Callagy v Sklarek
2019 NY Slip Op 31373(U)
May 15, 2019
Supreme Court, Suffolk County
Docket Number: 12-3457
Judge: Joseph Farneti
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ORIGINAL

SHORT FORM ORDER

INDEX No. 12-3457

CAL. No. 17-02488MM

SUPREME COURT - STATE OF NEW YORK
I.A.S. PART 37 - SUFFOLK COUNTY

PRESENT:

Hon. JOSEPH FARNETI
Acting Justice of the Supreme Court

MOTION DATE 5-16-18 (002)
MOTION DATE 6-7-18 (003)
ADJ. DATE 10-11-18
Mot. Seq. # 002 - MD
003 - MG

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JOHN CALLAGY, AS EXECUTOR OF THE ESTATE OF ALFRED CALLAHAN, JR.,

Plaintiff,

- against -

HOWARD SKLAREK, M.D., SOUTHAMPTON PULMONARY MEDICINE, P.C., SOUTHAMPTON HOSPITAL, ANGELA SOTERIOU, M.D., DONNA BALDASSARE, D.O., ALEXIS HUGELMEYER, D.O., ALEXIS HUGELMEYER, D.O., P.C., ALAN GANDOLFI, M.D., RAJOO PATEL, M.D., EASTERN SUFFOLK CARDIOLOGY, P.C., and N. MAZZO, R.N.,

Defendants.

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Upon the following papers numbered 1 to 74 read on this motion for summary judgment : Notice of Motion/ Order to Show Cause and supporting papers 1 - 31 ; 57 - 70 ; Notice of Cross Motion and supporting papers __; Answering Affidavits and supporting papers 32 - 54 ; 71 - 72 ; Replying Affidavits and supporting papers 55 - 56 ; 73 - 74 ; Other ___; it is,

ORDERED that the motion (seq. #002) by the defendants Southampton Hospital, Donna Baldassare, D.O., and Nicole Mazzo, R.N., and the motion (seq. #003) by the defendants Rajoo Patel, M.D., and Eastern Suffolk Cardiology, P.C., are consolidated for the purposes of this determination; it is further

ORDERED that the motion by the defendants Southampton Hospital, Donna Baldassare, D.O., and Nicole Mazza, R.N., for an Order granting summary judgment in their favor and dismissing the complaint as asserted against them is denied; and it is further

ORDERED that the motion by the defendants Rajoo Patel, M.D., and Eastern Suffolk Cardiology, P.C., for an Order granting summary judgment in their favor and dismissing the complaint as asserted against them is granted.

This is a medical malpractice and wrongful death action to recover damages for injuries allegedly sustained by the plaintiff's decedent, Alfred Callahan, Jr., then age 65, during his admission to the defendant Southampton Hospital from June 13 to June 28, 2010. Due to a motor vehicle accident that injured his spinal cord, the decedent was paralyzed since he was 27 years old. For around 14 years prior to this hospitalization, the decedent was a patient of the defendant Howard Sklarek, M.D. On June 7, Dr. Sklarek prescribed Paxil to the decedent to treat depression. On June 11, the decedent called Dr. Sklarek to report some abnormal symptoms after taking about three doses of Paxil. Dr. Sklarek advised him to stop taking the medication.

On June 12, the decedent's son, Alfred Callahan, III, went to his father's house, where he saw that the decedent was not able to catch his breath or speak, so Mr. Callahan called for emergency services. The decedent was taken to Southampton Hospital via ambulance, where he was admitted early the next day for treatment. Dr. Sklarek was an attending physician at Southampton Hospital, and his practice, the defendant Southampton Pulmonary Medicine, P.C., had a contract to provide intensive care unit (ICU) services there at this time. The defendant Donna Baldassare, D.O., was a first-year resident at Southampton Hospital doing a rotation in the ICU, under Dr. Sklarek's supervision, during the decedent's admission. Upon his admission, the decedent presented with profound hyponatremia (low sodium), which was indicative of moderate or severe pneumonia, due to a syndrome of inappropriate antidiuretic hormone (SIADH). The decedent's admitting history and physical forms noted "severe hyponatremia questionable reaction to Paxil." During the afternoon on June 13, the decedent suffered a seizure, which required him to be intubated while in the emergency room. After various testing, the decedent was diagnosed with severe community-acquired pneumonia, which in turn caused acute respiratory distress syndrome (ARDS), and he was admitted to the intensive care unit (ICU). Dr. Sklarek believed that the decedent was suffering from hyponatremia due to pneumonia, and that his seizure was triggered by these conditions, as well as hypoxemia (low oxygen) from ARDS. In the alternative, Dr. Sklarek opined that the decedent might have an independent seizure disorder, so he asked for neurology to follow the decedent in the ICU.

Throughout his stay at Southampton Hospital, the decedent was on ventilation with an artificial airway, first with an endotracheal tube, then with a tracheostomy tube. On June 13, for the purposes of medical management and airway protection, Dr. Baldassare wrote a long-term sedation order for the decedent. Also on that date, Dr. Baldassare wrote an emergent order for Ativan, as the decedent was having a seizure and neither Dr. Sklarek or Dr. Mantovani were in the ICU at that time. On June 14, she wrote an order for left and right wrist restraints. On June 15, Dr. Sklarek wrote another order for wrist restraints due to episodes of the decedent being agitated and flailing, including an occasion where he may have grabbed the endotracheal tube. In addition, according to Dr. Sklarek's note on that date, the decedent almost self-extubated when he, Dr. Baldassare, and other hospital staff members were in the room, despite the use of freedom splints and mittens.

As a result of the decedent's hypertension and an abnormal electrocardiogram (EKG) on June 14, his care team requested a cardiology consult. On June 16, the defendant Rajoo Patel, M.D., who was employed by the defendant Eastern Suffolk Cardiology, P.C., saw the decedent. At that time, the decedent was intubated, and Dr. Patel noted that he was agitated. Dr. Patel did not recall if any restraints were being utilized on the decedent at that time. After reviewing the decedent's records and test results, Dr. Patel's assessment was that the abnormal EKG was most likely the result of an electrolyte disturbance, though he recommended a noninvasive coronary artery disease evaluation when the decedent stabilized, and he suggested continuing intravenous (IV) fluids, IV antibiotics, and low-dose dopamine.

On June 21, the decedent was evaluated for the surgical placement of a tracheostomy tube, as the current endotracheal tube was not keeping him sufficiently oxygenated. The decedent agreed to the procedure, and nonparty Dr. Dalencourt performed this surgery on June 22. Dr. Sklarek did not see the decedent again until June 23, and his note on that date indicates that there were no restraint orders made during the intervening week. Also on June 23, Dr. Sklarek wrote an order for a Versed drip to medically sedate the decedent. Dr. Baldassare's note on this date shows she also saw the decedent and she observed that the tracheostomy tube was in place.

Ms. Mazza was employed by Southampton Hospital as an ICU nurse during the decedent's admission. On June 23, Ms. Mazza assessed the decedent as to his sedation level and his level of agitation to make a determination as to whether physical restraints were necessary. Ms. Mazza authored a nursing note around 8:00 p.m. indicating that the decedent was wearing bilateral freedom splints, which did not require a written order from a physician. Ms. Mazza also noted that the decedent was not agitated, that he was arousable for most of the day, that he was receiving a high dose of morphine, and that he was also receiving Versed. During her assessment, Ms. Mazza noted that the decedent was awake and appeared calm. As a result of her assessment, Ms. Mazza did not recommend that an order for wrist restraints be written. The medical records indicate that Ms. Mazza changed the dressing on the decedent's tracheostomy during this assessment, although she testified at her deposition that she did not do so.

On June 23 at 8:25 p.m., the decedent's ventilator alarm went off, and Ms. Mazza immediately attended to him. The medical records indicate that the decedent told Ms. Mazza, "I cannot breathe," and that he was pale and sweating. At 8:29 p.m., the decedent went into respiratory distress and a code 5 was called. During the code, respiratory therapist Jay Thompson used an artificial manual breathing unit

(AMBU) through the existing tracheostomy tube to help the decedent breathe, but his oxygen saturation levels continued to fall. In addition, Ms. Mazza and Mr. Thompson observed that the decedent's face was showing signs of subcutaneous emphysema during this time. As a result of the decedent's low oxygen saturation level, Ms. Mazza called the defendant hospitalist Alexis Hugelmeyer, D.O., to manage the code. Upon her arrival, Dr. Hugelmeyer observed that the decedent's head and neck were puffy, and a chest x-ray done at 8:38 p.m. showed that the tracheostomy tube was displaced. At around 8:45 p.m., the defendant Alan Gandolfi, M.D., reestablished the decedent's airway by removing the tracheostomy tube, then placing an endotracheal tube through the tracheotomy. Although Dr. Hugelmeyer testified at her deposition that the decedent lost his pulse during this tube exchange, and that she ordered cardiopulmonary resuscitation (CPR) with AMBU bagging right away, the code sheet indicates that the decedent lost his pulse at 8:32 p.m., and that CPR was initiated at 8:40 p.m. The decedent was then shocked three to four times between 8:46 p.m. and 8:47 p.m., and although his pulse was restored at 8:47 p.m, he was in a nonresponsive state thereafter. Dr. Hugelmeyer's note as to the code states that the decedent apparently dislodged the tracheostomy tube, which led to cardiopulmonary arrest. Dr. Patel also authored a note at 10:25 p.m. stating that he assisted in the code. Dr. Hugelmeyer testified at her deposition that Dr. Patel was present for the code, but that she could not recall when he arrived or whether he ordered medications to be administered to the decedent, including sodium bicarbonate, magnesium sulfate, and Amiodarone.

On June 24 at 7:20 a.m., Dr. Sklarek wrote a note indicating that he saw the decedent, and that, as a result of the code the previous evening, the decedent had extensive subcutaneous emphysema and possible anoxic encephalopathy. On June 28, the decedent was seen by nonparty neurologist Dr. Henry Moreta, who ordered an electroencephalogram (EEG). The EEG showed bilateral cerebral dysfunction. Based upon his examination of the decedent and the EEG results, Dr. Moreta's impression was that the decedent had suffered anoxia or anoxic hypoxic encephalopathy due to a lack of oxygen to the brain. As a result of the decedent's comatose state and Dr. Moreta's findings, Dr. Sklarek opined that the decedent had little to no possibility for meaningful recovery, and he discussed a terminal extubation with Mr. Callahan. On June 28, Mr. Callahan gave permission to perform this procedure, and the decedent passed away shortly thereafter.

By his complaint, as amplified by his bills of particulars, the plaintiff John Callagy alleges that the decedent was injured as a result of the defendants' medical malpractice. As relevant to the instant motions, the plaintiff alleges that Southampton Hospital, Dr. Baldesarre, and Ms. Razza (hereinafter referred to as "the Hospital defendants") were negligent in, among other things, failing to properly monitor the decedent's tracheostomy, failing to properly restrain the decedent to prevent him from manipulating his artificial airway, and failing to maintain his airway during the code. In addition, the plaintiff alleges that Dr. Patel and Eastern Suffolk Cardiology, P.C. (hereinafter referred to as "the cardiology defendants") were negligent in, among other things, failing to properly partake in and run the code on June 23, and failing to timely begin CPR on the decedent during that time. The plaintiff further alleges that, as a result of the defendants' malpractice, the decedent suffered various injuries, including acute respiratory failure, cardiac arrest, and anoxic brain injury, all of which contributed to his death.

The Hospital defendants now move for summary judgment dismissing the complaint as asserted against them, arguing that they did not deviate or depart from good and accepted practice in rendering

medical treatment to the decedent, and that their treatment was not a proximate cause of his injuries and death. In support, the Hospital defendants submit, among other things, copies of the decedent's medical records during his June 2010 admission, transcripts of the parties' deposition testimony, and an affidavit of Steve H. Salzman, M.D., a board-certified physician in internal medicine, pulmonary diseases, and critical care. The plaintiff opposes the Hospital defendants' motion, arguing, *inter alia*, that the Hospital defendants departed from good and accepted medical practice in their treatment of the decedent in various ways, namely by Dr. Baldassare and Ms. Mazza failing to order or request necessary chemical and physical restraints in light of the decedent's pattern of nearly extubating himself, and by Mr. Thompson and Ms. Mazza failing to properly AMBU bag the decedent during the code. In opposition, the plaintiff submits, among other things, an affirmation of a board-certified critical care physician. In reply, the Hospital defendants submit an affirmation of their attorney.

The cardiology defendants also move for summary judgment, arguing that none of the medical care rendered by them to the decedent deviated or departed from good and accepted practice, nor was their treatment of him a proximate cause of his injuries and death. In support, the cardiology defendants submit, among other things, an affidavit of Mark A. Goodman, a board-certified physician in internal medicine and cardiovascular disease. The plaintiff does not oppose the motion by the cardiology defendants. In response to the cardiology defendants' motion, Southampton Hospital submits an affirmation of its attorney, requesting that the Court dismiss any claims for vicarious liability asserted against it on the basis of the care rendered by the cardiology defendants.

As healthcare providers, doctors and hospitals owe a duty of reasonable care to their patients while rendering medical treatment, and a breach of this duty constitutes medical malpractice (*see* ***Dupree v Giugliano***, 20 NY3d 921, 924, 958 NYS2d 312, 314 [2012]; ***Scott v Uljanov***, 74 NY2d 673, 675, 543 NYS2d 369 [1989]; ***Tracy v Vassar Bros. Hosp.***, 130 AD3d 713, 715, 13 NYS3d 226, 288 [2d Dept 2015]). To recover damages for medical malpractice, a plaintiff patient must prove both that his or her healthcare provider deviated or departed from good and accepted standards of medical practice, and that such departure proximately caused his or her injuries (*see* ***Gross v Friedman***, 73 NY2d 721, 535 NYS2d 586 [1988]; ***Bongiovanni v Cavagnuolo***, 138 AD3d 12, 16, 24 NYS3d 689, 692 [2d Dept 2016]; ***Stukas v Streiter***, 83 AD3d 18, 23, 918 NYS2d 176 [2d Dept 2011]).

To establish its entitlement to summary judgment in a medical malpractice action, a defendant healthcare provider must prove, through medical records and competent expert affidavits, the absence of any such departure, or, if there was a departure, that the plaintiff was not injured as a result (*see* ***Bongiovanni v Cavagnuolo***, *supra*; ***Mitchell v Grace Plaza of Great Neck, Inc.***, 115 AD3d 819, 982 NYS2d 361 [2d Dept 2014]; ***Faccio v Golub***, 91 AD3d 817, 938 NYS2d 105 [2d Dept 2012]). To sustain this burden, the defendant must address and rebut any specific allegations of malpractice set forth in the plaintiff's bill of particulars (*see* ***Schuck v Stony Brook Surgical Assoc.***, 140 AD3d 725, 33 NYS3d 369 [2d Dept 2016]; ***Seiden v Sonstein***, 127 AD3d 1158, 7 NYS3d 565 [2d Dept 2015]; ***Lormel v Macura***, 113 AD3d 734, 979 NYS2d 345 [2d Dept 2014]). If such a showing is made, the burden then shifts to the plaintiff patient to submit evidentiary facts or materials in rebuttal, but only as to those elements on which the defendant met his or her *prima facie* burden (*see* ***Keesler v Small***, 140 AD3d 1021, 35 NYS3d 356 [2d Dept 2016]; ***Abakpa v Martin***, 132 AD3d 924, 19 NYS3d 303 [2d Dept 2015]; ***Williams v Bayley Seton Hosp.***, 112 AD3d 917, 977 NYS2d 395 [2d Dept 2013]; ***Stukas v Streiter***,

supra). However, summary judgment is inappropriate in a medical malpractice action where the parties present conflicting opinions by medical experts (*see* ***Leto v Feld***, 131 AD3d 590, 15 NYS3d 208 [2d Dept 2015]; ***Gressman v Stephen-Johnson***, 122 AD3d 904, 998 NYS2d 104 [2d Dept 2014]; ***Moray v City of Yonkers***, 95 AD3d 968, 944 NYS2d 210 [2d Dept 2012]).

In general, a hospital may not be held liable for the acts of a physician who was not its employee, such as an independent physician retained by the patient, and the affiliation of a doctor with a hospital alone is insufficient to impute the doctor's alleged negligent conduct to the hospital (*see* ***Hill v St. Clare's Hosp.***, 67 NY2d 72, 79, 499 NYS2d 904, 909 [1986]; ***Bleiler v Bodnar***, 65 NY2d 65, 72, 489 NYS2d 885, 889 [1985]; ***Seiden v Sonstein***, *supra*; ***Zhuzhingo v Milligan***, 121 AD3d 1103, 995 NYS2d 588 [2d Dept 2014]). Further, a hospital may not be held liable for injuries suffered by such a patient where the employees of the hospital merely carry out the orders of the private attending physician, unless the hospital staff commits independent acts of negligence or the attending physician's orders are contraindicated by normal practice (*see* ***Seiden v Sonstein***, *supra*; ***Zhuzhingo v Milligan***, *supra*; ***Fink v DeAngelis***, 117 AD3d 894, 986 NYS2d 212 [2d Dept 2014]). Moreover, 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 (*see* ***Quille v New York City Health & Hosp. Corp.***, 152 AD3d 808, 59 NYS3d 131 [2d Dept 2017]; ***Leavy v Merriam***, 133 AD3d 636, 638, 20 NYS3d 117 [2d Dept 2015]; ***Bellafiore v Ricotta***, 83 AD3d 632, 920 NYS2d 373 [2d Dept 2011]). Under the doctrine of respondeat superior, an employer may be held vicariously liable for injuries resulting from intentional torts or negligence committed by an employee acting within the scope of his or her employment (*see* ***Judith M. v Sisters of Charity Hosp.***, 93 NY2d 932, 693 NYS2d 67 [1999]; ***Hoffman v Verizon Wireless, Inc.***, 125 AD3d 806, 5 NYS3d 123 [2d Dept 2015]; ***Gui Ying Shi v McDonald's Corp.***, 110 AD3d 678, 972 NYS2d 307 [2d Dept 2013]).

At the outset, by his affidavit, Dr. Salzman specifically states that he has no opinion as to whether the nonmoving defendants, including Dr. Hugelmeyer, departed or deviated from good and accepted medical practice in their treatment of the decedent during his admission. As such, the Hospital defendants' submissions fail to address the issue of vicarious liability, even though the plaintiff alleges that Dr. Hugelmeyer was an employee of Southampton Hospital at the time she rendered medical treatment to the decedent, and that such treatment deviated from the standard of care (*see* ***Judith M. v Sisters of Charity Hosp.***, *supra*; ***Hoffman v Verizon Wireless, Inc.***, *supra*; ***Gui Ying Shi v McDonald's Corp.***, *supra*). Therefore, the Hospital defendants fail to establish, *prima facie*, that Dr. Hugelmeyer was an independent physician, precluding summary judgment on that issue (*see* ***Hill v St. Clare's Hosp.***, *supra*; ***Winegrad v New York Univ. Med. Ctr.***, 64 NY2d 851, 853, 487 NYS2d 316 [1985]; ***Stukas v Streiter***, *supra*).

Nevertheless, the Hospital defendants' submissions establish, *prima facie*, their entitlement to partial summary judgment by demonstrating the absence of a deviation or departure from good and accepted standards of medical practice in the treatment they rendered to the decedent, and that such treatment was not a substantial contributing factor in causing his injuries and death (*see* ***Bongiovanni v Cavagnuolo***, *supra*; ***Mitchell v Grace Plaza of Great Neck, Inc.***, *supra*; ***Faccio v Golub***, *supra*).

By his affidavit, Dr. Salzman opines, within a reasonable degree of medical certainty, that the decedent's ventilator, including his endotracheal tube and his later tracheostomy tube, was properly monitored throughout the course of his admission. Dr. Salzman states that hospital staff adjusted the ventilator based upon blood work, vital signs, physical examinations, and the decedent's overall condition, and he opines that all these actions were within the standard of care. Dr. Salzman further opines that the decedent's ventilator and breathing tubes were properly managed from the time he was intubated on June 13 until the time the tracheostomy tube dislodged on June 23.

In addition, Dr. Salzman opines that the decedent was properly sedated and restrained throughout his admission. Dr. Salzman states that the decedent's care team had a standing order to increase the decedent's dose of Versed should he become agitated, and he opines that this order was within the standard of care. Further, Dr. Salzman opines that all orders for chemical and physical restraints were followed by Southampton Hospital employees; that Ms. Mazza properly observed the decedent during her assessment on June 23; that Ms. Mazza correctly did not request further chemical or mechanical restraints for the decedent on June 23, as he was receiving high doses of medication, wearing bilateral freedom splints, and was calm and awake; and that, as there is no evidence that Dr. Baldassare was aware that the decedent was agitated, restless, or otherwise a danger to himself on June 23, Dr. Baldassare correctly did not order further chemical or mechanical restraints. Dr. Salzman further opines that Dr. Baldassare was in frequent contact with Dr. Sklarek and Dr. Mantovani, that she properly communicated with them at all times during the decedent's admission, and that these doctors supervised her care, including directing her to write orders regarding the decedent.

Moreover, Dr. Salzman opines that Mr. Thompson's use of the AMBU bag to oxygenate the decedent during the code on June 23 was appropriate. Dr. Salzman states that the medical records show that Mr. Thompson, and not Ms. Mazza, was operating the AMBU bag during the code, and that Dr. Baldassare was not present during this time. Further, Dr. Salzman opines that the fact that the decedent suffered subcutaneous emphysema in his face and neck is not indicative of negligence; rather, this fact merely illustrates that the tracheostomy tube was dislodged. Dr. Salzman opines that it was proper for Mr. Thompson to attempt to use an AMBU bag on the decedent to determine if there was a viable airway or any mechanical problems with the ventilator prior to calling the code, and that the code was timely called when the AMBU bag attempt failed to restore the decedent's oxygen saturation levels.

Further, the cardiology defendants' submissions demonstrate, *prima facie*, that they did not depart from good and accepted practice in their treatment of the decedent, and that the decedent was not injured as a result of said treatment (*see* ***Bongiovanni v Cavagnuolo***, *supra*; ***Mitchell v Grace Plaza of Great Neck, Inc.***, *supra*; ***Faccio v Golub***, *supra*). By his affidavit, Dr. Goodman states that the standard of care for a cardiologist called to consult a patient is to assess, evaluate, and diagnose any underlying cardiac conditions. Dr. Goodman states that, if there are no underlying cardiac conditions causing the patient's ailment, a consulting cardiologist's role is limited to supporting the patient hemodynamically while attempts are made to diagnose and treat the underlying illness as efficiently as possible. In addition, Dr. Goodman states that the standard of care for a cardiologist who appears for a code while it is in progress is to assist the physician running the code, and to ensure nothing untoward happens to the patient. Dr. Goodman opines that Dr. Patel properly diagnosed the decedent with an electrolyte disturbance during his consult on June 16, and that such diagnosis did not contribute to his injuries or death. Dr. Goodman

further opines that, as Dr. Hugelmeyer was managing the code on June 23, Dr. Patel had no obligation to take over management of same. In addition, Dr. Goodman opines that, although it is unclear if Dr. Patel ordered certain medications, even if these drugs were given to the decedent, none were contraindicated or could have caused him to suffer anoxic brain injury. Moreover, Dr. Goodman opines that the cause of the decedent's respiratory failure and anoxic encephalopathy was caused by the dislodgment of his tracheostomy tube, and not by any action or inaction taken by the cardiology defendants.

As Dr. Salzman and Dr. Goodman base their conclusions upon the decedent's medical records and the parties' deposition testimony, in addition to their education, knowledge, and medical experience, the Hospital defendants and the cardiology defendants have met their initial burden on the motion (*see* ***Schmitt v Medford Kidney Ctr.***, 121 AD3d 1088, 996 NYS2d 75 [2d Dept 2014]; ***Lahara v Auteri***, 97 AD3d 799, 948 NYS2d 693 [2d Dept 2012]; ***Arkin v Resnick***, 68 AD3d 692, 890 NYS2d 95 [2d Dept 2009]). Further, as the plaintiff does not oppose the cardiology defendants' motion, their motion is granted.

The Hospital defendants having met their initial burden on the motion, the burden shifted to the plaintiff to submit admissible evidence raising a triable issue of fact (*see* ***Keesler v Small***, *supra*; ***Abakpa v Martin***, *supra*; ***Williams v Bayley Seton Hosp.***, *supra*). In opposition, the plaintiff submits an affirmation of a critical care physician. The plaintiff's critical care expert opines, within a reasonable degree of medical certainty, that Southampton Hospital's staff deviated from the standard of care in its treatment of the decedent on June 22 and June 23, and that same proximately caused his injuries and death. The decedent's medical records show that there were no orders written for chemical or mechanical restraints on June 22 or June 23, that he underwent surgery to place a tracheostomy tube on June 22, and that Ms. Mazza changed the dressing on the fresh tracheostomy, though she denied having done so during her deposition.

The plaintiff's expert states that the standard of care required that a nurse request and a doctor write orders for additional chemical and mechanical restraints on June 22 and June 23, as the decedent had a new tracheostomy and a history of attempts to pull out his lines and tubes during his admission. As Dr. Baldassare did not order any restraints on June 22 or June 23, and Ms. Mazza did not request same after her June 23 assessment, the plaintiff's expert opines that this was a departure from the standard of care. Although the plaintiff's expert acknowledges that Dr. Baldassare was a resident at the time she rendered treatment to the decedent, he finds that she was heavily involved in the decedent's day-to-day care, as she independently ordered an emergency dose of Ativan in response to the decedent's seizure, and that she was aware of his history of agitation and attempts to extubate himself. As such, the plaintiff's expert raises a triable issue of fact as to whether Dr. Baldassare exercised independent medical judgment with regards to the treatment she rendered to the decedent (*see* ***Quille v New York City Health & Hosp. Corp.***, *supra*; ***Leavy v Merriam***, *supra*; ***Bellafiore v Ricotta***, *supra*).

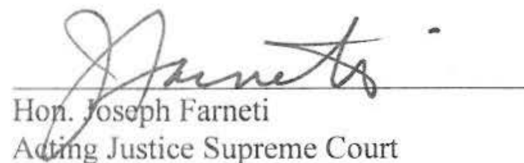
In addition, the plaintiff's expert states that the standard of care required Southampton Hospital's respiratory therapists, Shari Hymes and Arthur Ruderman, to monitor the tracheostomy after it was placed to ensure that it remained in position, and that it was secured and fastened at all times. As the medical records are devoid of evidence that these respiratory therapists monitored the tracheostomy on June 22 and June 23, the plaintiff's expert opines that this monitoring was not done and same was a deviation

from good and accepted practice. Further, the plaintiff's expert states that the standard of care required that an AMBU bag be used through the mouth to keep the decedent oxygenated during the code as soon as it became apparent that using this device through the tracheostomy was not effective. As Ms. Mazza and Mr. Thompson observed symptoms of subcutaneous emphysema, namely the decedent's head and neck becoming puffy during Mr. Thompson's use of the AMBU bag, and symptoms of hypoxia, namely an oxygen saturation level of 38%, the plaintiff's expert opines that Ms. Mazza and Mr. Thompson departed from the standard of care by failing to switch the AMBU bag from the tracheostomy to the decedent's mouth. Moreover, the plaintiff's expert further opines that these departures and deviations were a proximate cause of the dislodgment of the decedent's tracheostomy tube and his anoxic brain injury, all of which contributed to his death. As the parties have presented conflicting opinions by medical experts, summary judgment is inappropriate (*see* ***Leto v Feld***, *supra*; ***Gressman v Stephen-Johnson***, *supra*; ***Moray v City of Yonkers***, *supra*).

In light of the foregoing, the Hospital defendants' motion is denied, and the cardiology defendants' motion is granted.

The unredacted affirmation of the plaintiff's medical expert submitted for in camera review is being returned by mail to the plaintiff's counsel simultaneously with the issuance of this Order.

Dated: May 15, 2019



Hon. Joseph Farneti
Acting Justice Supreme Court

_____ FINAL DISPOSITION __X__ NON-FINAL DISPOSITION