longer in the acute surgical care of Dr. Castro." "It is for this reason," Dr. Reiner concludes (in ¶ 14 of his opening affirmation), that "the care and treatment by [the defendant surgeons] was not a substantial factor in the development of [the patient's] respiratory event, her pain and suffering, or her subsequent death." The Court finds that the defendant surgeons have made a prima facie showing of their entitlement to judgment as a matter of law through their expert's opening affirmation and through their entries in the hospital records and in the physicians' office records.

In opposition, plaintiffs' expert affirmation[7] unsuccessfully challenges the validity of Dr. Reiner's opinions. With respect to the need for surgery, plaintiffs' expert affirmation contends that once the upper endoscopy revealed no obstruction, surgery to remove the gastric band became unnecessary and the patient, instead, could have been treated with intravenous fluids and vitamins until her nausea/vomiting was resolved. This general statement, however, lacks sufficient specificity or certainty to create a question of fact as to whether Dr. Castro's decision to perform surgery – in the face of the patient's continuing

[7] Because the supplemental affirmation of plaintiffs' expert subsumes in content their expert's initial affirmation, the Court cites solely to plaintiffs' expert supplemental affirmation.

symptoms suggesting an obstruction and Dr. Rivito's recommendation to consider removal of the gastric band – was a deviation from the standard of care (*see Helfer v Chapin*, 96 AD3d 1270, 1272 [3d Dept 2012]).

First, plaintiffs' expert affirmation neglects to consider the patient's history of abdominal complaints following the placement of a gastric band. Plaintiffs' expert affirmation ignores the undisputed fact that the patient had been uncomfortable with her gastric band as early as March 2004 when, after more than a year's absence and three "no shows," she returned to the physicians' office where she initially saw Dr. Castro and later Dr. Ferzli. Plaintiffs' expert affirmation misses the crucial fact that the patient complained of abdominal pain in the location of her gastric band during her initial visit to LMC on June 8, 2004, that she complained of abdominal pain and nausea/vomiting in her subsequent visit to LMC on June 10, 2004, and that she continued to so complain until her surgery six days later.

Second, contrary to the position of plaintiffs' expert, the results of the patient's upper endoscopy did not foreclose surgery. As an initial matter, plaintiffs' expert affirmation glibly passes over the fact that the patient's upper endoscopy was performed with a *pediatric* endoscope, which is obviously thinner and shorter than a regular endoscope that is used on adults. The fact that a pediatric scope passed all the way through to the patient's duodenum merely ruled out a *complete* obstruction. Indeed, the upper endoscopy revealed a "[l]arge amount of fluid in the body proximal to [*i.e.*, above] the banding." It stands to reason that,

if the patient experienced no obstruction whatsoever, she would not have had so much fluid collected in her esophagus and, as a result, the endoscopist would not have recommended removal of her gastric band.

More fundamentally, plaintiffs' expert affirmation focuses on distractions and grasps at straws in an attempt to bolster plaintiffs' untenable position that surgery was unnecessary and unwarranted. According to their expert affirmation (in ¶ 16), "*[a]pparently* unbeknownst to her [the patient], this surgery was both unnecessary and unwarranted . . . ." (emphasis added). However, Dr. Castro's entries in the hospital records, coupled with the patient's consent form, indicate that the patient preferred surgery over the placement of a feeding tube.[8] In this regard, the Court considers plaintiffs' position that surgery was not medically indicated as evidence of the allegedly negligent treatment and that they do not have a separate claim for lack of informed consent (*see Benfer v Sachs*, 3 AD3d 781, 783 [3d Dept 2004]).[9]

Next, plaintiffs' expert affirmation places undue emphasis on Dr. Castro's pretrial testimony (at pages 67-69 of his deposition) that the two alternatives which he presented to the patient – either surgery or a feeding tube – had an equal chance of success, even though surgery was obviously riskier than a feeding tube. Plaintiffs' expert affirmation posits (in

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[8] Plaintiffs have submitted no deposition testimony, if any, from the patient's boyfriend (the father of her unborn child) or her sister, both of whom visited the patient throughout her hospitalization.

[9] Moreover, plaintiffs failed to raise a triable issue of fact on the issue of informed consent, since they do not address this cause of action in their opposition papers (*see Brady v Westchester County Healthcare Corp.*, 78 AD3d 1097, 1099 [2d Dept 2010]).

¶ 25) that "[w]hen a doctor is confronted with a condition that can be treated in multiple ways, and each course of treatment, has roughly the same chance of success, the doctor must cho[o]se the course of treatment that poses the least risk to the patient." "Therefore," plaintiffs' expert affirmation maintains (in ¶ 25), "the failure of Dr. Castro to cho[o]se the least risky course of treatment needless[ly] endangered this patient . . . [and] was a violation of safe and accepted medical practice [and] caused the patient's injuries . . . [and] death." This argument rests on a false premise. The patient was the decision maker, while Dr. Castro was her adviser and surgeon. The decision whether to have surgery, or not, was the patient's, not Dr. Castro's, to make. The patient was not something of a "blank slate" upon which Dr. Castro could "write" his preference. In fact, before the patient was admitted to LMC, Dr. Castro and Dr. Ferzli each had suggested to her to take time to think about surgery. Specifically, in March 2004, Dr. Castro advised her that surgery during her first trimester of pregnancy was contraindicated. In early June 2004, Dr. Ferzli advised her to wait until after delivery of her baby to revisit the status of her gastric band. Subsequently, Dr. Castro again advised her, during her hospitalization at LMC, to consider a non-surgical intervention. By emphasizing the side effects of surgery, Dr. Castro framed his advice to her in a way that clearly reflected his own bias against surgery and in favor of a feeding tube. She, however, insisted on surgery. All evidence in the record demonstrates her conscious decision to have surgery with full knowledge that she had been offered the option of a less risky alternative. She was not a "blank slate," and she did not construct her preference for surgery on the

spot.[10] As the defense expert Dr. Reiner notes (in ¶ 4 of his reply affirmation), "[i]t was not the standard of practice . . . for Dr. Castro, when confronted with these circumstances, to refuse to perform the laparoscopic procedure (*nor does plaintiffs' physician say so*)" (emphasis added). Indeed, plaintiffs' expert affirmation fails to demonstrate that gastric band removal was not within applicable standards of practice as a treatment for the patient's symptoms if she elected surgery after being informed of its risks and its less adverse alternatives. Finally and crucially, there are significant differences in how patients and physicians weigh the goals and consequences of available treatments. Here, the patient wanted to resolve her complaints quickly and permanently by way of surgery, even though its adverse side effects were more serious than those of a feeding tube. That Dr. Castro had a different perspective for addressing the patient's complaints did not permit him to substitute his judgment for that of the patient. He could not simply tell the patient what to do without factoring in her wishes (*see Giambrone v Farha*, 34 Misc 3d 1203[A], 2011 WL 6938218, *8, 2011 NY Slip Op 52422[U] [Sup Ct, Kings County 2011] ["the principles of patient autonomy (the right of the individual to control the course of . . . her own medical treatment) that are the basis of our society and our health care system are not to be taken lightly. It has been the law of New York that a competent adult has the right to control or refuse his or her own medical treatment."] [citations omitted]).

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[10] The patient was mentally competent. No language barrier existed precluding her from understanding the risks and alternatives to surgery. Dr. Castro is bilingual in English and in Spanish, the patient's native language.

Turning to the subject of the patient's post-operative care, plaintiffs' expert affirmation charges that the defendant surgeons failed timely and properly to monitor the patient after surgery. As a threshold matter, plaintiffs' expert affirmation suggests (in ¶¶ 17 and 26) that Dr. Castro abandoned the patient when he left for vacation shortly after surgery and before she was discharged from the recovery room. However, this is not a case in which a physician left a patient without appropriate medical attention.[11] Rather, the patient was left in the care of, among others, Dr. Castro's surgical colleague, Dr. Chaudry.

Plaintiffs' expert affirmation next asserts (in ¶ 27) that "[t]he records clearly indicate that when [the patient's] condition started to deteriorate . . . the *surgeons* were made 'aware[ ]' of her condition," and that "[a]s a result of the surgeon's not attending to [the patient] post operatively, she was cause[d] to sustain a hypoxic episode . . . ." (emphasis added). This assertion is factually incorrect. A 3:20 P.M. nursing note indicates that the patient complained of difficulty breathing, that an unidentified surgeon, among others, was then present at her bedside, and that the restoration of her breathing (first via non-rebreather mask and thereafter by intubation/Ambu-bagging) was ongoing. It was not, as plaintiffs' expert affirmation implies, that "surgeons" were aware of the patient's respiratory distress but were standing idly at her bedside. To the contrary, as or when this note was written, Dr. Bauer had already been called and he had already been working on restoring the patient's

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[11] *See Alvarado v Miles*, 32 AD3d 255, 257 (1st Dept 2006), *affd* 9 NY3d 902 (2007) (to establish a prima facie case of abandonment, there must be evidence of "an affirmative 'willful abandonment' or a refusal to treat the patient").

breathing, in the presence of, among others, an unidentified surgeon. Because that particular "surgeon" was never identified, it cannot be stated with certainty, as plaintiffs' expert affirmation does, that this surgeon was either Dr. Castro or Dr. Ferzli. Indeed, Drs. Castro and Ferzli, at their pretrial depositions, denied that either of them was the "surgeon" to whom the 3:20 P.M. nursing note referred.

Lastly, plaintiffs' expert affirmation posits (in ¶ 26) that "the surgeon remains responsible for the care and treatment of the patient even after the surgery is complete." This statement is inherently broad, as it contains no limitation as to the time and scope of surgeon's post-operative obligations. It disregards the necessary division of labor in hospital units, which, in this case, were surgery, recovery room, and L&D service. It presumes, with no medical support, that Dr. Castro (or his designee) was required to monitor the patient's post-operative condition at all times. Yet, even assuming that Dr. Castro (or his designee) were required to monitor the patient's post-operative condition at all times, plaintiffs' expert affirmation fails to articulate specifically what Dr. Castro did or failed to do that is alleged to have caused the patient's injuries, nor has plaintiffs' expert affirmation established a causal connection. Consequently, nothing in the record before the Court raises a triable issue of fact as to whether the alleged acts or omissions by Dr. Castro and the other defendant surgeons delayed the discovery and, more importantly, worsened the outcome of the patient's respiratory distress (*see Garrett v University Assoc. in Obstetrics & Gynecology, P.C.*, 95 AD3d 823, 826 [2d Dept 2012]).

Significantly, plaintiffs' expert affirmation does *not* blame Dr. Castro for prescribing the patient a clear liquid diet after surgery, even though Dr. Castro testified (at pages 102-103 of his deposition) that, post-operatively, the patient retained a 50% probability of vomiting if she were given something to eat or drink, but that despite this 50% probability, he did not consider the patient to be at an increased risk of vomiting (and, hence, aspiration), and thus took no precaution to maintain the patient NPO post-operatively. It is also significant that plaintiffs' expert affirmation does *not* blame Dr. Castro for retaining a standing order for Demerol and Phenergan, both of which she received at 3 P.M., or about 20 minutes before her respiratory distress was discovered at 3:20 P.M. If, as plaintiffs' expert affirmation claims, Dr. Castro or the other defendant surgeons were required to monitor the patient post-operatively at all times, it follows that Dr. Castro should have prohibited a concurrent administration of Demerol and Phenergan about fours hours after her surgery under general anesthesia. It may be highly likely that something occurring after this surgery did cause this patient's aspiration and respiratory distress, but plaintiffs' expert affirmation has not shown on this record that Dr. Castro or the other defendant surgeons were responsible for it.

Because Dr. Castro is not directly liable to plaintiffs, Dr. Ferzli and his physicians' office, George Ferzli, M.D., P.C., likewise are not vicariously liable. Accordingly, the cross motion of Dr. Castro, Dr. Ferzli, and George Ferzli, M.D., P.C. is granted, and the complaint is dismissed as to these defendants.

The Defendant Anesthesiologists – Dr. Bauer and Dr. Nalbandian

Anesthesiologist Dr. Bauer also moves for summary judgment. In support, Dr. Bauer submits expert affirmations of Wendy Silverstein, M.D., a New Jersey licensed physician and a board-certified anesthesiologist.[12] Based upon her review of, among other things, the pleadings, deposition transcripts, and Dr. Bauer's entries in the hospital records, Dr. Silverstein opines that: (1) Dr. Bauer properly administered anesthesia to the patient during surgery, (2) the patient's stable condition in the recovery room indicated that Dr. Bauer's administration of anesthesia to her during surgery was appropriate and did not cause the patient's subsequent injuries, (3) the patient's symptoms at 3:20 P.M., while she was in the L&D service, were unrelated to the anesthesia administered to her three-four hours earlier that day and that, if there had been a problem with anesthesia, the patient would have experienced it while she was still in the recovery room, (4) Dr. Bauer correctly decided to, and did, intubate the patient at about 3:30 P.M., and (5) Dr. Bauer appropriately transported the patient to the ICU. The Court finds that Dr. Bauer has made a prima facie showing of his entitlement to judgment as a matter of law through the opening affirmation of his expert physician and his entries in the hospital records. The burden, therefore, shifts to plaintiffs

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[12] Pursuant to CPLR 2106, only a physician who is licensed to practice in New York is authorized to sign an affirmation; an out-of-state physician must make his or her statement by affidavit. Dr. Silverstein is licensed in the State of New Jersey, and as such, her affirmations are technically defective under CPLR 2106. However, this deficiency of form is deemed waived because plaintiffs have not raised the issue in opposition (*see Scudera v Mahbubur*, 299 AD2d 535 [2d Dept 2002]).

to rebut Dr. Bauer's prima facie showing by raising a triable issue of fact as to both the departure element and the causation element (*see Stukas v Streiter*, 83 AD3d 18, 25 [2d Dept 2011]).

The Court finds that plaintiffs have failed to rebut Dr. Bauer's prima facie showing on either the departure element or the causation element. First, their expert affirmation (in ¶ 20) criticizes Dr. Bauer for not signing his 3:30 P.M. note until 5:15 P.M. As Dr. Bauer explained (at page 80 of his pretrial deposition), however, he arrived at the patient's bedside at about 3:30 P.M., worked on her continuously from about 3:30 P.M. until about 5:15 P.M. to restore her breathing, and wrote his note when, at the conclusion of his efforts, she had already been connected to a ventilator in the ICU.

Second, plaintiffs' expert affirmation asserts (in ¶ 20) that "the failure to timely attend to and intubate the patient by the hospital's *anesthesiologist* is an additional violation of safe and accepted medical practice . . ." (emphasis added). The word "anesthesiologist," as used in plaintiffs' expert affirmation, is susceptible of two meanings because at least two anesthesiologists were involved in the patient's care on June 16: (1) Dr. Bauer provided anesthesia during surgery and thereafter intubated the patient at the L&D service, and (2) nonparty Dr. Coopersmith was in charge of the patient in the recovery room and signed

her out to the L&D service.[13] It is undisputed that Dr. Bauer intubated the patient promptly after he was called to her bedside in the L&D service and after his prior efforts to increase her oxygen saturation (via non-rebreather mask and Albuterol) had failed. The duty of Dr. Bauer as an anesthesiologist was circumscribed by "those medical functions undertaken by the physician and relied on by the patient" (*Wasserman v Staten Is. Radiological Assoc.*, 2 AD3d 713, 714 [2d Dept 2003] [internal quotation marks omitted]).[14] His duty was limited to providing the patient with anesthesia during surgery and to providing her respiratory support when he was called to the patient's bedside thereafter. He was not required to monitor the patient continuously post-operatively either while she was in the recovery room or after she was moved to the L&D service. Dr. Bauer's position that he owed the patient no such post-operative duty is supported by the hospital records clearly reflecting that Dr. Coopersmith was in charge of the recovery room and that Dr. Coopersmith released the patient from the recovery room to the L&D service. It was the duty of Dr. Coopersmith, not of Dr. Bauer, to monitor the patient while she was in the recovery room and to determine whether she was ready to be transferred to the L&D service.

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[13] In addition, nonparty anesthesiologist Dr. Li was at the patient's bedside at 3:20 P.M. on June 16.

[14] In *Wasserman*, the Second Department held that an internist and three general surgeons established their prima facie entitlement to summary judgment by presenting evidence which showed that they did not depart from good and accepted medical practice by deferring to the orthopedic specialists for the assessment and treatment of the plaintiff's ankle, and that they could not be charged with a duty to diagnose a nerve disorder in the plaintiff's ankle, since they were not involved in this aspect of her care. In *Boone v North Shore Univ. Hosp. at Forest Hills* (12 AD3d 338 [2004]), the Second Department reaffirmed the holding in *Wasserman*, when it ruled that a urologist's duty of care did not extend to the treatment rendered by a general surgeon.

Third, plaintiffs' expert affirmation contends (in ¶ 33) that "the [hospital] records indicate that the patient began having difficulty breathing while in the recovery room, yet no treatment for this condition was rendered by the hospital staff." However, the expert affirmation fails to identify any of the hospital records from which this contention was derived (*see Lahara v Auteri*, 97 AD3d 799 [2d Dept 2012] [plaintiff's expert affirmation was conclusory, speculative, and without basis in the record, and, thus, was insufficient to defeat defendants' motion for summary judgment]; *Shahid v New York City Health & Hosps. Corp.*, 47 AD3d 800, 802 [2d Dept 2008] [rejecting the expert's opinion that was based upon a string of assumptions not supported by facts in the record]).[15]

Fourth, plaintiffs' expert affirmation emphasizes (in ¶ 18) that the recovery room nursing note indicated that the patient was "tolerating ice chips," thus suggesting that Nurse Weber then on duty in the recovery room provided the patient with ice chips. According to an excerpt from Nurse Weber's deposition (at page 49 thereof), Nurse Weber gave the patient ice chips to alleviate the dryness of her mouth.[16] Plaintiffs' expert affirmation characterizes Nurse Weber's administration of ice chips to the patient – the volume of ice chips is not

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[15] Although the *Shahid* decision was subsequently criticized on other grounds in *Stukas v Streiter*, 83 AD3d 18 (2d Dept 2011), the specific holding for which this case is cited herein remains good law.

[16] Excerpts from Nurse Weber's deposition transcript are reproduced in Exhibits E, F, and G of the supplemental reply affirmation of LMC and Dr. Muralikrishnan.

disclosed by the hospital record – as an egregious violation of the applicable standards of medical care.[17] According to plaintiffs' expert affirmation (in ¶ 18):

> "[N]either the *anesthesiologist* nor the [recovery room] nurse noted that the patient was to be NPO [nothing by mouth] in the [recovery room]. The failure of the *hospital anesthesiologist* and [the recovery room] personnel to place and maintain this patient on NPO status was a significant deviation from safe and accepted medical practice. Had the nurse not administered the ice chips, . . . the patient would not have vomited, aspirated, progress[ed] to multi-organ failure & ultimately died" (emphasis added).

The flaw in plaintiffs' analysis is the imposition of a non-existing legal duty on Dr. Bauer. As stated, Dr. Bauer's involvement in the patient care was limited. It was Dr. Castro, the operating surgeon, not Dr. Bauer, who determined whether the patient should have been kept NPO post-operatively. It was Dr. Castro who determined that the patient should no longer be kept NPO post-operatively. Moreover, it was Dr. Coopersmith, not Dr. Bauer, who monitored the patient in the recovery room and who signed her out to the L&D service. It was not Dr. Bauer's legal duty to check upon and override Dr. Castro's order to lift NPO. Nor was it Dr. Bauer's legal duty to check up on his fellow

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[17] In his further reply (in ¶ 16), Dr. Bauer points out that the "ice chips" theory was never pleaded in plaintiffs' bills of particulars. However, the "use of an unpleaded defense in a summary judgment motion is not prohibited as long as the opposing party is not taken by surprise and does not suffer prejudice thereby" (*Rosario v City of N.Y.*, 261 AD2d 380, 380 [2d Dept 1999]). "[T]he key is not what is in the pleadings, but whether the moving party was surprised or prejudiced" (*Valenti v Camins*, 95 AD3d 519, 523 [1st Dept 2012]). Here, both Drs. Bauer and Castro were extensively questioned about the propriety of keeping the patient NPO post-operatively, thus indicating plaintiffs' concern with the patient receiving ice chips in the recovery room. Moreover, by leave of court, Drs. Bauer and Castro each submitted surreplies in which they addressed plaintiffs' "ice chips" theory.

anesthesiologist Dr. Coopersmith. As set forth in the supplemental affirmation of Dr. Bauer's expert (in ¶ 24), "it is not the standard of care for an anesthesiologist to author a post-operative note regarding diet or NPO absent extreme circumstances that did not exist in this case." Therefore, because Dr. Bauer owed no legal duty to the patient upon her transfer from the operating room to the recovery room, he cannot be held liable for Nurse Weber's administration of ice chips while in the recovery room, particularly because she was no longer NPO as per Dr. Castro's order. Significantly, plaintiffs' expert affirmation offers no opinion as to whether Dr. Bauer should have overridden Dr. Castro's order revoking the patient's NPO status.

Fifth, plaintiffs' expert affirmation asserts (in ¶ 32) that "the patient was clearly in respiratory distress by 3:30 P.M. while in the regular room. But again, the patient was not intubated until after suffering a prolonged period of hypoxia." However, Dr. Bauer merely responded to a hypoxic event, and he promptly intubated the patient after his less intrusive attempts at improving her oxygen saturation failed. According to Dr. Bauer's expert (in ¶ 40 of her supplemental affirmation), his being called at about 3:20 P.M. and his being at the patient's bedside by about 3:30 P.M. constituted "timely attention according to accepted standards of care and clinical practice." More importantly, as Dr. Bauer's expert points out and as his entries in the hospital records confirm, Dr. Bauer could not have caused a hypoxic event because, by the time he arrived, the patient was already hypoxic (*see Kaplan v Hamilton Med. Assoc.*, 262 AD2d 609, 610 [2d Dept 1999] [granting summary judgment to

defendant physicians who demonstrated, by expert affidavit, that the patient was already in need of a medication by the time the patient first presented to the physicians]).

Lastly, plaintiffs' expert affirmation maintains (in ¶ 37) that the patient's death would have been avoided if she had been properly diagnosed and treated by Dr. Bauer, Dr. Muralikrishnan, and the LMC staff who were each responsible for monitoring and treating the patient following her surgery. This opinion on causation is unacceptably conclusory and does not adequately differentiate between the different defendants who treated the patient at different times (*see Micciola v Sacchi*, 36 AD3d 869, 871 [2d Dept 2007]).

Accordingly, the branch of Dr. Bauer's amended motion under sequence No. 15 for summary judgment dismissing all claims and cross claims insofar as asserted against him is granted. The complaint and all cross claims against Dr. Bauer are dismissed.

With respect to anesthesiologist Dr. Nalbandian, who has been deposed and whose only involvement in this case was assisting Dr. Bauer in transporting the patient to the ICU, plaintiffs do not oppose this motion, as they do not address liability of this physician in their responsive papers. Thus, the branch of the amended motion under sequence No. 15 for summary judgment dismissing all claims and cross claims insofar as asserted against Dr. Nalbandian is granted without opposition.

The Defendant Obstetrician – Dr. Muralikrishnan

In support of his motion for summary judgment, obstetrical resident Dr. Muralikrishnan relies on the expert affirmation of Dr. Prince. According to Dr. Prince, Dr. Muralikrishnan's treatment of the patient was appropriately limited to his area of obstetrics and gynecology by examining her and monitoring fetal movement and heart beat. Dr. Prince maintains that Dr. Muralikrishnan properly deferred to the surgical team when he first met the patient on June 14 (two days before her surgery) and, after noting her vomiting and inability to tolerate any diet, referred her to the surgical service. Dr. Prince opines that Dr. Muralikrishnan properly deferred to the surgical team when he next saw the patient in the afternoon of June 16 following her surgery. Dr. Prince emphasizes that Dr. Muralikrishnan rendered no treatment with respect to her gastric band removal and was not involved in the decision to intubate, extubate, or re-intubate her. The Court finds that Dr. Muralikrishnan has made a prima facie showing that he did not depart from good and accepted medical practice and that he did not proximately cause the patient's injuries and death (*see Heller v Weinberg*, 77 AD3d 622, 623 [2d Dept 2010], *lv denied* 16 NY3d 707 [2011]).

Plaintiffs have failed to raise a triable issue of fact in opposition.[18] Their expert affirmation as to Dr. Muralikrishnan is conclusory, speculative, and without basis in the record. While plaintiffs' expert affirmation lays blame specifically at the feet of Dr. Muralikrishnan for his failure to determine initially the cause of the patient's nausea/vomiting, the expert affirmation overlooks the undisputed evidence that the entire multi-disciplinary team of the LMC physicians had been searching it for six days preceding surgery but were unable to find it. Even now, with the benefit of hindsight, plaintiffs' expert is unable to articulate any basis for the patient's nausea/vomiting at any time during any of the six days from her admission to LMC on June 10 and until her surgery on June 16. The fact that Dr. Muralikrishnan also was unable to determine its cause when, during that six-day period, he saw the patient only once and referred her to the surgical service cannot, now, be considered malpractice. Furthermore, plaintiffs' expert affirmation misstates the evidence in asserting that Dr. Muralikrishnan never attended to the patient after he learned that she was having difficulty breathing on June 16 following her surgery. To the contrary, Dr. Muralikrishnan was at the patient's bedside at that time.

Equally important, plaintiffs' expert affirmation does not claim that anything Dr. Muralikrishnan did or did not do proximately caused any of the patient's injuries. Rather,

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[18] Although plaintiffs' expert is a surgeon, rather than an obstetrician, the Court accepts the affirmations of plaintiffs' expert at the summary judgment stage "where there is no opportunity to fully explore the scope of the physician's expertise" (*DaRonco v White Plains Hosp. Ctr.*, 215 AD2d 339, 340 [1st Dept 1995] [plaintiff's expert, a thoracic surgeon, could provide an affirmation in opposition to a summary judgment motion in a case involving an audiologist, a non-physician]).

plaintiffs' expert affirmation as to Dr. Muralikrishnan is a shotgun pleading that lumps together his and other defendants' names without providing any specific factual allegations as to why the patient would not have been injured but for his alleged acts or omissions. There is nothing in plaintiffs' expert affirmation from which the validity of the ultimate conclusion about Dr. Muralikrishnan's alleged fault either in causing or in failing to correct the patient's respiratory distress can be inferred (*see Romano v Stanley*, 90 NY2d 444, 451-452 [1997] ["an expert's affidavit proffered as the sole evidence to defeat summary judgment must contain sufficient allegations to demonstrate that the conclusions it contains are more than mere speculation and would, if offered alone at trial, support a verdict in the proponent's favor"]). Accordingly, the complaint is dismissed as to Dr. Muralikrishnan.

The Defendant Hospital

In support of its motion for summary judgment, defendant LMC submits its hospital records and an affirmation of its expert, Dr. Henry K. Prince, a board-certified obstetrician and gynecologist. Based on the hospital records and the deposition testimony, he opines to a reasonable degree of medical certainty that LMC conformed with accepted standards of medical practice at all times and did not proximately cause any of the patient's injuries. More particularly, Dr. Prince opines that the LMC staff appropriately treated the patient for her initial complaints of nausea and vomiting on June 8 and 9, 2004. Dr. Prince states that the LMC staff: (1) appropriately kept the patient NPO in light of her inability to tolerate any diet, (2) properly monitored the patient before and after her surgery, (3) appropriately

intubated, extubated, and re-intubated the patient, (4) maintained her proper ventilation and respiration, (5) appreciated the significance of her complaints, signs, and symptoms, and (6) properly informed her of the risks concerning her treatment. The Court finds that LMC has made a prima facie showing of entitlement to summary judgment and that the burden of proof shifts to plaintiffs to create a triable issue of material fact.

The Court finds that plaintiffs have failed to establish the existence of a material issue of fact requiring a trial with respect to the defendant LMC. Plaintiffs' expert affirmation does not advance against LMC any new theory of liability that is substantively different from the theories which they have asserted against the other moving defendants. Accordingly, for the same reasons set forth above with respect to the other moving defendants, the Court finds that plaintiffs have failed to rebut LMC's prima facie showing.

On a concluding note, the Court is aware that all of the moving defendants have been let out of the case. This may seem a harsh result, but is mitigated by the fact that the Court has extended plaintiffs every courtesy. The Court re-opened the record of the instant summary judgment motions to enable plaintiffs to take a pretrial deposition of Nurse Weber and to submit a supplemental expert affirmation. Plaintiffs, however, have not put the Court's assistance to good use. Plaintiffs have failed to include a transcript of Nurse Weber's pretrial deposition with their supplemental papers, thus contradicting their previously stated position that this pretrial deposition was critical to their case. More importantly, their expert (in ¶¶ 18 and 36 of supplemental affirmation) came up with an

extraordinarily broad assertion that "[h]ad the nurse [Weber] not administered the ice chips [to the patient], . . . the patient would not have *vomited*, aspirated, progress[ed] to multi-organ failure & ultimately died" (emphasis added). However, plaintiffs' expert has failed to point to any hospital record or deposition testimony supporting this claim. The Court's independent review of the voluminous medical records and the deposition testimony likewise has failed to find any support for the expert's assertion that the patient vomited either in the recovery room or on the L&D service. In sum, plaintiffs' "ice chips" theory is factually unsupported.

A recent appellate decision in *Ostrov v Rozbruch*, 91 AD3d 147 (1st Dept 2012), another medical malpractice action, supports the Court's disposition of this case. In *Ostrov*, the First Department held that, in the context of summary judgment, "[s]upplemental affirmations . . . should be *sparingly* used to clarify limited issues, and should not be utilized *as a matter of course* to correct deficiencies in a party's moving or answering papers" (emphasis added). In analyzing *Ostrov*, a recent article in the New York Law Journal counseled that:

> "Lawyers defending summary judgment motions must remember . . . that the picture that can be developed at trial is essentially irrelevant if the required proof is not timely submitted in opposition to the motion. The *Ostrov* decision, which resulted in the dismissal of a medical malpractice action

after plaintiff went to great effort and expense to support an untimely supplemental submission, vividly makes the point."

(Patrick M. Connors, *"Just One More Thing": Supplemental Submissions on Summary Judgment*, NYLJ, Sept 17, 2012).[19]

This constitutes the decision, order, and judgment of the Court.

ENTER,

MM

J. S. C.

NANCY T. SUNSHINE
Clerk

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[19] Plaintiffs' request (in ¶ 45 of their affirmation in opposition) that Dr. Coopersmith be compelled to respond to a subpoena is not properly before the Court because it was not made by way of a notice of motion or order to show cause (*see* CPLR 2211, 2214; *see also Bauer v Facilities Dev. Corp.*, 210 AD2d 992, 993 [4th Dept 1994] [affidavits submitted in opposition to defendants' motions were insufficient to constitute a cross motion]).