SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NEW YORK: PART 1

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SOBEIDA J. CORTORREAL, INDIVIDUALLY, AND AS ADMINISTRATOR OF THE ESTATE OF FELIPA CORTORREAL, DECEASED,

Plaintiffs,

Index No.: 805386/2013

-against-

DECISION AND ORDER

NEW YORK PRESBYTERIAN HOSPITAL, JASON D. WRIGHT, M.D., REBECCA AREND, M.D., LAUREEN S. OJALVO, M.D., HANNAH WUNSCH, M.D., "JOHN OR JANE" COHEN, said name being fictitious and presently unknown, and COLUMBIA UNIVERSITY,

Defendants.

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Martin Shulman, J.:

Motion sequence numbers 001, 002, 003 and 004 are consolidated for disposition.

In this action alleging medical malpractice and wrongful death, defendants Laureen S. Ojalvo, M.D. (Dr. Ojalvo) (motion sequence 001), Jason D. Wright, M.D. (Dr. Wright) (motion sequence 002), Hannah Wunsch, M.D. (Dr. Wunsch) (motion sequence 003), and The New York and Presbyterian Hospital s/h/a New York Presbyterian Hospital (NYPH) and The Trustees of Columbia University in the City of New York s/h/a Columbia University (Columbia) (motion sequence 004) separately move, pursuant to CPLR 3212, for summary judgment dismissing the complaint.

Background

Plaintiff Sobeida J. Cortorreal (plaintiff or Mr. Cortorreal) alleges, individually and on behalf of the estate of Felipa Cortorreal (Mrs. Cortorreal or patient), that defendants

negligently performed a robotic-assisted hysterectomy, bilateral salpingo-oophorectomy, pelvic lymphadenectomy and vaginectomy on May 14, 2012, which resulted in the perforation of Mrs. Cortorreal's sigmoid colon. Plaintiff further alleges that defendants failed to timely detect and treat the perforation, which resulted in sepsis and Mrs. Cortorreal's eventual death.

On March 29, 2012, Mrs. Cortorreal presented to her gynecologist, non-party Dr. Sarah Kelly (Dr. Kelly), for an endometrial biopsy. The reason for the referral was vaginal bleeding since November 2011. At the time, Mrs. Cortorreal was 87 years old with a medical history that included type 2 diabetes, hypertension, hypercholesterol, urinary problems, coronary artery disease, morbid obesity (218 pounds), obstructive sleep apnea and osteoarthritis. Dr. Kelly noted that a December 13, 2011 sonogram indicated an irregularity in Mrs. Cortorreal's endometrium. She then referred Mrs. Cortorreal to Dr. Wright.

Dr. Wright indicated that her pap smear results and endometrial stripe were "highly concerning for malignancy" (Bastone Aff. in Supp., Exh. A, ¶ 10[1]). During his deposition, Dr. Wright testified that following the pap smear, a "biopsy was consistent with endometrial cancer; that's when I raised the question about the treatment options for endometrial cancer" (id., Exh. H [Wright EBT] at 19).

On April 4, 2012, Mrs. Cortorreal visited her primary doctor, Margrit Wiesendanger M.D., who indicated that Mrs. Cortorreal "was 'fed up' with the uterine

[1] Exhibit A to all of the moving papers consists of an expert affirmation submitted on each defendant's behalf by Daniel Tobias M.D. (Dr. Tobias), a gynecologic oncologist. Dr. Tobias' affirmation is cited herein as the "Tobias Aff."

bleeding and wanted to have a hysterectomy" (Tobias Aff., ¶ 12). After doing a hysteroscopy and dilation and curettage in April 2012, Dr. Wright diagnosed Mrs. Cortorreal with endometrial cancer (*id.*, ¶ 14).

In his note memorializing the May 14, 2012 discussion he had with Mrs. Cortorreal concerning the risks of the robotic hysterectomy, Dr. Wright wrote:

> Assessment eighty-seven year old with endometrial cancer. Discussion number one: Endometrial cancer. Findings reviewed with patient and daughter. CT negative for metastatic disease. Discuss findings at length with patient and daughter. Discuss the risk of surgery including but not limited to bleeding, infection, damage to internal organs, VTE. Also discuss alternatives including radiation and no treatment. Strong desire to proceed with surgery. Will plan robotic hysterectomy BSO. Understands risks and complications including need for laparotomy. . .

(Wright EBT at 26-27; *see also* Bastone Aff., Exh. M at 75, 86 [consent for surgical/invasive procedure signed by Mrs. Cortorreal]).

On that same day Dr. Wright performed a robotic-assisted hysterectomy, bilateral salpingo-oophorectomy, pelvic lymphadenectomy and vaginectomy. Citing Dr. Wright's notes in the medical records, Dr. Tobias states that:

> Dr. Wright inspected the bladder, the ureters, the bowels and the operative field. No areas of injury were identified. Surgicel and Evicel were placed in the obturator fossa, the fascia was closed with a Carter Thompson device and the skin was closed with interrupted sutures. Dr. Wright documented that the patient tolerated the procedure well, and her estimated blood loss was 150 ml.

(Tobias Aff., ¶ 19).

On that same day, Dr. Ojalvo, a resident, saw Mrs. Cortorreal after the surgery at 6:46 p.m., and indicated in her notes that Mrs. Cortorreal was doing well overall with no complaints, and that she had not needed pain medication while in the Post-Anesthesia Care Unit (PACU). Dr. Ojalvo also reviewed Mrs. Cortorreal's vital signs and examined

her. She documented hypoactive bowel sounds (a sign that bowel activity has slowed) and a soft, non-tender, non-distended abdomen. Dr. Ojalvo's plan on that day included analgesics as necessary, a clear diet overnight with advancing diet as tolerated in the morning, continuous monitoring of vital signs and a further follow up with Dr. Wright. Notes early in the day of May 15, 2012 indicate "overall doing well" (Bastone Aff., Exh. M at 318). Towards the end of the day on May 15 and in the early hours of May 16 the notes indicate a fever and complaint of abdominal pain (*id.* at 342).

On May 16, 2012, Dr. Ojalvo evaluated Mrs. Cortorreal at 6:42 a.m. She reviewed the records up to that point, including Mrs. Cortorreal's complaints of abdominal and lower back pain. She noted that Zosyn had been started due to a possible urinary tract infection based upon an abnormal urinalysis.

Also on May 16, 2012, two days after the operation, the hospital ordered cultures "to rule out infection," since Mrs. Cortorreal complained of lower abdominal pain and had a fever (Wright EBT at 41-42; Bastone Aff., Exh. M at 358). A note from Dr. Ojalvo indicates that Mrs. Cortorreal had "hypoactive BS" and her abdomen was "mildly tender to palpation" (*id.*). She additionally noted: "infectious source unknown at this time," for which she surmised that "atelectasis most likely given she is post-op, and has decreased air movement at lung bases," and ordered testing and continued monitoring to determine the source (*id.*; Tobias Aff., ¶ 41). Dr. Wright considered and agreed with these recommendations (Bastone Aff., Exh. M at 359 ["seen and agree with above assessment and plan by Dr. Ojalvo"]).

A note in the May 17, 2012 medical records, recorded around midnight, indicates that as the day progressed on May 16 the "patient became oliguric early in the day and

UOP did not respond to fluid bolus's. As day progressed she c/o abdominal pain, became slightly more distended, and was hypotensive. She was transferred to the SICU because of hypotension and oliguria" (*id.* at 407).

Dr. Ojalvo saw Mrs. Cortorreal again the next day, May 17, and noted that Mrs. Cortorreal had been transferred back to the SICU overnight because of oliguria, as well as complaints of "severe abdominal and back pain . . . and then became hypotensive..." (*id.* at 432). The notes indicate that CT scans of Mrs. Cortorreal's abdomen and pelvis were ordered to determine the source of pain and infection (*id.)*. Additional hospital notes for that same day indicate the continuation of pressor support for low blood pressure with improved blood pressure and improved urine output, although Mrs. Cortorreal continued to complain of abdominal pain (*id.* at 436). Dr. Wright agreed with this assessment (*id.*).

Dr. Moeun Son, a second-year resident at the hospital who treated Mrs. Cortorreal indicated in the notes on May 17 the same results of the CT scan, as well as improving urine output, and then decreased urine output, as well as lower abdominal pain and tightness. He wrote: "[c]alled by SICU team concern for possible worsening sepsis picture" (*id.* at 543). Dr. Wright's May 17 notes indicate "persistent hypotension . . . [n]ow on increased norepinephrine and vasopressin . . . cultures negative to date ... CT today negative for extravasation of contrast, fluid collection . . . close monitoring" (*id.* at 541).

According to Dr. Wright, after the surgery on May 14, 2012, Mrs. Cortorreal continued to have worsening abdominal pain, she was "hypotensive" (low blood pressure), had decreased urine output, and was "not responding to resuscitation"

(Wright EBT at 61). Based on these findings, "we were concerned that there could be some intra-abdominal source of infection, which is why we decided to take her back to the operating room" (*id.* at 58).

Towards the end of the day on May 17, Dr. Wright was preparing Mrs. Cortorreal for a second surgery and wrote: "After transfer to SICU, pt had stabilized on one pressor, but throughout the day, has required increased pressor support and continues to have markedly distended abdomen, though not acute abdomen. However, given continued worsening sepsis picture (increasing pressor support, increasing venous lactate, worsening neutropenia) and concerning abdominal exam, concern for possible bowel leak or intraabdominal collection not seen on CT scan. Will bring back to OR for re-exploration with diagnostic laparoscopy . . ." (Bastone Aff., Exh. M at 544).

On May 18, 2012, Dr. Wright performed a laparoscopy, laparotomy and end-colostomy, along with co-surgeon Valeria Simone, M.D. Dr. Wright's operative findings indicated that bowel contents were identified within the abdominal cavity, and the patient had a small area of bowel leakage in the rectosigmoid colon.[2] Dr. Wright examined the entire small bowel multiple times without finding a defect. A small defect was detected in the sigmoid colon. It was decided that an end colostomy would be performed, at which point the general surgeon, Dr. Simone took over the procedure" (Tobias Aff., ¶ 59).

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[2] The part of Mrs. Cortorreal's colon that had the colostomy was the rectosigmoid colon, which is the part of the colon that is behind the uterus.

Dr. Simone "saw a thickened and inflamed sigmoid colon with and [sic] area of perforation and exudate. Dr. Simone dissected the sigmoid colon and created and [sic] end colostomy. The colostomy was placed in the lower left quadrant" (*id.*, ¶ 60). After the surgery, Mrs. Cortorreal was moved to the ICU. ICU attending physician Matthew Coleman evaluated the patient on May 18 and indicated that her current issues included "septic shock from intra-abdominal source, post op uterine cancer s/p hysterectomy" (*id.*, ¶62; Exh. M at 610).

On May 29, 2012, ICU attending physician Dr. Wunsch evaluated Mrs. Cortorreal and noted that she had a "complicated post-op course - ?intra-abd sepsis with decreased UOP and altered MS," she also noted "responsiveness improved" (*id.,* Exh. M at 2183). On June 1, Dr. Wunsch met with Mrs. Cortorreal's family and communicated that her "persistent sleepiness, vasodilation and acute renal failure are all due to infection that is slowly improving" (*id.* at 2689). She further explained that Mrs. Cortorreal may need a tracheostomy in order to "progress with her care," but that her daughter was concerned "regarding the long-term situation . . . her mother would not want to live like this for a prolonged period of time." The doctors suggested that Mrs. Cortorreal be "supported through the weekend, with a reassessment regarding her trajectory on Monday to determine whether we think she is likely to recover with a tracheostomy" (*id.*).

On July 18, 2012, Dr. Wunsch noted that Mrs. Cortorreal's current problems included "profound septic shock" (*id.* at 10546) and, on July 19, 2012, Dr. Wunsch wrote in her notes: "The patient lacks the capacity because she is terminally ill with septic shock. . . . The patient has an Irreversible [sic] and incurable condition, and treatment

involves pain, suffering or other burden that would be inhumane or extraordinarily burdensome. It is therefore appropriate to proceed with withdrawal of vasopressors and other medications" (*id.* at 10766). On that day, with the permission of Mrs. Cortorreal's family, hospital staff withdrew all medical intervention and Mrs. Cortorreal died.

The autopsy results indicate, under "final note," that Mrs. Cortorreal had "a post-operative course complicated by multiple problems, including a non-healing surgical wound, bowel perforation, and severe infection" (Bastone Aff., Exh. K [bills of particulars attachment]). The autopsy report describes the "immediate" cause of death as:

> severe infection with multilobar pneumonia. Autopsy findings pertaining to a severe systemic infection include acute bronchopneumonia involving all lobes, and inflammation of the trachea and abdominal subcutaneous fat. Autopsy findings and previous culture results suggest that the respiratory tract and abdominal wound could be possible sources of her persistent infection, with multilobar pulmonary involvement as the immediate cause of death.

(*id.*).

This action consists of two consolidated actions. The complaint in the first action names NYPH as the only defendant and contains five causes of action: (1) medical malpractice; (2) wrongful death; (3) lack of informed consent; (4) negligent hiring; and (5) loss of services. The complaint in the second action seeks damages against Dr. Wright, Dr. Arend, Dr. Ojalvo, Dr. Wunsch, "John or Jane" Cohen, and defendant Columbia, and contains the same first, second, third and fifth causes of action, but seeks damages based upon the doctrine of respondeat superior as against Columbia in the fourth cause of action.[3] The consolidated actions are predicated upon the following

[3] On or about May 29, 2014, Dr. Wright, Dr. Ojalvo, Dr. Wunsch and Columbia interposed answers. Named defendants Rebecca Arend, M.D. and "John or Jane"

allegations, as contained in plaintiff's bills of particulars, alleging that defendants: (1) failed to prevent perforation of the patient's bowel during a hysterectomy; (2) failed to diagnose and treat a bowel perforation; (3) failed to provide proper post-operative care and treatment, which included the failure to timely and properly order and/or perform appropriate diagnostic or laboratory testing and studies and refer the patient to appropriate specialists; (4) failed to diagnose and treat an infectious process/sepsis; and (5) failed to appreciate bacterial colonization, failed to appreciate the inability to urinate, failed to appreciate the urgency of Mrs. Cortorreal's deteriorating physical condition, and failed to appreciate the implications of renal failure (Bastone Aff., Exh. K at 2).

DISCUSSION

A. Timeliness of the Motions

Mr. Cortorreal argues that these motions for summary judgment are untimely, as they were filed after the 60-day time frame provided in the parties' preliminary conference order (Kessler Aff., Exh. F). Plaintiff argues that the note of issue was filed on January 31, 2017, that 60 days from that date is April 1, 2017, and the motions were served and filed on April 3, 2017, two days late. However, as defendants point out, April 1, 2017 was a Saturday, allowing for the service of the motions on the "next succeeding business day," Monday April 3, 2017 (General Construction Law, § 25-a [1] ["When any period of time, computed from a certain day, within which or after which or before which an act is authorized or required to be done, ends on a Saturday, Sunday

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Cohen were not served and did not answer or otherwise appear in this action.

or a public holiday, such act may be done on the next succeeding business day. . . ."]). Under the statute, these motions were filed timely.

B. Summary Judgment

1. General Standard for Summary Judgment

An award of summary judgment is appropriate when no issues of fact exist. *See* CPLR 3212(b); *Sun Yau Ko v Lincoln Sav. Bank*, 99 AD2d 943 (1st Dept), *aff'd* 62 NY2d 938 (1984); *Andrea v Pomeroy*, 35 NY2d 361 (1974). In order to prevail on a motion for summary judgment, the proponent must make a prima facie showing of entitlement to judgment as a matter of law by providing sufficient evidence to eliminate any material issues of fact. *Winegrad v New York Univ. Med. Ctr.*, 64 NY2d 851, 853 (1985); *Alvarez v Prospect Hosp.*, 68 NY2d 320, 324 (1986). Indeed, the moving party has the burden to present evidentiary facts to establish his cause sufficiently to entitle him to judgment as a matter of law. *Friends of Animals, Inc. v Associated Fur Mfrs., Inc.*, 46 NY2d 1065 (1979). "Failure to make such a prima facie showing requires a denial of the motion, regardless of the sufficiency of the opposing papers" (*Masucci v Feder*, 196 AD2d 416, 419 [1st Dept 1993]).

In deciding the motion, the court views the evidence in the light most favorable to the nonmoving party and gives him the benefit of all reasonable inferences that can be drawn from the evidence. *See Negri v Stop & Shop, Inc.*, 65 NY2d 625, 626 (1985). Moreover, the court should not pass on issues of credibility. *Assaf v Ropog Cab Corp.*, 153 AD2d 520, 521 (1st Dept 1989). While the moving party has the initial burden of proving entitlement to summary judgment (*Winegrad, supra*), once such proof has been offered, in order to defend the summary judgment motion, the opposing party 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, 562 (1980); *Freedman v Chemical Constr. Corp.*, 43 NY2d 260 (1977); see also, *Friends of Animals, Inc.*, *supra*.

2. Standard for Medical Malpractice/Wrongful Death Causes of Action

"To sustain a cause of action for medical malpractice, a plaintiff must prove two essential elements: (1) a deviation or departure from accepted practice, and (2) evidence that such departure was a proximate cause of plaintiff's injury" (*Frye v Montefiore Med. Ctr.*, 70 AD3d 15, 24 [1st Dept 2009]). "The elements of a cause of action to recover damages for wrongful death are (1) the death of a human being, (2) the wrongful act, neglect or default of the defendant by which the patient's death was caused, (3) the survival of distributees who suffered pecuniary loss by reason of the death of patient and (4) the appointment of a personal representative of the patient" (*Chong v New York City Tr. Auth.*, 83 AD2d 546, 547 [2d Dept 1981]).

When a defendant has met its burden of showing entitlement to judgment "[i]n a medical malpractice action, a plaintiff, in opposition to a defendant physician's summary judgment motion, must submit evidentiary facts or materials to rebut the prima facie showing by the defendant physician that he was not negligent in treating plaintiff so as to demonstrate the existence of a triable issue of fact" (*id.* at 419-420 [internal quotation marks and citation omitted]). Specifically, a plaintiff must offer expert support that is neither conclusory nor based upon mere speculation (*see Rodriguez v Montefiore Med. Ctr.*, 28 AD3d 357, 357 [1st Dept 2006] [defendant's motion for summary judgment was granted where "plaintiff's expert offered only conclusory assertions and mere speculation that her cancer would have been discovered earlier and would not have

spread if appellants had more aggressively pursued her, and expedited and tracked her follow-up visits more actively"]).

In order to recover for medical malpractice based upon lack of informed consent, a patient must establish that "the physician failed to disclose material risks, benefits and alternatives to the medical procedure, that a reasonably prudent person in the patient's circumstances having been so informed would not have undergone such procedure, and that lack of informed consent was the proximate cause of the injury" (*Shkolnik v Hospital for Joint Diseases Orthopaedic Inst.*, 211 AD2d 347, 350 [1st Dept 1995]). New York Public Health Law § 2805-d (1) defines lack of informed consent as:

> the failure of the person providing the professional treatment . . . to disclose to the patient such alternatives thereto and the reasonably foreseeable risks and benefits involved as a reasonable medical, dental or podiatric practitioner under similar circumstances would have disclosed, in a manner permitting the patient to make a knowledgeable evaluation.

(*See Johnson v Staten Is. Med. Group*, 82 AD3d 708, 709 [2d Dept 2011]; *see also Balzola v Giese*, 107 AD3d 587, 588 [1st Dept 2013] ("To prevail on [a failure to procure informed consent] claim, a plaintiff must establish . . . that defendant failed to disclose material risks, benefits and alternatives to the medical procedure . . .").

C. Dr. Wright

Dr. Wright denies that he deviated from the accepted standard of care. He relies on his expert, Dr. Tobias, who concludes that "[i]t is my opinion to a reasonable degree of medical certainty that the procedure was properly performed. Dr. Wright's operative report details that proper surgical technique was employed. He visualized the surgical field and adjacent structures for any evidence of injury prior to completing the surgery, and no signs of injury were present" (Tobias Aff., ¶ 82). Dr. Tobias additionally states

that "a perforation of the sigmoid colon is a known and identified risk of a robotic-assisted hysterectomy, bilateral salpingo-oophorectomy, pelvic lymphadenectomy, and vaginectomy" which "can occur absent any negligence" (*id.*, ¶83).

With respect to Mrs. Cortorreal's post-operative care, Dr. Tobias also concludes that she was properly monitored after her first surgery, between May 14 and May 18. He states that after that first surgery, Mrs. Cortorreal "initially displayed no signs or symptoms of a sigmoid colon perforation immediately following surgery" (*id.*, ¶ 84). She was transferred from the operating room to the PACU and her vital signs were stable and she had no complaints. Prior to leaving the PACU, she was passing urine via a catheter; her abdomen was soft, non-tender and non-distended; she had not yet passed flatus and had hypoactive bowel signs (Bastone Aff., ¶ 89; Exh. M at 258, 300-301). Mrs. Cortorreal first complained of pain at 12:55 a.m. on May 15, 2012 (*id.*, ¶ 90; Exh. M at 310). However, according to Dr. Tobias, "post-operative pain" following this type of surgery is "a common occurrence" that "did not indicate a need for further treatment or testing at that time" (*id.*, ¶ 88). Her complaints were controlled with pain medications; her vital signs remained stable; she had no complaints of chest pain; no shortness of breath; no fever or chills; and her abdomen remained non-tender and non-distended (*id.*, ¶ 86; Exh. M at 311-317).

Mrs. Cortorreal began to exhibit signs of a possible infection on the evening of May 15 into May 16, 2012. Her vital signs became abnormal and her symptoms included "more consistent complaints of pain, more severe pain, and a fever" (*id.*, ¶ 91; Exh. M at 358-362). A urinalysis came back abnormal and Mrs. Cortorreal was given

Zosyn, an antibiotic (*id.*, ¶ 89). She reported feeling better after administration of Tylenol and antibiotics (*id.*).

Dr. Wright's examination of Mrs. Cortorreal on May 16 revealed some improvement, however, her blood pressure declined. A CT of the abdomen and pelvis was ordered due to a concern of sepsis. She was then transferred to the SICU for additional monitoring. Dr. Wright testified that symptoms such as fever, lower abdominal complaints and low blood pressure are common in a post-operative period, yet, when Mrs. Cortorreal's symptoms became "progressively severe and persistent, that's when the decision was made" to perform the second surgery on May 18, 2012: "At that time, she had had decreased urine output, she had progressive hypotension, she was not responding to resuscitation, and she had increasing abdominal pain" (Wright EBT at 58, 61). These symptoms led to a concern that there may be an injury of gastrointestinal origin" (*id.* at 57).

On this point, Dr. Wright testified as follows:

> Q: As of post-operative day two, did you consider the possibility of this patient having a bowel perforation?
> A: We were concerned and monitoring her very closely. That's why we got the CT scan and were watching the evolution of her symptoms.

(id., Exh. H at 119).

Dr. Wright states that once Mrs. Cortorreal was in the ICU he was no longer her attending physician. However, he again became involved in her care on May 18, 2012 when he performed the exploratory laparoscopy. During this procedure, he discovered an injury to the sigmoid colon and sought Dr. Simone's assistance to manage the surgery. The post-operative report states: "Intra-operatively the patient was noted to

have bowel contents within the abdominal cavity. The patient had a small area of bowel leakage in the rectosigmoid colon" (*id.* at 126).

When questioned about sepsis and the cause of Mrs. Cortorreal's sepsis, Dr. Wright responded:

Q: Did Ms. Cortorreal go into septic shock during the time that she was admitted after May 14, 2012?
A: She definitely had sepsis, yes.
Q: What causes sepsis?
A: I mean there are many causes for sepsis.
Q: What caused Ms. Cortorreal's sepsis?
A: Probably infection.

(*id.* at 121).

He further opined as to the cause of the sepsis:

Q: As a result of the operation of May 18, 2012 that you performed with Dr. Simone, did you reach a conclusion within a reasonable degree of medical certainty as to the cause of Ms. Cortorreal's sepsis?
A: Certainly I think based on the surgical findings she had had peritonitis; that was probably one contributing factor. But again, she had underlying medical co-morbidity. She was a patient in her late eighties, so she was certainly at high risk for complications.

(*id.* at 122).

As for the determination to perform the exploratory surgery on May 18 rather than sooner, Dr. Tobias concludes:

> [i]t is my opinion to a reasonable degree of medical certainty that an exploratory laparoscopy is a surgical procedure that carries attendant risks for any patient, including Mrs. Cortorreal. It was therefore appropriate for the defendants to initially proceed with continued monitoring and management of Mrs. Cortorreal's symptoms immediately following her surgery. Mrs. Cortorreal [sic] post-operative course was marked by the onset of certain symptoms, including abdominal pain and fever, that subsided with medical intervention. It was only after Mrs. Cortorreal's symptoms began to persist despite medical interventions and progress in severity that further surgical management was appropriate.

(Tobias Aff., ¶ 93).

After this surgery, Mrs. Cortorreal was in the ICU for the remainder of her hospitalization, except for May 26 and May 27, 2012. Dr. Wright claims that he was not her attending while she was in the ICU. Through the medical records, his own deposition testimony, and Dr. Tobias' expert affirmation, Dr. Wright establishes his prima facie entitlement to judgment as a matter of law.

Plaintiff's expert is a gynecologic oncologist whose identity is redacted. This expert states that as of May 16, 2012, the second day after the surgery, "it was completely obvious, [Mrs. Cortorreal] was not following an ordinary post-operative course[4] from a robotic hysterectomy that is believed to be much 'easier on the patient for recovery' than an open operation. Thus a bowel perforation should have been suspected during the day on Post-Operative Day #2" (Kessler Aff., Exh. I [plaintiff's expert's affidavit], ¶ 8 [emphasis in original]). Plaintiff's expert states that Mrs. Cortorreal's symptoms during the post-surgical period were indicative of bowel perforation and sepsis.

The expert concludes that if Dr. Wright and "his team" had properly evaluated Mrs. Cortorreal after surgery and acted more quickly, she would not have suffered "continued sepsis and died" (*id.*). Ultimately, plaintiff's expert opines that:

> A bowel injury is a well-known complication of surgery, especially a minimally invasive procedure, however, the failure to detect the injury in a prudent and timely manner can result in the patient [sic] demise. Dr. Wright and the New York Presbyterian Hospital staff missed multiple opportunities for intervention and to a reasonable degree of medical certainty, Ms. Cortorreal would have survived had they intervened

[4] Dr. Wright testified that "he initially planned on a 48-hour discharge from the initial robotic hysterectomy and staging procedure. However Ms. Cortorreal did not meet post-operative milestones during the first 48 hours" (Kessler Aff., Exh. I, ¶ 20).

> appropriately. Defendants' mere "monitoring" of the patient's rapidly deteriorating condition was nothing more than presiding over the death of the patient.

(*id.*, ¶ 30).

On post-operative day three, May 17, 2012, the same second-year resident noted that Mrs. Cortorreal "became oliguric early in the day . . . voiding only 160 cc of urine" in 12 hours "and her urine output did not respond to fluid boluses" (*id.*, ¶ 7). Also on that day, her abdominal pain increased, and her abdomen became more distended, and she became more hypotensive with respect to her dropping blood pressure into the 70s/30s (*id.*).

1. Medical Malpractice/Wrongful Death

This court finds that plaintiff's expert's affidavit raises a triable issue of fact as to whether Dr. Wright departed from good and accepted practice in failing to timely recognize and treat Mrs. Cortorreal's perforated bowel. Plaintiff's expert's analysis and opinion highlight the gap between the time the CT scan was performed and read on May 16, the time of Mrs. Cortorreal's worsening symptoms, and the time the surgery was performed, at approximately midnight on May 18. These observations are based upon the medical records and Dr. Wright's deposition testimony.

Specifically, the medical records, dated in the early morning hours of May 16, indicate that Mrs. Cortorreal complained of lower back and abdominal pain on the night of May 15 and had a persistent fever. On the morning of May 16, she continued to complain of abdominal pain and distention. She had not yet passed flatus since the surgery. She had an infection, but the source was unknown. During the night of May 16, she was returned to the SICU because she became oliguric early in the day and her

urine output did not respond to fluid boluses. She also complained of abdominal pain, a distended abdomen and was hypotensive. A hospital note from May 17 at approximately 1:43 a.m. states: "as day progressed, pt c/o worsening abd pain, became more distended, and then became increasingly hypotensive, as low as 70s/30s on the floor" (Bastone Aff., Exh. M at 413). The notes indicate that she was transferred to the SICU for "more intensive monitoring" (*id.* at 415). At this same time, she was prepared for the CT scan to determine the source of her infection.

During his deposition, Dr. Wright testified that sepsis is potentially fatal, and it is important to diagnosis and treat sepsis as soon as possible. He was asked:

> Q: Isn't it important to find sepsis as soon [sic] possible because it can be fatal?
> A: Yes, that's why all of these symptoms were being monitored. Again, in the post-operative period, many of these signs and symptoms are normal. She was closely monitored and transferred to the ICU.

(Wright EBT at 108-109). As of post-operative day two Dr. Wright considered the possibility of the patient having a bowel perforation and they were monitoring her very closely.

The medical records indicate that by midnight on May 18, Mrs. Cortorreal had several symptoms of sepsis, including low blood pressure and decreased urine output. She had "been complaining of abdominal pain since postop," and she had not had a bowel movement or passed flatus (Bastone Aff., Exh. M at 554). Plaintiff's expert questions why, with this information available to Dr. Wright, he did not perform the surgery on the afternoon of May 17. Plaintiff's expert concludes that the delay in performing the surgery resulted in Mrs. Cortorreal's death, as well as two months of pain and suffering. Included in this assessment is plaintiff's expert's opinion that had

Dr. Wright understood the CT-scan results, he would have performed the surgery earlier.[5]

Additionally, plaintiff's expert's affidavit raises questions as to Dr. Wright's and Dr. Tobias' conclusion that "continued monitoring and management was appropriate," and that it was only after her symptoms began to "persist" that the surgery was "appropriate." Based on the conflicting opinions of the parties' medical experts and the note dated the early morning of May 16 that indicated a doctor's concern for Mrs. Cortorreal's "high risk for progression to urosepsis," this court finds that questions of fact exist concerning whether the delay in performing the surgery was a deviation from accepted medical practice.

There are also questions of fact as to whether the delay in surgery was the proximate cause of Mrs. Cortorreal's death from sepsis. According to Dr. Wright, sepsis is a possibly fatal condition if not treated early. The medical records and Dr. Wright's deposition testimony indicate a concern, as early as the second post-operative day, that Mrs. Cortorreal possibly suffered from sepsis and a bowel perforation. As noted above, plaintiff's expert's affidavit raises questions about whether Dr. Wright's decision not to perform the surgery until May 18 was a deviation from accepted medical practice, and whether that delay was a proximate cause of Mrs. Cortorreal's extended pain and suffering and shortened life.

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[5] Plaintiff's expert states that the CT scan showed that Mrs. Cortorreal had more free air within her abdominal cavity than should be considered normal post-operatively (Kessler Aff., Exh. I at ¶ 26).

In light of the conflicting expert opinions as to the surgery's timing, this court cannot find, as a matter of law, that the delay was not responsible for patient's reduced life expectancy. Accordingly, Dr. Wright's motion for summary judgment must be denied as to the medical malpractice and wrongful death causes of action. However, plaintiff's claims must be limited to allegations of negligence commencing on post-operative day two (May 16, 2012) and thereafter. As defendants note, plaintiff's expert fails to identify any departure in the manner in which the first surgery was performed, as well as on post-operative day one. Moreover, plaintiff's expert does not dispute Dr. Tobias' opinion that a bowel perforation can occur without any negligence on the surgeon's part during the procedures Mrs. Cortorreal underwent.

2. Lack of Informed Consent

On the issue of lack of informed consent with respect to Dr. Wright, no question of fact exists. As previously stated, plaintiff bears the burden of establishing that Dr. Wright did not inform her of the reasonably foreseeable risks associated with the robotic hysterectomy, that a reasonably prudent patient in the same position would not have undergone the procedure, and that the failure to obtain informed consent proximately caused the injury (*Shkolnik v Hospital for Joint Diseases Orthopaedic Inst.*, *supra*).

Here, both experts agree that perforation of the colon is a common complication of a robotic hysterectomy (Kessler Aff., Exh. I, ¶ 30; Tobias Aff., ¶ 83). However, plaintiff's counsel and his expert fail to address the adequacy of the information provided to Mrs. Cortorreal.

The medical records for May 14, 2012 state:

Endometrial Cancer
Findings reviewed with patient and daughter
CT negative for metastatic disease
Discussed findings at length with patient and daughter
Discussed risk of surgery including but not limited to bleeding, infection, damage to internal organs, VTE
Also discussed alternatives including radiation and no treatment

(Bastone Aff., Exh. M at 75). The above notation specifically indicates that Dr. Wright discussed the risks of infection and damage to internal organs with the patient, thus enabling her "to make a knowledgeable evaluation" (Public Health Law 2805-d [1]). The notes also indicate that Dr. Wright advised Mrs. Cortorreal of alternatives to the procedure, including radiation therapy and no treatment at all, and she strongly desired to have the procedure performed (*id.*). Finally, the records also include the consent form that the patient executed on May 14, 2012 authorizing Dr. Wright to proceed with the robotic hysterectomy (*id.* at 86).

Dr. Tobias opines that a reasonably prudent person having Stage 1A endometrial cancer, like Mrs. Cortorreal, would, given the disease's mortality rate and progression, elect to proceed with the surgery despite the known risks (Tobias Aff., ¶76). As plaintiff wholly fails to refute or even address the lack of informed consent claim, Dr. Wright's motion for summary judgment (motion sequence 2) is granted as to that cause of action.

D. Dr. Ojalvo

Dr. Ojalvo moves for summary judgment on the ground that she was a resident under medical supervision when treating Mrs. Cortorreal and did not exercise independent medical judgment. She also relies upon Dr. Tobias' affirmation to establish

that she did not deviate from the standard of care and was not responsible for obtaining Mrs. Cortorreal's informed consent.[6]

With respect to a resident's liability for medical malpractice, New York courts have held:

> It is well settled that a "resident who assists a doctor during a medical procedure, and who does not exercise any independent medical judgment, cannot be held liable for malpractice so long as the doctor's directions did not so greatly deviate from normal practice that the resident should be held liable for failing to intervene"

Green v Hall, 119 AD3d 1366, 1367 [4th Dept 2014] [citations omitted]; *see also Bellafiore v Ricotta*, 83 AD3d 632, 633 [2d Dept 2011]). It is undisputed that Dr. Ojalvo was a resident at all times during Mrs. Cortorreal's treatment and that attending physicians, including Dr. Wright, supervised her treatment of the patient.

Chart entries indicating a resident's intent to discuss matters therein with the attending physicians establish the resident's work as being under the supervision of hospital attendings (*Crawford v Sorkin*, 41 AD3d 278, 280 [1st Dept 2007]). In *Crawford*, the court held as follows:

> the motion court properly dismissed claims against Dr. Holsey, the resident, in the absence of evidence that she had exercised independent medical judgment. There is no record evidence that Dr. Holsey was acting other than under the supervision and at the direction of the hospital attendings, a fact that was not altered by her status as "night chief resident" on the labor and delivery ward. Indeed, Dr. Holsey's entries in the chart reflect her intent to discuss repeat labs and other such matters with the attendings (internal citation omitted).

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[6] The informed consent cause of action as to Dr. Ojalvo is now moot in light of this court's finding that Dr. Wright obtained the patient's informed consent to the first surgery.

This standard applies even where the resident plays an active role in the plaintiff's procedure (*see Muniz v Katlowitz*, 49 AD3d 511, 514 [2d Dept 2008]).

Here, the medical records contain Dr. Ojalvo's multiple, detailed notes signaling her intent to discuss her entries with the attending physicians.[7] Her notes in the medical records do not evidence that Dr. Ojalvo exercised any independent medical judgment in treating Mrs. Cortorreal. Rather, the medical records indicate that her entries were reviewed and approved by the attending physicians and she discussed Mrs. Cortorreal's treatment with other members of the medical team treating her.

Plaintiff's opposition fails to even address Dr. Ojalvo's argument regarding her status as a resident and the above cited case law applicable to residents. Furthermore, his expert does not dispute that she was supervised by more senior medical personnel at all times, a fact borne out by the record. Nor does plaintiff's expert identify any directions given to Dr. Ojalvo that so greatly deviated from the standard of care as to obligate her not to follow them.

Finally, plaintiff's counsel's argument that Dr. Ojalvo was a Columbia employee for whom Columbia was responsible under the theory of respondeat superior has no bearing on whether she can be held liable for medical malpractice as a supervised resident not exercising any independent judgment. Accordingly, Dr. Ojalvo's submissions establish that, as a resident, she cannot be held liable for medical malpractice.

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[7] For example, in the May 16, 2012 medical record, Dr. Wright states: "Seen and agree with above assessment and plan by Dr. Ojalvo" (Bastone Aff., Exh. M at 359).

As to Dr. Ojalvo's alleged departures from the standard of care, plaintiff's expert's affidavit primarily focuses on Dr. Wright's alleged malpractice. In an attempt to create questions of fact, plaintiff's expert states that Dr. Ojalvo departed from good and accepted medical practice because: (1) on day two she failed to determine the source of Mrs. Cortorreal's infection, "i.e. colon perforation," and (2) on day three, she merely recommended "close monitoring" (Kessler Aff., Exh. I at ¶¶ 22, 28). Further, plaintiff's expert states that Dr. Ojalvo should have discussed the need for surgery with Dr. Wright. These conclusory and unsupported claims are insufficient to establish that Dr. Ojalvo departed from accepted standards of medical care. For the foregoing reasons, Dr. Ojalvo has established entitlement to judgment as a matter of law and her motion for summary judgment (motion sequence 1) dismissing her as a defendant herein is granted.

E. Dr. Wunsch

As previously noted, plaintiff's bill of particulars alleges that defendants failed to prevent perforation of the patient's bowel during a hysterectomy, failed to diagnose and treat a bowel perforation, failed to provide proper post-operative care and treatment, failed to timely perform appropriate testing to refer patient to the appropriate specialists, failed to diagnose sepsis, and failed to appreciate many of the symptoms patient exhibited. In her motion for summary judgment, Dr. Wunsch, an ICU attending physician, notes that she saw Mrs. Cortorreal for the first time on May 29, 2012, after both the May 14, 2012 robotic hysterectomy and after the May 18, 2012 colostomy.

She thus argues, correctly, that the allegations regarding the failure to prevent a bowel perforation during a hysterectomy and the failure to diagnose and treat a bowel

perforation are inapplicable to her. Similarly, Mrs. Cortorreal had already been diagnosed with sepsis prior to first presenting to Dr. Wunsch, a fact Dr. Wunsch knew and appreciated. She thus did not fail to diagnose sepsis. Dr. Wunsch argues that since she provided care to Mrs. Cortorreal only when she was admitted to the SICU, and only on dates during which Dr. Wunsch was assigned to the unit, she is not liable in this action. At all other times, different physicians were responsible for her care in the SICU.

Dr. Wunsch saw Mrs. Cortorreal intermittently from May 29, 2012 up to July 19, 2012, the date of her death. Contrary to plaintiff's allegations, the medical records and deposition testimony indicate that Dr. Wunsch provided proper post-operative care, timely referred the patient for appropriate testing, worked with other specialists and otherwise appreciated her symptoms. Dr. Wunsch's entries in the medical records contain her detailed observations of Mrs. Cortorreal's symptoms, diagnoses and proposed treatment plan (see, e.g., Bastone Aff., Exh. M at 2180, 2183, 2340, 2633, 3970, 4106, 10355, 10127 and 10131), and her deposition testimony references the ICU team's interaction with infectious disease and other specialists (*id.*, Exh. I at 27).

Dr. Tobias opines that the treatment Mrs. Cortorreal received from the SICU team from late May until mid-July, 2012, which included Dr. Wunsch, did not deviate from medically accepted standards. Based upon the foregoing, Dr. Wunsch has sufficiently established her entitlement to judgment in her favor as a matter of law.

In opposition, plaintiff argues that Dr. Wunsch has not met her burden of proof entitling her to judgment and thus, the burden of proof has not shifted to him. Specifically, Mr. Cortorreal argues that the defendants' expert made only the most

cursory commentary with regard to Dr. Wunsch and Dr. Ojalvo. However, other than citing to Dr. Wunsch's testimony that she is a Columbia employee, plaintiff's opposition contains no facts concerning Dr. Wunsch, let alone any facts that would link her to the allegations in the bill of particulars. Indeed, plaintiff's expert does not even mention Dr. Wunsch and only discusses Mrs. Cortorreal's medical history through May 18, 2012, the date Drs. Wright and Simone performed the exploratory laparotomy with end colostomy.

Plaintiff does reference the SICU team's alleged failure "to follow the Hospital's own protocols for hourly monitoring set forth in their own Sepsis standard of care rules" (Kessler Aff., Exh. I at ¶ 32). However, his expert's opinion with respect to the SICU team are conclusory, offering no factual detail with respect to Dr. Wunsch's treatment of Mrs. Cortorreal. In fact, plaintiff's expert fails to identify any symptom or symptoms that Dr. Wunsch failed to appreciate; any laboratory, radiological, or diagnostic test that Dr. Wunsch failed to order; or any procedure that Dr. Wunsch failed to suggest.

Finally, the lack of informed consent cause of action must be dismissed as to Dr. Wunsch as moot (see discussion above). Parenthetically however, plaintiff's bill of particulars and supplemental bill of particulars as to Dr. Wunsch fail to identify any procedure or treatment she performed for which she failed to obtain the patient's informed consent.

For the foregoing reasons, no questions of fact exist regarding Dr. Wunsch's treatment of Mrs. Cortorreal and therefore she has established entitlement to judgment as a matter of law. Her motion for summary judgment (motion sequence 3) dismissing her as a defendant herein must be granted.

F. NYPH and Columbia

In the complaint, Mr. Cortorreal alleges that NYPH is liable for the negligence of its hospital employees, who deviated from the standard of care. Further, plaintiff alleges that NYPH is liable for its own negligence in failing to investigate its medical staff's qualifications. In the second complaint, Mr. Cortorreal alleges that Dr. Wright was an employee of Columbia and was granted privileges at NYPH. During his deposition, Dr. Wright testified that he was continuously employed at Columbia from 2006 through all the dates relevant to this action.

These defendants argue only that there was no deviation from accepted medical practice and there was informed consent for the relevant procedures. However, they do not address the issue as to vicarious liability. Because plaintiff alleged in the complaint that these defendants are vicariously liable on the grounds of Dr. Wright's employment and privileges, the question of respondeat superior is unresolved on these submissions and the question of vicarious liability remains as to Dr. Wright.

In accordance with the foregoing, it is

ORDERED that defendant Laureen S. Ojalvo, M.D.'s motion for summary judgment (motion sequence 001) is granted and the complaint is dismissed against her with costs and disbursements to said defendant as taxed by the clerk upon the submission of an appropriate bill of costs, and the clerk is directed to enter judgment accordingly; and it is further

ORDERED that defendant Hannah Wunsch, M.D.'s motion for summary judgment (motion sequence 003) is granted, and the complaint is dismissed as against

her with costs and disbursements to said defendant as taxed by the clerk upon the submission of an appropriate bill of costs, and the clerk is directed to enter judgment accordingly; and it is further

ORDERED that the action is severed and continued as to the remaining defendants; and it is further

ORDERED that the branch of defendant Jason D. Wright, M.D.'s motion for summary judgment (motion sequence 002) seeking dismissal of the lack of informed consent cause of action is granted and the claim is dismissed; and it is further

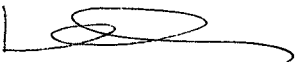
ORDERED that defendant Jason D. Wright, M.D.'s motion is otherwise denied, except that plaintiff's claims shall be limited to alleged negligence occurring on and after May 16, 2012; and it is further

ORDERED that the branch of defendants NYPH and Columbia's motion for summary judgment (motion sequence 004) seeking dismissal of the lack of informed cause of action is granted and the claim is dismissed, and the motion is otherwise denied.

Counsel for the remaining parties are directed to appear for a pre-trial conference at Part 1 MMSP, 60 Centre St., Room 325, New York, New York on March 6, 2018 at 9:30 a.m. In the event that no settlement can be reached, counsel shall be prepared on that date to stipulate to a firm trial date in Part 40 TR.

The foregoing is this court's decision and order.

Dated: New York, New York
February 15, 2018



Hon. Martin Shulman, J.S.C.