Gonzales v Donn
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June 13, 2019
Supreme Court, New York County
Docket Number: 805174/2012
Judge: George J. Silver
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Index №. 805174/2012

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NEW YORK, PART 10

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JOSE N. GONZALES, as administrator of the Estate of MARIA DEL ROSARIO GONZALES, deceased, and JOSE N. GONZALES, Individually, **Index №. 805174/2012**

Plaintiff

-against-

GULBAHAR DONN, M.D., ROBERTO CANTU, M.D., MART1NE LOUIS, M.D., NAGESWARA MANDAVA, MD., JOSIE AQUINO, M.D., HUMBERTO PORTILLO, M.D., QUEENS HEALTH CENTER, FLUSING HOSPITAL MEDICAL CENTER, BELLEVUE HOSPITAL CENTER and NEW YORK CITY HEALTH AND HOSPITALS CORPORATION, and LUCOT CHERENFANT, M.D.

Defendants

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HON. GEORGE J. SILVER:

In this medical malpractice action, defendant NEW YORK CITY HEALTH AND HOSPITALS CORPORATION s/h/a BELLEVUE HOSPITAL CENTER ("Bellevue") moves pursuant to CPLR §3212, for summary judgment and an order dismissing the complaint of plaintiff JOSE N. GONZALES ("plaintiff"), as administrator of the estate of MARIA DEL ROSARIO GONZALES ("decedent"), as against it. Separately, HUMBERTO PORTILLO, M.D. ("Dr. Portillo"), JOSE AQUINO, M.D. ("Dr. Aquino"), GULBAHAR DONN, M.D. ("Dr. Donn"), and Lucot Cherenfant, M.D. ("Dr. Cherenfant") move for the same relief. Likewise, NAGESWARA MANDAVA, M.D. ("Dr. Mandava"), and FLUSHING HOSPITAL MEDICAL CENTER ("Flushing Hospital") move for the same relief. In addition, NEW YORK HOTEL TRADES COUNCIL AND HOSPITAL ASSOCIATION OF NEW YORK CITY, INC., HEALTH CENTER INC., i/s/h/a QUEENS HEALTH CENTER ("NYHTC") moves for the same relief. Similarly, MARTINE LOUIS, M.D. ("Dr. Louis") moves for the same relief. Finally, ROBERT CANTU, M.D. ("Dr. Cantu") moves for the same relief. As will be discussed herein, plaintiff opposes certain branches of defendants' respective applications, and does not oppose other branches.[1]

[1] At various points throughout this decision, the collective defendants are referred to as "defendants" or "moving defendants."

BACKGROUND

On February 25, 2011, decedent, who was 37-years-old and 38 weeks pregnant at the time, presented to NYHTC, where she was evaluated by Dr. Aquino. When seen by Dr. Aquino, decedent complained of abdominal pain since the previous night that had been preceded by four episodes of vomiting. Dr. Aquino observed a uterine contraction, which was confirmed on palpation. The fetal heart rate was recorded as 156 beats per minute. Decedent was unable to lie down due to pain. She had a rapid heart rate although her remaining vital signs were normal. An ambulance was called to transport decedent to defendant Flushing Hospital.

Once there, decedent was admitted to the labor and delivery unit at 12:13 p.m. Decedent was later brought to the operating room ("OR") at 12:22 p.m. for a "crash c-section for no fetal tracing." A caesarian section ("c-section") was performed by Dr. Cherenfant, and a male infant was delivered at 12:36 p.m.

During the c-section, 2 liters of blood were identified in the peritoneum.[23] After delivery, the source of this massive bleeding could not be identified, and a surgery consult was called. Dr. Cantu, a surgeon, scrubbed in and noted that there appeared to be blood coming from the upper abdomen. Dr. Cantu made a midline incision (to inspect the abdomen) and discovered a large, approximately 15 x 20 cm. hematoma involving the right lobe of the liver (indicative of a rupture of the liver capsule).[4] Several areas of active bleeding were cauterized and the area was purposefully packed with sponges known as laparotomy pads ("lap pads"). The abdomen was thoroughly irrigated and suctioned dry. Decedent was transferred to the recovery room in stable condition. She was intubated and sedated.

At 2:45 p.m., decedent was transferred to the surgical intensive care unit ("SICU") at Flushing Hospital. She remained intubated and sedated. By 7:30 p.m., it was noted that she was in a state of shock. Decedent had a rapid heart rate despite aggressive fluid resuscitation, and it was documented that her urine output had dropped significantly in the last hour. By the time of the 7:30 p.m. note, she had already received four (4) units of packed red blood cells ("PRBCs"), two (2) units of fresh frozen plasma ("FFP") and five (5) units of cryoprecipitate. As is evident from the above, decedent had lost and continued to lose a tremendous amount of blood at a rapid pace.

Overnight, decedent required a further massive transfusion of blood products. She became more unstable on the morning of February 26, 2011, as reflected by a drop in hematocrit[5] and persistent metabolic

[2] The average human has 5 liters of blood. Therefore, 2 liters are the equivalent of 40% of the total blood volume in the average human.
[3] The peritoneum is a large membrane in the abdominal cavity that connects and supports internal organs.
[4] 3 The liver capsule (aka Glisson's capsule) is a layer of connective tissue that surrounds the liver. A ruptured liver capsule is a rare and life-threatening condition usually associated with pregnancy.
[5] The proportion of red blood cells in an individual's total blood. Red blood cells are vital to a human's health and transport oxygen and nutrients throughout the body.

acidosis.[6] The attending surgeon, Dr. Louis, took decedent back to the operating room ("OR") for a re-exploration, and damage-control laparotomy.[7]

During the surgery, which was performed by Dr. Louis and Dr. Mandava, a large amount of blood and clots were removed. The six lap pads that had been purposefully placed the prior day were removed and the lower quadrants were packed after visualization of a dry uterine incision. The surgeons thereafter turned their attention to the upper abdomen and discovered significant bleeding coming from several portions of the liver. The surgeons attempted a maneuver to control the bleeding and purposefully packed the wound with 29 lap pads. An abdominal vacuum ("VAC") dressing was placed thereafter to promote healing of the wound.

The surgeons noted that decedent was unstable during the procedure, requiring the use of vasopressors.[8] She also received multiple transfusions of blood products — 12 units of PRBCs, 12 units of FFP and 12 units of platelets.[9] Decedent lost more than five (5) liters of blood during the procedure (meaning that she lost more than the total amount of blood volume in the average human in her time at Flushing Hospital).

After the surgery, she was transferred to the SICU in "an unstable condition, very critical." Thereafter, decedent was transferred to Bellevue for further management. Upon arrival at Bellevue on February 26, 2011, decedent was unstable and critically ill with a rapid heart rate and a systolic blood pressure in the 70s. A massive transfusion protocol[10] was initiated and she was taken to interventional radiology, where a mesenteric angiogram showed no active arterial branch bleeding. She was then taken to Bellevue's SICU. She remained intubated and sedated. As testified to by Bellevue attending surgeon Spiros Frangos, M.D. ("Dr. Frangos"), decedent's "status throughout the whole hospitalization is deemed critically ill." A note by trauma surgery attending Joseph Carter, M.D. indicated that decedent's hematocrit and platelets remained low. She was coagulopathic[11] with a high INR[12] of two (2). There was difficulty ventilating and oxygenating her, which was suggestive of ARDS (acute respiratory distress syndrome)[13] or transfusion-related acute lung injury (TRALI).[14] She continued to show signs of metabolic acidosis and shock from her ongoing intraperitoneal bleeding. Decedent's hypovolemia[15] was being treated with blood transfusions, fluids, laboratory work every two hours and monitoring of her input/output.

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[6] When the kidneys cannot remove enough acid from the body, a potential indicator of failing kidney function.
[7] Surgery performed on the abdomen using a full-size incision.
[8] Medications that contract blood vessels and raise blood pressure.
[9] Platelets are tiny cells that circulate and help the blood to clot.
[10] Activated by a clinician in response to a patient who is experiencing massive bleeding. Once a patient is in the protocol, the blood bank is able to insure rapid and timely availability of blood components to facilitate resuscitation.
[11] Condition in which the blood's ability to form clots is impaired, making an individual susceptible to uncontrolled bleeding.
[12] Standardized measurement of the time it takes for the blood to clot.
[13] A disease in which fluid leaks into the lungs making breathing difficult or impossible.
[14] A rare but serious syndrome characterized by sudden acute respiratory distress following transfusion.
[15] A life-threatening condition that results from the loss of more than 20% of the body's blood or fluid supply.

On February 28, 2011, decedent remained in critical condition and she received two (2) units of PRBCs and 1 unit of FFP. She had multiple lines and IVs in place. A VAC remained over the abdominal wound, which drained blood tinged fluid. Decedent was given the antibiotic cefazolin between February 28 and March 2, 2011.

On March 1, decedent was seen by surgery, and it was noted that she was in critical condition. She continued to bleed. A decision was made to take her to the OR for an exploratory laparotomy.

The surgery proceeded with attending surgeons Steven M. Cohen, D.O ("Dr. Cohen"), and George Miller, M.D. ("Dr. Miller") and decedent was found to have a ruptured liver capsule with bleeding from the lower surface areas of the liver. She underwent an abdominal washout and the surgeons attempted to stop the bleeding from the liver with an Argon beam laser. She was provided with further blood transfusions during the surgery (2 units of PRBCs, one (1) unit of platelets and 1 unit of FFP). She was brought back to the ICU in critical condition following the surgery.

She received an additional blood transfusion post-operatively (2 units of FFP, 1 unit of PRBCs and 1 unit of platelets). Due to kidney failure, decedent received dialysis on March 1 and 2, 2011.[16] A sedation holiday[17] was attempted with "minimal response" (meaning that she was not yet ready to be removed from sedation). On March 2, decedent received an additional one (1) unit of platelets. Laboratory work revealed a high white blood cell count and a left shift, indicative of an infectious process.

On March 3, decedent experienced hypotension during dialysis, resulting in the need for an additional transfusion of two (2) units of platelets and two (2) units of PRBCs. Due to hypoxia,[18] her ventilator setting was adjusted. Additionally, in response to the laboratory work that raised a concern for infection and a blood culture that was positive for gram positive cocci in chains (enterococcus faecalis), she was started on the broad-spectrum antibiotics IV Zosyn (which she completed on March 10, 2011) and IV Vancomycin (which she completed on March 10, 2011).

Decedent was brought back to the OR on March 4, 2011 (the attending surgeon was Dr. Cohen), where she underwent an abdominal washout, repacking of the abdomen, replacement of the VAC dressing and placement of an IVC filter.[19] Oozing from a few areas of the liver was controlled and repaired. Segment six (6) of the right lobe of the liver had a "woody appearance and was possibly completely ischemic." Given decedent's low platelet count of 34, however, a decision was made to re-pack the liver and return to the OR in 24 to 35 hours for an additional surgery. She was thereafter taken to the ICU for further resuscitation in guarded condition. She was given two (2) units of platelets and two (2) units of PRBCs.

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[16] Decedent thereafter received dialysis on a semi-regular basis for the next 10 days.
[17] When a patient is removed from sedation briefly to assess how they respond and whether they are ready to be removed from sedation.
[18] When the tissues in the body do not receive adequate oxygenation.
[19] The filter, a small device placed in the vein carrying deoxygenated blood to the heart, prevents clots from moving through the blood to the lungs.

A CT scan of the abdomen and pelvis interpreted on March 6, 2011 revealed excess fluid surrounding both lungs (bilateral pleural effusions) and consolidation. On March 6, 2011, decedent was returned to the OR for an abdominal washout and change of VAC dressing. No bleeding was found during the surgery and all packing was removed. A right chest tube was placed in an attempt to drain the excess fluid around the lung. She also received two (2) units of PRBCs, four (4) units of FFP, eight (8) units of platelets and one (1) unit of cryoprecipitate intra-operatively.

A March 7, 2011 progress note provides some insight into decedent's overall condition approximately ten days after her admission to Bellevue. It was documented that she had been receiving blood products frequently and that she remained sedated, with minimal responsiveness. She remained on the ventilator and received nutrition via artificial means. Foley catheter was in place. A VAC was still connected to her abdomen. It was noted: "There has been no major change to the patient's condition,"

Decedent underwent abdominal closure and open gastrostomy tube placement on March 8, 2011. The operative report (authored by the attending Omar Bholat, M.D.) indicated that decedent required a gastrostomy tube given her prolonged ICU course and her need for tube feedings moving forward. During the surgery, Dr. Bholat found no evidence of intraperitoneal bleeding and he indicated that the liver was hemostatic (no blood). The surgeon closed the fascia with the skin left open. The wound VAC was placed back on top of the abdomen. Decedent was brought back to the ICU in stable but critical condition.

On March 11, 2011, it was noted that decedent had an "acute deterioration" the prior night secondary to a possible mucus plug. She later became septic,[20] which progressed to septic shock.[21] She was placed on multiple vasopressors for hypotension and was now started on the antibiotics IV imipenem (until April 7, 2011), IV polymyxin B (until March 14, 2011) and IV Vancomycin (until March 14, 2011), along with the anti-fungal IV caspofungin (until March 17, 2011). It was further documented that due to kidney failure and her inability to tolerate dialysis, decedent was started on a temporary treatment for acute renal failure in unstable patients, known as CVVH (continuous venovenous hemodiafiltration). Decedent was still characterized as "critically ill" with a "guarded prognosis." Decedent was being closely followed by infectious diseases.

By March 12, 2011, decedent had improved and she was taken off the vasopressors. She continued to receive CVVH.[22] An attending ICU note from March 13, 2011 documented that decedent had resolving septic shock but that she remained in multisystem organ failure. She was still intubated and sedated with no response to pain. An abdominal CT scan performed on March 14, 2011 revealed a possibility of infected fluid and bilateral pleural effusions.

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[20] Potentially life-threatening condition caused by the body's response to an infection that can result in multi-organ failure.

[21] A life-threatening condition that happens when blood pressure drops to a dangerously low level after an infection. This reduces the amount of blood and oxygen that reaches the body's organs, preventing them from proper functioning.

[22] She continued off and on the CVVH for the remainder of her hospitalization.

The following day (March 15, 2011), decedent had fevers, exhibited hypotension and was re-started on the vasopressors that had been discontinued on March 12, 2011. On March 16, 2011, decedent was brought to the OR for a tracheostomy.[23] The Operative Report by attending surgeon Prashant Sinha, M.D. explained that due to respiratory failure, decedent had been on a ventilator for the entirety of her stay. The Operative Report continues: "As it was unlikely that the patient would be extubated anytime soon, the decision was made to take the patient for tracheostomy." Her VAC dressing was also changed during the surgery. Following the procedure, she was taken back to the ICU in stable condition.

A positive blood culture yielded the bacterium acinetobacter calcoaceticus-baumanii complex,[24] also on March 16, 2011. Decedent was thereafter maintained on IV imipenem and started on the antibiotic oral Vancomycin (until the following day). She was restarted on the antibiotics IV polymyxin B (until March 24, 2011) and IV Flagyl (until March 23, 2011) and given one dose of IV amikacin.

A chest x-ray performed on March 18, 2011 revealed increasing congestive heart failure.[25] Blood and urine cultures came back as positive for the bacteria enterococcus faecium VRE and serratia marcescens, respectively, on March 19, 2011. She was restarted on oral Vancomycin on March 20, 2011 (until March 24, 2011). On March 21, infectious diseases consultant Elizabeth Miller, M.D. ("Dr. Miller") noted that a chest x-ray revealed a "white out" of the right lung (complete filling of the entire right chest cavity by fluid, resulting in collapse of the right lung) likely due to pleural effusion (this was confirmed the next day by CT scan). Dr. Miller recommended diagnostic sampling of the pleural effusion (via thoracentesis).[26] Decedent was provided with further doses of IV amikacin on March 21 and 22, 2011.

A further note from Dr. Miller on March 22, 2011 included the following differential diagnosis for decedent's ongoing infectious issues: cholangitis given persistent abnormal liver function tests (less likely as abnormal liver function tests were likely more reflective of liver failure) vs. intra-abdominal abscess vs. GI translocation from colitis, hospital acquired pneumonia with worsening pleural effusions +/- parapneumonic effusion vs. line infection. Dr. Miller recommended repeat radiological imaging and continuing decedent on her current antibiotics, with the exception of IV Flagyl, which was discontinued. Dr. Miller documented: "If feasible. would perform thoracentesis to rule out infected parapneumonic effusion given increased effusions."

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[23] Surgical procedure that provides an air passage from the skin through the soft tissues of the neck into the trachea to assist with ventilation when the usual route for breathing is obstructed or impaired, or the endotracheal tube has been in place for a prolonged period.

[24] This bacterium often affects immunocompromised individuals in the hospital setting and has shown resistance to multiple antibiotics, making it difficult to treat.

[25] Condition in which the heart pumps inefficiently, causing fluid to accumulate around the lungs, which in turn causes
the heart to pump even less efficiently.

[26] Procedure during which a needle is inserted into the pleural space (between the lungs and chest wall) to drain excess
fluid.

Infectious diseases fellow Thomas Norton, M.D. wrote on March 26: "Given severe liver failure, patient has a very poor prognosis. Doubt patient would be considered for transplant. . . overall goals of care may be futile without hepatic function."

Cultures on decedent's blood and urine continued to come back as positive on March 26, 2011. She was continued on IV imipenem and restarted on oral Vancomycin (until March 30, 2011) and IV amikacin (until March 29, 2011).

On March 28, 2011, decedent underwent yet another abdominal VAC change and washout of the inferior extraperitoneal space[27] by Dr. Cohen in the OR. The surgery was scheduled after a portion of decedent's abdominal wound appeared slightly dusky with foul- smelling drainage that morning. During the surgery, the presence of foul-smelling drainage was noted but this was believed to from the location of the incision.

Board certified plastic surgeon David Ehrlich, M.D. also performed a debridement of a left lower extremity wound on March 28, 2011. Following the surgeries, decedent was transferred back to the ICU. On April 1, 2011, infectious diseases recommended drainage of the pleural effusions that had been identified on CT scan. On April 5, 2011, decedent decompensated and spiked a fever. She was brought to the OR for abdominal exploration and washout by attending surgeon Dr. Frangos. During the surgery, a pocket of purulent fluid near the liver was suctioned out and copiously irrigated. At the close of the surgery, she was taken back to the ICU in critical, unchanged condition.

After the surgery, decedent was continued on IV imipenem (which she had been on since March 11, 2011 and was discontinued on April 7, 2011), IV polymyxin B (that had been restarted on March 31, 2011 and was discontinued on April 15, 2011) and IV linezolid (that had been started on April 1, 2011 and was discontinued on April 13, 2011). Oral Vancomycin (until April 15, 2011) and IV Flagyl (until April 8, 2011) were added.

Decedent was again brought back to the OR on April 8, 2011 for a further abdominal washout, VAC change and left lower extremity debridement performed by attending surgeon Ronald Simon, M.D. Dr. Simon performed yet another abdominal washout with dressing change in the OR on April 10, 2011. Id

A CT scan of the chest performed on April 11, 2011 revealed: "[A] slight interval increase in size of the small left pleural effusion. Stable partially loculated right pleural effusion." Scott Brandman, M.D., the radiologist who interpreted the study, concluded that the interval increase in atelectasis and consolidation of the left lower lobe were suspicious for worsening pneumonia.

A chest x-ray also performed on April 11, 2011 revealed "increased interstitial fluid content within both lungs with bilateral pleural effusions." A progress note from April 11, 2011 documents that decedent was on the following antibiotics: IV polymyxin B, IV linezolid, oral Vancomycin and IV tigecycline (which

[27] Portion of the abdomen that does not lie within the peritoneum.

had been started on April 7, 2011). The IV imipenem and IV Flagyl had been discontinued on April 7 and 8, 2011, respectively.

Due to the concerning findings on the radiological studies of April 11, 2011, and decedent's persistent infections that were not responding to antibiotic treatment (despite adjustment and close follow-up by infectious diseases consultants), a decision was made to proceed with a thoracentesis. Furthermore, the source of decedent's infections remained unknown and infectious diseases believed that there may have been an infection in the pleural space that would not improve without drainage.

On April 12, 2011, interventional radiologist Richard LeFleur, M.D. ("Dr. LeFleur") performed the thoracentesis, under fluoroscopic guidance, during which 60 cc. of turbid yellow fluid was aspirated and sent for laboratory analysis. Dr. LeFleur also placed a French pigtail catheter in the right upper abdomen for abscess drainage. It was noted that decedent tolerated the procedure well without complication.

The procedures were complicated by a right-sided hemothorax,[28] which was diagnosed a short time thereafter. A chest tube was placed overnight between April 12 and 13, 2011 and 700 cc. of bloody fluid was drained. Furthermore, another transfusion protocol was initiated and decedent was transfused with six (6) units of PRBCs, twelve (12) units of FFP and two (2) units of platelets.

A second chest tube was placed during the afternoon hours of April 14, 2011; however, by the evening, it was clear that despite the best efforts of Bellevue staff, decedent's was beginning to succumb to her condition. She was hypotensive and on vasopressors. Palliative care was instituted.

On April 15, 2011, decedent went asystole and was pronounced dead at 9:10 A.M. Dr. Frangos noted that the cause of death was "multifactorial with unrelenting infections and severely dysfunctional hepatic function playing primary roles."

The cause of death was: "Hemothorax Complicating Thoracentesis for Management Of Complications Of Spontaneous Rupture Of Liver During Pregnancy" and the manner of death was "Therapeutic Complication." In the course of his investigation, the Medical Examiner performed a microscopic examination of, among other things, decedent's lungs. His finding were "Diffuse marked bronchopneumonia, acute and organizing, with focal intraalveolar hemorrhage."

ARGUMENTS

A. Bellevue

In support of its motion for summary judgment, Bellevue annexes the pleadings, exhibits, medical records and affirmations of four experts to advance the position that plaintiff's claims of malpractice against Bellevue are lacking in merit, thus entitling the institution to judgment in its favor. Bellevue submits the affirmations of board-certified critical care surgeon Philip Barie, M.D. ("Dr. Barie"), board-certified interventional radiologist Jacob Cynamon, M.D. ("Dr. Cynamon"), board-certified general surgeon Dan

[28] Collection of blood in the space between the chest wall and the lung.

Reiner, M.D. ("Dr. Reiner") and board-certified pathologist Alex Williamson, M.D. ("Dr. Williamson")" in support of its motion for summary judgment.

Each of Bellevue's experts opines that the care and treatment provided by Bellevue, its staff and physicians was at all times within good and accepted medical practice and was not a proximate cause of the injuries alleged. Specifically, Bellevue's experts conclude that prior to her transfer to Bellevue, decedent suffered a serious and fatal injury that caused her to lose a tremendous amount of blood in a short period of time. The loss of blood resulted in multiorgan failure and shock. Her blood was no longer able to clot and her bone marrow shut down, making her susceptible to multiple and persistent infections.

Bellevue's experts opine that decedent was critically ill with a limited chance of survival upon her arrival at Bellevue. They further explain that the hospital made every effort to save her life, including close monitoring in the SICU, frequent blood work and radiological imaging, multiple surgeries and consults from multiple medical specialties. With her status declining and fluid accumulating around her lungs, the experts underscore that Bellevue made a reasoned decision, in the exercise of its best medical judgment, to proceed with a thoracentesis,[29] concluding that the benefits of the procedure far outweighed its risks. Bellevue's experts further reason that decedent unfortunately suffered a known and accepted consequence of the thoracentesis, which Bellevue managed appropriately. Bellevue highlights that it miraculously was able to keep decedent alive for two months before she passed away on April 15, 2011, when her body finally succumbed to the multiple medical issues with which she had been plagued with. As such, Bellevue submits that it is entitled to judgment in its favor.

Although plaintiff annexes the expert affirmations of an obstetrician and gynecologist ("OB/GYN") and general surgeon to plaintiff's omnibus opposition to defendants' collective motions, neither plaintiff's expert OB/GYN nor general surgeon opine that Bellevue, or its staff, departed from accepted standards of care in their care for decedent.

In reply, Bellevue highlights plaintiff's omission, and states that plaintiff's experts do not opine that Bellevue, its staff and/or physicians departed from accepted standards of care in their management of decedent. Bellevue further submits that plaintiff's experts do not opine that any actions or inactions of Bellevue, its staff and/or physicians proximately caused decedent's injuries. Consequently, Bellevue reiterates the position that it is entitled to judgment in its favor.

B. Dr. Portillo, Dr. Aquino, Dr. Donn, and Dr. Cherenfant

In support of their separate motion for summary judgment, Drs. Aquino, Donn, and Cherenfant annex the expert affirmation of board-certified OB/GYN Michelle Fried, M.D. ("Dr. Fried") who opines that the physicians were not negligent in any manner, and in fact provided better than good and acceptable medical care to decedent, and did not cause her injury or death. Dr. Fried highlights that Dr. Portillo, an OB/GYN at NYHTC, provided initial prenatal care to decedent during the pregnancy, and as of the last date of his treatment, January 14, 2011, decedent was doing well and had no signs of any problem. Next, Dr. Fried

[29] Aforementioned procedure during which a needle is inserted into the pleural space (between the lungs and chest wall) to drain excess fluid.

highlights that Dr. Aquino, a family practitioner, treated decedent for unrelated conditions during the pregnancy, and on the date of the c-section, February 25, 2011, when decedent presented to Dr. Aquino at NYHTC with a complaint of abdominal pain. Dr. Fried emphasizes that Dr. Aquino promptly sent decedent to Flushing Hospital via ambulance. Dr. Fried explains that Dr. Donn, the OB/GYN who cared for decedent toward the end of her pregnancy, actually saw decedent the day before the c-section, at which time decedent had no complaints, a sonogram was performed which showed nothing amiss, and there was no reason to suspect a problem.

Finally, Dr. Fried, referring to the medical records, explains that Dr. Cherenfant, also an OB/GYN, was on call at Flushing Hospital when decedent arrived and he performed the c-section on February 25, 2011, an emergent procedure done because the fetal monitoring showed abnormalities. He successfully delivered a baby boy, but observed active bleeding in the abdominal cavity for which he could find no source. As such, Dr. Fried observes that Dr. Cherenfant appropriately called surgical consultant, Dr. Cantu, who operated on decedent and discovered that the source of the bleeding was the liver. Dr. Fried further opines that as Dr. Cherenfant was not operating in the area of the liver, it is therefore inconceivable that he in any way caused injury to the liver. As such, Dr. Fried concludes that that there are no triable issue of fact for a jury to consider with respect to Drs. Portillo, Aquino, Donn, and Cherenfant. As such, the physicians submit that this motion should be granted in its entirety, and plaintiff's allegations of malpractice against them must be dismissed with prejudice.

In opposition, plaintiff's counsel affirms that plaintiff is not opposing the summary judgment motions of Dr. Cherenfant and Dr. Portillo. Instead, plaintiff argues that Dr. Aquino deviated from accepted standards of care by evaluating decedent even though she is not an OB/GYN, and incorrectly assuming "that [decedent] was having contractions." It is plaintiff's expert's opinion that Dr. Aquino was unqualified to examine decedent, and may have contributed to decedent's injuries by intervening in a circumstance where it would have been preferable to have harnessed the expertise of an OB/GYN. Plaintiff also argues that Dr. Donn should have detected problems with decedent's liver even though she exhibited no symptoms of HELLP (hemolysis, elevated liver enzymes, low platelet count) syndrome,[30] nor of the rupture of the liver. Plaintiff also argues that Dr. Donn should not have suspected that decedent was in labor and in need of a c-section, even though decedent was noted as having palpable contractions.

In reply, Dr. Aquino argues that plaintiff's expert fails to allege any departures on behalf of Dr. Aquino, other than that Dr. Aquino "wrongly assumed that [decedent] was having contractions" when she examined decedent at NYHTC on February 25, 2011. Moreover, Dr. Aquino highlights that plaintiff's expert's contention that the decedent's signs and symptoms upon her presentation to NYHTC on February 25, 2011 were not consistent with labor is belied not only by the medical records, but also deposition testimony. Specifically, when Dr. Aquino examined decedent on February 25, 2011, Dr. Aquino emphasizes that decedent experienced at least one contraction which Dr. Aquino observed and palpated. In addition, Dr. Aquino testified that she had to wait for the contraction to subside before she was able to take the fetal heart

[30] HELLP usually develops before the 37th week of pregnancy but can occur shortly after delivery. Many women are diagnosed with preeclampsia beforehand.

rate. Furthermore, contrary to plaintiff's expert's assertion, Dr. Aquino emphasizes that decedent did not complain of only upper abdominal pain, but rather complained of pain and cramping in "the whole abdomen" i.e., all four quadrants. Therefore, Dr. Aquino challenges plaintiff's expert's suggestion that it was a departure for Dr. Aquino to have considered labor as one of her differentials for decedent, who presented at 38 weeks gestation with abdominal pain, observable palpable contractions, and normal vital signs (except for mild tachycardia which can also be consistent with pain or dehydration). Additionally, Dr. Aquino challenges, among others, plaintiff's suggestion that it was also a departure to promptly send decedent via ambulance to Flushing Hospital to rule out labor. As such, Dr. Aquino submits that plaintiff's evidence is insufficient to defeat Dr. Aquino's prima facie entitlement to summary judgment. Moreover, Dr. Donn submits that because decedent exhibited no symptoms of HELLP nor of liver rupture, and because decedent had observable/palpable contractions at 38 weeks gestation, it was not a departure for Dr. Donn to have considered labor as a possible differential, nor was it a departure for Dr. Donn to have recommended that decedent undergo a c-section.

C. Dr. Mandava and Flushing Hospital

In support of their separate motion, Dr. Mandava and Flushing Hospital submit the affirmation of Jeffrey Aronoff, M.D. ("Dr. Aronoff"), who opines that decedent's liver rupture and bleed were timely and appropriately recognized and identified, that the exploratory laparotomy was timely and appropriately performed, that decedent was properly monitored, and that the second-look laparotomy was timely and properly performed. Specifically, Dr. Aronoff notes that decedent suffered a catastrophic spontaneous liver rupture prior to her emergency presentation, as evidenced by the discovery of dark red old and new blood in the abdomen during the emergent c-section/exploratory laparotomy. During the procedure, decedent's liver was noted to be friable and likely to tear or crumble under contact, so a repair was not possible. Dr. Aronoff further opines that decedent's liver was properly packed to control the ongoing hemorrhage, her condition was stabilized, and she was closed temporarily with the plan for a second look laparotomy within 48-72 hours for re-exploration and removal of the packing.

Dr. Aronoff also opines that decedent, who was critically ill at this time, was properly admitted to the SICU following this first operation. Indeed, Dr. Aronoff highlights that decedent was continually monitored from her SICU admission at approximately 2:45 p.m. on February 25, 2011, until the exploratory second look damage control laparotomy, which was performed, due to hemodynamic instability, at 10:00 AM on February 26, 2011. Dr. Aronoff goes on to explain that this second surgery revealed a large area of profuse bleeding in the superior and posterior aspects of the right lobe. The areas of hemorrhaging were irrigated and packed, requiring 29 laparotomy pads to temporize hemostasis. Dr. Aronoff opines that this second surgery was timely and properly performed, and that decedent was then transferred to the ICU in unstable, very critical condition.

In opposition, plaintiff submits the affirmations of a general surgeon and OB/GYN, both of whom opine that after the staff at Flushing Hospital was able to stabilize decedent following the first exploratory laparotomy, she should have been transferred to a Level 1 trauma center, which would have been better able to deal with a massive blood loss or massive blood replacement. They also opine that the decision to admit

decedent to the Flushing Hospital SICU under constant monitoring, perform a reexploration/ damage control laparotomy approximately 19 hours after the first surgery was completed, and then transfer decedent to Bellevue was a departure from the standard of care that deprived decedent of the chance for a better outcome.

In reply, Dr. Mandava and Flushing Hospital submit that plaintiff's bill of particulars does not contain any claim that Flushing Hospital and Dr. Mandava were negligent for not transferring plaintiff to a Level 1 trauma center following her first surgery. Instead, Dr. Mandava and Flushing Hospital argue that this this claim was raised for the first time in plaintiff's opposition to their summary judgment motion. As such, Dr. Mandava and Flushing Hospital submit that this court should not now consider this belated opinion. On the merits, Dr. Mandava and Flushing Hospital challenge the opinions of plaintiff's experts as speculative and conclusory, and reiterate their position that they are entitled to judgment in their favor.

D. NYHTC

In support of its separate motion, NYHTC annexes that affirmation of Mary E. D'Alton, M.D. ("Dr. D'Alton") who states, to a reasonable degree of medical certainty, that the care and treatment rendered by NYHTC, through its physicians (Dr. Portillo, Dr. Donn, and Dr. Aquino) to decedent was at all times in accordance with good and accepted medical practice and that nothing that NYHTC did or failed to do was the proximate cause of the injuries or alleged wrongful death of decedent. To be sure, Dr. D'Alton opines, to a reasonable degree of medical certainty, that there is no basis for plaintiff's claims that NYHTC, through its physicians Drs. Portillo, Donn and Aquino, failed to pick up on any signs that decedent had a condition of abdominal vascular compromise, including but not limited to a possible impending rupture of her liver. Dr. Portillo explains that decedent had an unremarkable pregnancy with the exception of her marginal placental previa. As such, D'Alton explains that decedent did not display any signs or symptoms that could have indicated abdominal vascular compromise or an impending rupture of the liver. Dr. D'Alton further opines that there are no actions that NYHTC's physicians did or failed to do that were the proximate cause of decedent's injuries. Notably, it is conceded by plaintiff that there is no basis for liability as against Dr. Portillo.

Significantly, while plaintiff's expert offers the opinion that decedent had HELLP syndrome on February 24th and 25th, plaintiff's opposition does not dispute that up until that date, decedent did not display any signs or symptoms of HELLP syndrome. Plaintiff also does not dispute that up until that date, decedent did not display the signs or symptoms of any other condition that would indicate or could potentially lead to the development of HELLP syndrome such as hypertension, preeclampsia or gestational diabetes, and that throughout decedent's pregnancy all of her medical tests at NYHTC including her blood pressure, urinalysis tests for protein and glucose, and blood tests for liver enzymes, platelet count and red blood cells were all normal.

Rather, plaintiff's opposition centers on plaintiff's expert's assertions that NYHTC's defendant physicians Dr. Aquino and Dr. Donn failed to "appreciate [decedent's] signs and symptoms, which were not consistent with labor" that by "wrongly assuming that [decedent] was in labor . . . delayed the diagnosis of HELLP in this patient" and that its failure to consider HELLP as the cause of decedent's "presenting signs

and symptoms" was a deviation from the standard of care and a substantial factor leading to decedent's injury.

In reply, NYHTC asserts that plaintiff's contention to this effect is purely conclusory and unsupported by the facts for numerous reasons including that (i) decedent's only presenting signs and symptoms identified that morning were abdominal pain and vomiting, symptoms that are consistent with being in labor, as well as a number of different conditions other than HELLP; (ii) there is evidence that decedent was in labor including that Dr. Aquino observed decedent as having uterine contractions and decedent reported to the ambulance operator on the way to Flushing Hospital later that morning that "my contractions are 5 mins apart"; (iii) all of her vital signs that morning were, as plaintiff's expert admits, "notably normal" with the exception of a mildly elevated heart rate, which is consistent with being in pain; (iv) there was no significant prior medical history, such as preeclampsia, to indicate she would develop HELLP Syndrome; and (v) decedent presented to the NYHTC at 9:39 a.m. on February 25, 2011, was triaged by a nurse, was seen by Dr. Aquino at 10:01 a.m. and evaluated, and Dr. Aquino appropriately sent decedent to Flushing Hospital where the baby was delivered, which, as plaintiff's expert admits, is the treatment for HELLP syndrome. NYHTC asserts that these assertions, as well as the records and sworn statement submitted by NYHTC demonstrate that NYHTC acted in accordance with good and accepted medical practice plainly constitute a prima facie showing of entitlement to judgment as a matter of law. Moreover NYHTC sharply disagrees with plaintiff's experts contention that "the failure of Dr. Donn to refer and have her patient timely transferred to a Level 1 [t]rauma [c]enter" was a deviation from the standard of care. To be sure, NYHTC argues that plaintiff's expert fails to address that Dr. Donn is an OB/GYN, not a general surgeon or a hepatic specialist, and that plaintiff has at no time supplemented plaintiff's bill of particulars to advance the position that decedent's ultimately transfer was the proximate cause of her injuries and death. Likewise, contrary to plaintiff's assertions, NYHTC posits that Dr. Donn did not fail to get a complete and accurate history from the doctors or staff at NYHTC, including reviewing the medical records.

E. Dr. Louis

In support of her separate motion for summary judgment, Dr. Louis annexes the affirmation of Dr. Aronoff, who notes that following decedent's surgery on February 25, 2011, decedent was admitted to the SICU at approximately 2:45 p.m. where Dr. Louis assumed management of her care. Dr. Aronoff opines, based on his review of the pertinent medical records, that decedent was properly monitored post-operatively in the SICU from February 25, 2011 and throughout her stay in the unit. As per Dr. Aronoff, the standard of care requires constant and continuous monitoring of a patient admitted to the SICU, especially a patient as critically ill as decedent. Dr. Aronoff highlights that the Flushing Hospital Critical Care Progress Record documents that constant and continuous monitoring of decedent commenced upon her admission to the SICU at approximately 2:45 p.m. on February 25, 2011 and continued throughout her stay in the unit. Specifically, decedent's temperature, pulse, respiration, blood pressure, pain scale, pulse, oxygen, pertinent events and the patient's response to treatment were recorded and chronicled by the SICU on a regular basis. Dr. Aronoff also opines that the second exploratory laparotomy was properly performed on February 26, 2011by Dr. Louis given the condition of decedent's liver. As per Dr. Aronoff, proper technique was utilized during this procedure, as the prior packing was removed in an organized fashion and each area was explored for vascular

and anatomic bleeding that could be controlled. Dr. Aronoff further explained that the second exploratory laparotomy was timely performed on February 26, 2011.

Dr. Aronoff also opines that plaintiff's allegation of a failure to repair vascular injuries during re-packing is meritless. Dr. Aronoff explains that the Flushing Hospital records, and all of the defendants' depositions, clearly document that a diffuse injury, not one due to major vascular damage, was the cause of the decedent's bleeding. He further opines that the description of the decedent's liver injury, which included a 15 x 20 cm. hematoma and diffuse bleeding from the liver edge, is consistent with a diffuse source of bleeding and not a precise source, as would be the case with a major vascular injury. Next, Dr. Aronoff opines that decedent's injuries and subsequent death were caused by a catastrophic event unrelated to the treatment rendered by Dr. Louis. As per Dr. Aronoff, that catastrophic event, specifically a spontaneous liver rupture, occurred prior to decedent's emergent presentation to Flushing Hospital on February 25, 2011, as evidenced by the discovery of dark red, old and new blood in the abdomen during the emergent C-section and subsequent exploratory laparotomy. Dr. Aronoff explains that no additional testing can be a predictor of an impending future catastrophic event such as a spontaneous liver rupture and that no action or inaction by Dr. Louis led to, or could have predicted or diagnosed her spontaneous liver rupture, especially since it occurred prior to any treatment by Dr. Louis.

Moreover, Dr. Aronoff explains that Dr. Louis did not proximately cause decedent's death. Dr. Aronoff observes that decedent died due to "hemothorax complicating thoracentesis for management of spontaneous rupture of [the] liver during pregnancy." Dr. Aronoff also opines that no additional testing can be a predictor of an impending, future catastrophic event, such as a spontaneous liver rupture, with which decedent presented to Flushing Hospital. As such, Dr, Aronoff concludes that there is no evidence or triable issue of fact, as the care and treatment rendered to decedent by Dr. Louis was at all times consistent with good and accepted medical practices and standards of care and was not the proximate cause of the injuries and damages, including death, claimed by plaintiff.

In opposition, plaintiff's expert affirmation is silent with respect to all the allegations in the bill of particulars and supplemental bill of particulars for Dr. Louis. Rather, plaintiff's opposition identifies two purported departures against Dr. Louis: 1) the failure to immediately transfer decedent following the surgery by co-defendant, Dr. Cantu, on February 25, 2011; and 2) the failure to timely recognize the deficiencies in her ability and that of co-defendant Flushing Hospital to properly care for decedent. Plaintiff states that Dr. Louis, in tandem with other physicians, proximately cause decedent's death through these purported departures.

In reply, Dr. Louis reiterates her position that plaintiff's allegations sounding in medical malpractice should be dismissed where, as here, plaintiff has failed to demonstrate that Dr. Louis departed from good and accepted standards of medical practice and that any departure was the proximate cause of decedent's injuries. At all times, Dr. Louis submits that she was not negligent in her treatment and management of plaintiff's condition. Moreover, as demonstrated by Dr. Aronoff, Dr. Louis argues that the claimed injuries were not caused by any negligence. Dr. Louis also states that plaintiff's previously unraised theories of liability against

Dr. Louis cannot be raised in opposition to her motion for summary judgment and therefore the motion should be granted in its entirety.

F. Dr. Cantu

Finally, in support of his separate motion, Dr. Cantu annexes the expert affirmation of Stephen Gorfine, MD ("Dr. Gorfine") who opines that Dr. Cantu was completely within the requisite standards of medical care and treatment at all times during the care and treatment of decedent. Dr. Gorfine explains that when Dr. Cantu was called in an emergency situation to find the source of decedent's bleed during her c-section, Dr. Cantu appropriately explored decedent's belly, first with his hands then by extending the incision to get better exposure. Dr. Gorfine elaborates by stating that Dr. Cantu extended the incision and observed a hematoma on the liver. In Dr. Gorfine's estimation, Dr. Cantu then appropriately cauterized a few portions of the liver that were bleeding, however, this did not stop the overall hemorrhaging. Dr. Gorfine explains that Dr. Cantu next appropriately packed the liver with six lap pads and closed decedent, who was then transported to the SICU.

Dr. Gorfine opines that he can find no evidence within any of the testimony given or medical records offered that Dr. Cantu deviated from the requisite standard of medical and surgical care. In Dr. Gorfine's assessment, Dr. Cantu came in during an emergency situation and determined the source of the bleed to be from the liver. He then ameliorated the bleed, making his participation appropriate and within the requisite standards of medical care. Dr. Gorfine affirms to a reasonable degree of medical certainty that decedent's liver was too friable for anything other than packing based on the visualization and palpation of the liver.

Under emergent circumstances, Dr. Gorfine states that Cantu did the best he could to stop the bleeding. Unfortunately, the bleeding recurred but through no fault of Dr. Cantu's work in the operating room. As such, Dr. Gorfine opines that decedent's death occurred despite no presence of fault attributable to Dr. Cantu.

Dr. Gorfine further highlights that the Medical Examiner indicated that the most likely etiology of decedent's injuries was HELLP syndrome, which occurred long before Dr. Cantu's treatment of decedent. Therefore, Dr. Cantu is not the proximate cause of decedent's injuries and there can be no liability on his part.

In opposition plaintiff, through his expert, argues that Dr. Cantu was a general surgeon with no expertise and only "minimal" experience with liver surgery. He further argues that there is no indication that any attending or staff at Flushing Hospital ever attempted to consult with a hepatobiliary surgeon or other liver specialist with regard to Mrs. Gonzales. Thus, the failure on the part of the defendant doctors at Flushing Hospital to timely recognize or appreciate the deficiencies in their own ability. Likewise, as with other defendants, plaintiff states that Dr. Cantu's liability is further predicated upon his alleged failure to transfer decedent to a Level 1 trauma center following the surgery.

In reply, to combat plaintiff's allegation that Dr. Cantu has minimal experience, Dr. Cantu highlights that he is a practicing general surgeon who has been board certified since 1989. He further states that he has prior experience in both liver and trauma surgery. Regardless, Dr. Cantu argues that decedent's situation was

an emergent scenario that required immediate care and Dr. Cantu, a highly experienced general surgeon, was ready and willing to help and was able to stop the bleeding. Further, Dr. Cantu emphasizes that plaintiff admits within his own affirmation that the liver was too friable to attempt any other method to ameliorate the bleed other than packing. Dr. Cantu further reiterates his position that he appropriately did his part in packing the liver to control the bleed once he was called in. As with the other defendants, Dr. Cantu states that plaintiff's previously unraised theories of liability against him, most significantly the failure to transport decedent to a Level 1 trauma center, cannot be raised in opposition to her motion for summary judgment and therefore the motion should be granted in its entirety.

DISCUSSION

A. Summary Judgment Standard

In an action premised upon medical malpractice, a defendant doctor or hospital establishes prima facie entitlement to summary judgment when he or she establishes that in treating the plaintiff there was no departure from good and accepted medical practice or that any departure was not the proximate cause of the injuries alleged (*Roques v. Noble*, 73 AD3d 204, 206 [1st Dept 2010]; *Thurston v Interfaith Med. Ctr.*, 66 AD3d 999, 1001 [2d Dept. 2009]; *Myers v Ferrara*, 56 AD3d 78, 83 [2d Dept. 2008]; *Germaine v Yu*, 49 AD3d 685 [2d Dept 2008]; *Rebozo v Wilen*, 41 AD3d 457, 458 [2d Dept 2007]; *Williams v Sahay*, 12 AD3d 366, 368 [2d Dept 2004]). In claiming that treatment did not depart from accepted standards, the movant must provide an expert opinion that is detailed, specific and factual in nature (*see e.g., Joyner-Pack v. Sykes*, 54 AD3d 727, 729 [2d Dept2008]). The opinion must be based on facts within the record or personally known to the expert (*Roques*, 73 AD3d at 207, *supra*). Indeed, it is well settled that expert testimony must be based on facts in the record or personally known to the witness, and that an expert cannot reach a conclusion by assuming material facts not supported by record evidence (*Cassano v Hagstrom*, 5 NY2d 643, 646 [1959]; *Gomez v New York City Hous. Auth.*, 217 AD2d 110, 117 [1st Dept 1995]; *Matter of Aetna Cas. & Sur. Co. v Barile*, 86 AD2d 362, 364-365 [1st Dept 1982]). Thus, a defendant in a medical malpractice action who, in support of a motion for summary judgment, submits conclusory medical affidavits or affirmations, fails to establish prima facie entitlement to summary judgment (*Winegrad v New York Univ. Med. Ctr.*, 64 NY2d 851, 853 [1985]; *Cregan v Sachs*, 65 AD3d 101, 108 [1st Dept 2009]; *Wasserman v Carella*, 307 AD2d 225, 226 [1st Dept 2003]). Further, medical expert affidavits or affirmations, submitted by a defendant, which fail to address the essential factual allegations in the plaintiff's complaint or bill of particulars do not establish prima facie entitlement to summary judgment as a matter of law (*Cregan*, 65 AD3d at 108, *supra*; *Wasserman*, 307 AD2d at 226, *supra*). To be sure, the defense expert's opinion should state "in what way" a patient's treatment was proper and explain the standard of care (*Ocasio-Gary v. Lawrence Hosp.*, 69 AD3d 403, 404 [1st Dept 2010]). Further, it must "explain 'what defendant did and why'" (*id. quoting Wasserman v. Carella*, 307 AD2d 225, 226 [1st Dept 2003]).

Once the defendant meets its burden of establishing prima facie entitlement to summary judgment, it is incumbent on the plaintiff, if summary judgment is to be averted, to rebut the defendant's prima facie showing (*Alvarez v Prospect Hosp.*, 68 NY2d 320, 324 [1986]). The plaintiff must rebut defendant's prima facie showing without "[g]eneral allegations of medical malpractice, merely conclusory and unsupported by

competent evidence" (*id.* at 325). Specifically, to avert summary judgment, the plaintiff must demonstrate that the defendant did in fact commit malpractice and that the malpractice was the proximate cause of the plaintiff's injuries (*Coronel v New York City Health and Hosp. Corp.*, 47 AD3d 456 [1st Dept. 2008]; *Koeppel v Park*, 228 AD2d 288, 289 [1st Dept. 1996]). To meet the required burden, the plaintiff must submit an affidavit from a medical doctor attesting that the defendant departed from accepted medical practice and that the departure was the proximate cause of the injuries alleged (*Thurston*, 66 AD3d at 1001, *supra*; *Myers,* 56 AD3d at 84, *supra*; *Rebozo*, 41 AD3d at 458, *supra*).

B. New Theories of Liability

CPLR §3043 governs bills of particulars in personal injury actions. Subsection (b) addresses supplemental bills and reads in part, ". . . that no new cause of cation may be alleged." The Appellate Division, First Department, has repeatedly held that new theories of liability may not be asserted for the first time in opposition to a summary judgment motion (*see Vargas v. St. Barnabas Hosp.*, 168 AD3d 596 [1st Dept 2019]; *Biondi v. Behrman*, 149 AD3d 562 [1st Dept 2017][ ] [since plaintiffs' opposition papers were insufficient absent this new theory of recovery, defendants' summary judgment motion should have been granted]; *Concepcion v. City of New York*, 139 AD3d 606 [1st Dept 2016]; *Abalola v. Flower Hosp.*, 44 AD3d 522 [1st Dept 2007]). As the Appellate Division, First Department held in *Ostrov v. Rozbruch* (91 AD3d 147, 154 [1st Dept 2010]), new theories of recovery should not be advanced for the first time on summary judgment. In granting summary judgment to the defendant, the court stated:

"As noted, both parties submitted supplemental expert affirmations from experts in different medical disciplines. Moreover, these affirmations expanded the scope of plaintiffs' theory of medical malpractice beyond what was encompassed in the complaint and bill of particulars. Indeed, plaintiffs' theory, as originally set forth in the complaint, alleged, inter alia, that the surgery was improperly performed. Her bill of particulars and supplementary bill of particulars only made oblique references to the failure to discuss alternatives to surgery and then only in the bill of particulars in response to defendant hospital's demands, not those of defendant doctor. 'A court should not consider the merits of a new theory of recovery, raised for the first time in opposition to a motion for summary judgment, that was not pleaded in the complaint' (*Mezger v Wyndham Homes, Inc.*, 81 AD3d 795, 796 [2d Dept 2011]; *see also Abalola v Flower Hosp.*, 44 AD3d 522 [1st Dept 2007]). Since the court found plaintiffs' opposition papers insufficient save for this new theory of recovery, defendant's motion should have been granted."

Conversely, in *DB v Montefiore Med. Ctr.* (162 AD3d 478 [1st Dept 2018]), defendants argued that plaintiffs' theory that his injuries were caused by hypoxia ischemia brought about by intercranial pressure should not be considered, because it was improperly raised for the first time in opposition to their motion. The Appellate Division, First Department, found that the theory was sufficiently pleaded in the bill of particulars to avoid surprise and prejudice to defendants as the bill of particulars alleged a hypoxic ischemic injury to the fetus due to, *inter alia*, the contraindicated use of Pitocin, the failure to accurately estimate fetal size and position and the progress of labor, the failure to prevent injury from trauma during labor and delivery, and the failure to timely perform a cesarean section. While the bill of particulars did not allege specifically that the ischemic injury was caused by the shunting of blood away from the brain due to pressure

caused by contractions and resulting from the above alleged deviations, defendants' demand for a bill of particulars did not seek that level of detail.

1. Bellevue

Here, with respect to Bellevue, the court finds that Bellevue has established its prima facie entitlement to summary judgment through the submission of the affirmations of Drs. Barie, Cynamon, Reiner, and Williamson. Specifically, each expert opines, with reference to the relevant medical records and pleadings, that decedent suffered a serious and fatal injury that caused her to lose a tremendous amount of blood in a short period of time. Moreover, they state that decedent's loss of blood resulted in multiorgan failure, an inability to clot, and an increased susceptibility to infection. Under such a circumstance, Bellevue's experts unanimously conclude that when decedent presented to Bellevue, she was critically ill and had a diminished chance for survival. They further explain that the hospital made every effort to save decedent's life, including close monitoring in the SICU, frequent blood work and radiological imaging, and multiple surgeries and consults from multiple medical specialties. With decedent's status declining and fluid accumulating around her lungs, Bellevue's experts state that the facility made a reasoned decision, in the exercise of its best medical judgment, to proceed with the insertion of a needle into the space between the lungs and chest wall to drain excess fluid. Unfortunately, Bellevue's experts deduce that decedent suffered a known and accepted consequence of that procedure, which Bellevue managed appropriately. Bellevue's experts further state that given decedent's condition, it is remarkable that she managed to survive for close to two months after her complications. As Bellevue's experts' opinions are detailed and predicated upon ample support within the record, they sufficiently establish the facility's prima facie entitlement to summary judgment.

As per the controlling law, in light of Bellevue's demonstration of its entitlement to summary judgment, the burden shifts to plaintiff to produce evidence in admissible form illustrating the existence of some material issues of fact (*Zuckerman*, 49 NY2d 557, *supra*). Plaintiff has failed to produce such evidence here. In plaintiff's opposition, and as reiterated at oral argument, plaintiff's experts do not opine that Bellevue, its staff and/or physicians, departed from accepted standards of care in their management of decedent's treatment. To be sure, plaintiff's experts do not opine that any actions or inactions of Bellevue, its staff and/or physicians caused decedent's injuries. In fact, plaintiff's experts endorse the conclusions of Bellevue's experts, insofar as plaintiff's experts contend that the thoracentesis was indicated, and that decedent's ultimate demise was "inevitable." As such, with respect to Bellevue's application, the court is not presented with a scenario in which plaintiff's experts have credibly opposed the conclusions of Bellevue's experts (*Elmes v. Yelon*, 140 AD3d 1009 [2d Dept 2016]["[s]ummary judgment is not appropriate in a medical malpractice action where the parties adduce conflicting medical expert opinions"]). Rather, the present scenario is one where plaintiff's experts have failed to contradict Bellevue's experts' conclusions that plaintiff was appropriately treated (*see Bartolacci-Mair v. Sassoon*, 149 AD3d 567 [1st Dept 2017][reversing trial court's denial of summary judgment in a medical malpractice action in which plaintiff's expert did not contradict defendant's expert opinion that plaintiff was appropriately treated]; *see also Courtney v. Port Auth. of N.Y. & N.J.*, 34 AD3d 716, 719 [2d Dept 2006][upholding the entry of summary judgment in a medical malpractice case and noting: "the plaintiff's expert did not refute the conclusions of the physicians' expert and did not explain how the alleged improper anticoagulant treatment related to

causation"]). Likewise, plaintiff has failed to challenge Bellevue's argument that negligent hiring and supervision claims are not cognizable in the Appellate Division, First Department (*see Rivera v. Bhuiyan*, 149 AD3d 493 [1st Dept 2017]). Accordingly, this court grants Bellevue's application for summary judgment in its entirety.

2. Dr. Portillo, Dr. Aquino, Dr. Donn, and Dr. Cherenfant

With respect to Drs. Portillo, Aquino, Donn, and Cherenfant's motion, it should be noted at the outset that plaintiff does not oppose the summary judgment motions of Dr. Cherenfant and Dr. Portillo, each of whom have established a prima facie entitlement to summary judgment through the detailed affirmation of Dr. Fried, and the supporting proofs documented within it. Likewise, Dr. Fried's affirmation supports a prima facie showing on behalf of Dr. Donn and Dr. Aquino in so far as Dr. Fried opines, based on detailed references to the record, that it is customary for a resident on the labor floor to evaluate a patient, and once that is complete, inform the attending OB/GYN of the need for a transfer to another hospital. Dr. Fried also gives credence to the notion that a liver rupture is incredibly rare even in the setting of HELLP syndrome, and could not be anticipated in a patient with no risk factors for HELLP syndrome or liver rupture. With respect to Dr. Aquino, Dr. Fried references the pertinent medical records when opining that upon decedent's presentation to NYHTC on February 25th, decedent exhibited symptoms consistent with labor. To be sure, it is documented that when Dr. Aquino examined decedent on February 25th, decedent experienced at least one contraction which Dr. Aquino observed and palpated. In addition, Dr. Aquino testified that she had to wait for the contraction to subside before she was able to take the fetal heart rate. Therefore, it is contradicted by the record for plaintiff's expert to suggest that it was a departure for Dr. Aquino to have considered labor as one of her differentials for decedent, who presented at 38 weeks gestation with abdominal pain, observable palpable contractions, and normal vital signs (except for mild tachycardia which can also be consistent with pain or dehydration).

Furthermore, the record reveals, contrary to plaintiff's expert's assertions, that decedent did not complain of only upper abdominal pain, but rather complained of pain and cramping in "the whole abdomen." As such, it is similarly unsound for plaintiff's expert to suggest that it was a departure for Dr. Aquino to promptly send decedent via ambulance to Flushing Hospital to rule out labor. Moreover, by plaintiff's expert's own admission, at the time of plaintiff's presentation to Dr. Aquino on February 25th, all of her vital signs were normal except for mild tachycardia. Thus, as Dr. Fried opines, there was no indication at that time to consider that decedent was experiencing anything other than labor, and to suggest that Dr. Aquino should have considered HELLP despite the fact that decedent did not have any of the classic risk factors for HELLP and was totally asymptomatic the day prior. Indeed, plaintiff's expert's challenges to Dr. Aquino's prima facie showing exemplify the kind of hindsight reasoning that the Appellate Division, First Department has been reluctant to endorse (*see e.g. G.L. v. Harawitz*, 146 AD3d 476 [1st Dept 2017]). Illustratively, plaintiff's expert even concedes that Dr. Aquino acted reasonably under the circumstance in attending to decedent within 20 minutes of her arrival at NYHTC, and promptly arranged for her transfer to Flushing Hospital via an ambulance. As such, it is contrary to evidence within the record for plaintiff to suggest that Dr. Aquino's actions were not only inappropriate but a departure from good and accepted medical practice of a family practitioner. Plaintiff's expert's additional challenge to Dr. Aquino based on her discipline is without merit,

as Dr. Aquino's actions are measured against those of other family practitioners, not OB/GYNs. Notably, once Dr. Aquino suspected labor, decedent was promptly referred to an OB/GYN, Dr. Donn. Finally, plaintiff's speculative reference to conversations decedent had with Dr. Aquino regarding decedent's condition prior to presenting to NYHTC appear to be "tailored" to avoid the consequences of summary judgment (*Coronel v. New York City Health and Hospitals Corp.*, 47 AD3d 456 [1st Dept 2008]; *Sunshine Care Corn. v. Warrick*, 100 AD3d 981 [2d Dept 2012]).

Likewise, based upon decedent's presentation to Dr. Donn on February 24th, where she exhibited no symptoms of HELLP nor of the rupture liver, and based upon the symptoms that were reported to Dr. Donn on February 25th, including abdominal pain and observable/palpable contractions at 38 weeks gestation, Dr. Fried opines that it was not a departure for Dr. Donn to have considered labor as a possible differential, nor was it a departure for Dr. Donn to have recommended that decedent undergo a c-section. Nevertheless, plaintiff's expert renders criticism against Dr. Donn for failing to produce sonogram films that were taken of decedent on February 24th. However, as explained by Dr. Fried, the sonogram films are of no import here, as they would simply depict the condition of the infant, and would have no bearing on the condition of plaintiff's liver. Moreover, in light of the fact that the plaintiff had no signs or symptoms of HELLP at that presentation, it is unlikely that the liver had begun leaking at that time, thus the sonogram films are irrelevant. Plaintiff may challenge this opinion, but such a challenge does not present a credible issue of fact where plaintiff has produced no evidence supporting the position that decedent's HELLP could have been diagnosed and treated at an earlier juncture in time. It is also speculative for plaintiff to contend that decedent would have arrived at a hospital much sooner than she presented to NYHTC, or that Drs. Donn and Aquino had any impact on that determination.

Finally, plaintiff's expert's contention that Dr. Donn departed from good and accepted medical practice in failing to transfer decedent to a Level 1 trauma center following decedent's liver rupture is without merit. In the first instance, this allegation was never raised by plaintiff in the bill of particulars and cannot be improperly alleged for the first time in opposition to summary judgment (*Ostrov*, 91 AD3d 147, *supra*). Moreover, plaintiff's expert cannot say, with medical certainty, when the liver ruptured. Further, following the c-section , decedent's care was transferred to the surgical team at Flushing Hospital. As such, there is no credible evidence to suggest that Dr. Donn either had, or could have had, a role in transferring decedent to a Level 1 trauma center.

As such, the court finds that in addition to Drs. Cherenfant and Portillo, Drs. Aquino and Donn are entitled to judgment in their favor.

3. Dr. Mandava and Flushing Hospital

Dr. Mandava and Flushing Hospital have similarly established, prima facie, that they complied with the standard of care and that their care and treatment of decedent did not proximately cause her injuries and death. Specifically, Dr. Aronoff, explains that decedent suffered a catastrophic spontaneous un-repairable liver rupture prior to her emergency presentation to Flushing Hospital. Dr. Arnoff further opines that despite taking all appropriate steps and providing all appropriate treatments, the bleeding could not be controlled so the decision was made to transfer decedent to Bellevue, which has a hepatobiliary transplant team. As Dr.

Aronoff's affirmation is detailed and predicated upon ample support within the record, it is sufficient to establish a prima facie showing.

In opposition, plaintiff does not challenge the care rendered by Dr. Mandava and Flushing Hospital, but rather states that after the staff at Flushing Hospital was able to stabilize decedent following the first exploratory laparotomy, she should have been transferred to a Level 1 trauma center. As previously mentioned, that theory does not appear in any iteration of plaintiff's bill of particulars. To be sure, plaintiff's bill of particulars does not contain any claim that Dr. Mandava and Flushing Hospital were negligence for not transferring decedent to a Level 1 trauma center following her first surgery. The gravamen of the bill of particulars is a general claim that defendants collectively failed to timely diagnose and treat decedent's HELLP syndrome. Contrary to plaintiff's arguments at oral argument, the mere use of general terminology about reference to transportation in the absence of any particular malpractice linked to that transportation does not suggest the present theory – that decedent should have been immediately transferred to a Level 1 trauma center. A rational and reasonable reading of the bill of particulars, in context, does not give credence to the present theory advanced by plaintiff.

Moreover, plaintiff cannot correct this deficient and defeat summary judgment based on new theories by the simple expedient move of seeking leave to amend (*Frye v Montefiore Med. Ctr.*, 100 AD3d 28, 38-39 [1st Dept 2012] [court properly denied leave to supplement the bill of particulars because it asserted a new theory of liability seven years after the action was commenced and after a summary judgment motion had been litigated focusing on the theories plaintiff had set forth in her original pleading and bills of particulars]). Accordingly, Dr. Mandava and Flushing Hospital are entitled to judgment in their favor.

4. NYHTC

NYHTC similarly has established a prima showing through affirmation of Dr. D'Alton, who states, to a reasonable degree of medical certainty, that the care and treatment rendered by NYHTC, through its physicians to decedent was at all times in accordance with good and accepted medical practice and that nothing that NYHTC did or failed to do was the proximate cause of the injuries or alleged wrongful death of decedent. As the alleged liability imputed to NYHTC stems from the actions of its physicians -- the aforementioned Dr. Portillo, Dr. Donn, and Dr. Aquino -- and as this court has already granted summary judgment with respect to each of those physicians, NYHTC is similarly entitled to judgment in its favor as there is no vicariously liability (*Bing v. Thunig*, 2 NY2d 656 [1957]).

Even if plaintiff were to claim that there is a separate basis for liability against NYHTC, plaintiff's opposition does not dispute that up until decedent's presentation, decedent did not display any signs or symptoms of HELLP syndrome. Rather, plaintiff's opposition relies on the previously discredited notion that NYHTC's physicians failed to "appreciate [decedent's] signs and symptoms, which were not consistent with labor." As explained in detail, *supra*, plaintiff's contentions to this effect are purely conclusory and unsupported by the evidence, which suggests, for instance, that Dr. Aquino measured contractions during her evaluation of decedent. As such, plaintiff cannot advance a position that is contradicted by the undisputed facts in evidence (*see e.g., Coronel*, 47 AD3d 456, *supra*). Nor can plaintiff advance, as previously stated, theories that were not present in plaintiff's bills of particulars.

Accordingly, NYHTC is entitled to judgment in its favor.

5. Dr. Louis

Dr. Louis has established a prima facie showing through the affirmation of Dr. Aronoff, who opines, based on his review of the pertinent medical records, that decedent was properly monitored post-operatively in the SICU from February 25, 2011 and throughout her stay in the unit. Dr. Aronoff specifically states that the standard of care requires constant and continuous monitoring of a patient admitted to the SICU, especially a patient as critically ill as decedent. Dr. Aronoff highlights that the Flushing Hospital Critical Care Progress Record documents that constant and continuous monitoring of decedent commenced upon her admission to the SICU at approximately 2:45 p.m. on February 25, 2011 and continued throughout her stay in the unit. Dr. Aronoff also opines that the second exploratory laparotomy was properly performed on February 26, 2011 by Dr. Louis given the condition of decedent's liver. Moreover, Dr. Aronoff explains that Dr. Louis did not proximately cause decedent's death. As Dr. Aronoff's affirmation is detailed and predicated upon ample support within the record, it is sufficient to establish a prima facie showing.

In opposition, plaintiff identifies two purported departures against Dr. Louis -- the failure to transfer decedent following the surgery by co-defendant, Dr. Cantu, on February 25, 2011 and the failure to timely recognize the deficiencies in her own abilities. Notably, plaintiff does not challenge the allegations set forth in plaintiff's bills of particulars with respect to Dr. Louis. As such, dismissal of those unopposed claims is warranted where Dr. Louis has sufficiently set forth that she did not depart from good and accepted standards of medical practice, and that any departure was not the proximate cause of decedent's injuries. As to those new theories proffered by plaintiff – the failure to timely transport and the failure to recognize one's own deficiencies – this court cannot entertain those claims for the reasons previously advanced. Indeed, those claims were first raised in opposition to Dr. Louis' motion and were not set forth in plaintiff's bills of particulars. As such, Dr. Louis' motion is granted in its entirety (*Vargas*, 168 AD3d 596, *supra*; *Biondi*, 149 AD3d 562, *supra*).

6. Dr. Cantu

Finally, Dr. Cantu has set forth a prima facie showing through the expert affirmation of Dr. Gorfine, who opines that Dr. Cantu was completely within the requisite standards of medical care and treatment at all times during the care and treatment of decedent. Specifically, Dr. Gorfine explains that when Dr. Cantu was called in an emergency situation to find the source of decedent's bleed during her c-section, Dr. Cantu appropriately explored decedent's belly, first with his hands then by extending the incision to get better exposure. Dr. Gorfine further opines that Dr. Cantu extended the incision and observed a hematoma on the liver. In Dr. Gorfine's estimation, Dr. Cantu then appropriately cauterized a few portions of the liver that were bleeding, however, this did not stop the overall hemorrhaging. Dr. Gorfine explains that Dr. Cantu next appropriately packed the liver with six lap pads and closed decedent, who was then transported to the SICU. Under the stresses of the situation with which he was presented, Dr. Gorfine states that Cantu did the best he could to stop decedent's bleeding. Though the bleeding did not stop, Dr. Gorfine opines that decedent's death occurred despite no presence of fault attributable to Dr. Cantu. As that opinion is accompanied by Dr. Cantu's

submission of deposition transcripts and medical records based upon the same, Dr. Cantu has established a prima facie defense entitling him to summary judgment (*Balzola v Giese*, 107 AD3d 587 [1st Dept 2013]).

As with Dr. Louis, plaintiff's opposition premised on Dr. Cantu's expertise and the alleged failure to transfer decedent to a Level 1 trauma center following the surgery, is insufficient to raise a triable issue of fact insofar as plaintiff advances new theories of liability absent from plaintiff's bills of particulars. As with other defendants, there is no claim in plaintiff's January 7, 2013 bill of particulars, or September 20, 2013, supplemental bill of particulars that decedent should have been transferred to a Level 1 trauma center instead of being admitted to the SICU. There also is no mention in any of plaintiffs bills of particulars of any of the specific medical devices listed in plaintiff's expert affirmations, nor is there any mention regarding a hepatobiliary team. To be sure, plaintiff's expert affirmations are silent with respect to all the allegations in the bill of particulars and the supplemental bill of particulars (*Ostrov v. Rozbruch*, 91 AD3d 147, 154 [1st Dept 2012]["A court should not consider the merits of a new theory of recovery, raised for the first time in opposition to a motion for summary judgment, that was not pleaded in the complaint"]; *see also People v. Grasso*, 58 AD3d 180, 212-213 [1st Dept 2008] ["'plaintiff cannot defeat an otherwise proper motion for summary judgment by asserting a new theory of liability ... for the first time in opposition to the motion'"]; *Abalola v. Flower Hosp.*, 44 AD3d 522, 522 [1st Dept 2007][plaintiff's expert "improperly raised, for the first time in opposition to the summary judgment motion, a new theory of liability ... that had not been set forth in the complaint or bills of particulars"]).

The situation with respect to Dr. Cantu is perhaps even more egregious than with his co-defendants. Without reference to any discernable evidence that has been proffered in this case, plaintiff argues that Dr. Cantu was part of the "consensus" decision to keep decedent at Flushing Hospital instead of transferring her to an outside hospital post-operatively. Plaintiff advances this position even though Dr. Cantu was not around following decedent's surgery. To be sure, Dr. Cantu was not around throughout the night, the next day on February 26th, or any other day to make any decisions regarding decedent's care and treatment. Rather, he came in, he controlled the bleed, and subsequently left for vacation. As such, it is contrary to a reasonable interpretation of the evidence for plaintiff to somehow suggest that Dr. Cantu had any influence on the decision to transfer decedent when he was not present. As such, judgment in Dr. Cantu's favor is warranted.

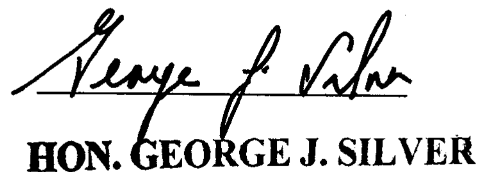
Based on the foregoing, and a thorough evaluation of the evidence adduced, the court finds that there are no material issues of fact requiring a trial in this matter, and that summary judgment should be granted in favor of the moving defendants, as a matter of law. Accordingly, it is hereby

ORDERED that defendants' respective motions for summary judgment are granted in their entirety; and it is further

ORDERED that the Clerk of the Court is directed to enter judgment in favor of the moving defendants, and dismissing this case.

This constitutes the decision and order of the court.

Dated: June 13, 2019



HON. GEORGE J. SILVER