Index №.805353/2014

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

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JUANITA BRIGHAM, as an Ancillary Administrator of the Estate of CHARLES BRIGHAM and JUANITA BRIGHAM, Individually, **Index №. 805353/2014**

Plaintiffs

-against-

SEAN GARVIN, M.D. AND HOSPITAL FOR SPECIAL SURGERY,

Defendants

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HON. GEORGE J. SILVER:

In this medical malpractice action, defendants SEAN GARVIN, M.D. ("Dr. Garvin") AND HOSPITAL FOR SPECIAL SURGERY ("HSS")(collectively, "defendants") move, pursuant to CPLR §3212 for summary judgment and an order dismissing the complaint of plaintiff JUNAITA BRIGHAM ("plaintiff"), as administrator of the estate of CHARLES BRIGHAM ("decedent") as against them. Plaintiff opposes defendants' application.

BACKGROUND

This action involves allegations that defendants were negligent in performing an endotracheal intubation while providing general anesthesia during a lumbar spine surgery performed by non-party Federico Girardi, M.D. ("Dr. Girardi") on October 1, 2012 at HSS. Decedent, then 65-years-old, was admitted to HSS to undergo the elective spine surgery due to a history of complaints of severe lower back pain from scoliosis with associated tingling and pain in his left leg. Dr. Girardi noted decedent to have scoliosis with multi-level spondylosis and stenosis. There are no allegations as to Dr. Girardi and the performance of the spine surgery.

The allegations in the bill of particulars as to Dr. Garvin allege that on October 1, 2012, Dr. Garvin failed to do a proper preoperative assessment, failed to properly insert and position the endotracheal tube, failed to properly assess anatomical landmarks, failed to take a chest x-ray to confirm proper endotracheal tube placement, used excessive cuff pressure, failed to give steroids in a timely matter to treat vocal cord paralysis, negligently caused airway trauma, negligently caused, failed to diagnose and treat vocal cord paralysis, negligently performed a laryngoscopy, failed to document cuff pressure, and failed to refer plaintiff to an ENT specialist. The bill of particulars as to HSS is identical to the initial bill of particulars as to Dr. Garvin.

A subsequent bill of particulars as to Dr. Garvin alleges that Dr. Garvin failed to obtain a proper history and negligently failed to appreciate the decedent's history of radiation treatment, failed to order additional imaging studies prior to intubation in light of decedent's past medical history, failed to request an ENT consult prior to intubation, failed to utilized fiberoptic or video laryngoscopy during intubation, failed to perform a chest x - ray intraoperatively, failed to administer an adequate dose of steroids intraoperatively to reduce the possibility of edema, failed to perform nasal airway ventilation, negligently reintubated the plaintiff, failed to administer paralytic prior to reintubation, failed to appreciate edema prior to extubation, failed to appreciate the length of surgery and the position of patient during surgery, failed to take into account the amount of fluids the decedent would receive intraoperatively, and failed to advise the plaintiff decedent of risks of vocal cord injury during intubation prior to surgery.

The claims in the original bill of particulars against HSS specify that HSS is vicariously liable for Dr. Garvin, but there is no allegation as to the care and treatment provided to decedent by any other staff member, employee, nurse, surgeon, or anyone else for whom HSS is claimed to be vicariously liable.

As a result of defendants' collective negligence, plaintiff alleges that decedent suffered vocal cord paralysis and difficulty swallowing.

ARGUMENTS

In support of the instant, defendants' annexes the pleadings, exhibits, medical records and affirmation of Jonathan Benumof, M.D. ("Dr. Benumof") a board-certified anesthesiologist, who states to a reasonable degree of medical certainty that the care and treatment rendered to decedent by Dr. Garvin was within the parameters of good and accepted medical practice. Indeed, Dr. Benumof opines that "Dr. Garvin acted within the standard of care and accepted medical practice in the manner in which he visualized the larynx for both the initial pre-surgery intubation and the emergency post-surgery re-intubation." Moreover, defendants allege that Dr. Garvin's treatment was not a substantial causative factor in decedent's vocal cord paralysis and difficulty swallowing. As Dr. Garvin's actions comported with applicable standards of care and did not proximately cause decedent's alleged injuries, defendants argue that HSS cannot be held vicariously liable. Collectively, based on Dr. Benumof's affidavit, the pleadings, testimony and records in this case, defendants' submit that there are no triable issues of fact, and that this motion should be granted in its entirety.

In opposition, plaintiff annexes the affirmation of a physician board-certified in anesthesiology who who opines that there were multiple departures from the accepted standard of care that contributed to the vocal cord injury sustained by decedent. As plaintiff's expert explains, decedent initially consulted with Dr. Girardi, an orthopedic surgeon, for possible lumbar spine surgery in 2012. Following the evaluation, decedent decided to proceed with the spinal surgery to be performed by Dr. Girardi at HSS. To accomplish such a surgery, decedent would require general anesthesia. As plaintiff's expert explains, in order to anesthetize a patient to administer general anesthesia, the patient would first require to be intubated. As plaintiff's expert explains, intubation is the process of inserting a tube called an endotracheal tube through the mouth and into the trachea. The purpose of endotracheal intubation is to provide delivery of anesthetic gases and airway protection during surgery.

In view of the planned surgery, decedent presented to HSS for pre-operative clearance. Patients that suffer from any co-morbidities who are planned for surgery undergo pre-operative clearance. As plaintiff's expert explains, the purpose of pre-operative clearance is to stratify the risk factors associated with surgery and anesthesia and also to optimize the patient in anticipation for surgery. Having reviewed decedent's pre-operative clearance record, plaintiff's expert opines that decedent had a past medical history significant for cancer, Type II diabetes mellitus, high cholesterol, GERD, history of a myocardial infarction and stroke.

According to plaintiff's expert, decedent was at a higher risk of complications associated with general anesthesia than the general population due to his significant past cardiac history. In view of his significant past medical history, it was recommended that decedent remain monitored in the post-anesthesia care unit ("PACU") overnight.

As part of the pre-operative clearance, decedent also underwent a pre-operative neurologic assessment and evaluation which was normal with the exception of left lower extremity tingling attributable to his back issues for which he was to undergo surgery. According to plaintiff's expert, decedent demonstrated absolutely no objective or subjective symptoms associated with Parkinson's disease at the time of his pre-operative assessment that took place less than two weeks prior to surgery. On September 1, 2012, decedent returned to HSS for his planned elective back surgery. Dr. Garvin first met decedent approximately 30 minutes prior to surgery. According to Dr. Garvin, he spoke to decedent prior to the surgery and decedent informed him that he had facial cancer for which he received radiation therapy. As plaintiff's expert explains, radiation therapy is an important significant past medical history because radiation therapy is known to distort the anatomy and may contribute to difficult intubation. Although Dr. Garvin testified that he was informed of this past medical history, he did not include that information in his pre-anesthesia assessment note. In fact, Dr. Garvin conceded that he did not ask where on the body decedent received radiation or its duration. According to plaintiff's expert, eliciting this type of information is critical and Dr. Garvin's failure to obtain that information prior to proceeding with intubation constituted a departure from accepted standard of care.

Moreover, when it was determined that the planned surgery was to be accomplished via the anterior followed by the posterior approach, plaintiff's expert opines that Dr. Garvin needed to discuss all associated risks of extubation including risks and complications of vocal cord injury with decedent. In plaintiff's expert's view, Dr. Garvin's failure to discuss the risks of extubation with decedent constituted a departure from accepted care. Plaintiff's expert also identifies that Dr. Garvin prematurely and erroneously extubated decedent in the operating room in view of the high risk of edema. Moreover, plaintiff's expert explains that once decedent was noted to have evidence of respiratory distress, the only option was to proceed with emergent reintubation. According to plaintiff's expert, had Dr. Garvin followed accepted standard of care and kept decedent intubated until the following morning as was planned, he would have reduced the probability of laryngeal edema which caused stridor and respiratory distress and would have avoided the need for emergent reintubation. As a direct result of the reintubation in the presence of laryngeal edema, plaintiff's expert opines that decedent sustained bilateral vocal cord injury.

Contrary to defendants' position, plaintiff's expert opines, to a reasonable degree of medical certainty and probability, that decedent's vocal fold complaints that he experienced following the October 1, 2012

surgery are unrelated to a suspected diagnosis of Parkinson's disease or other form of neuropathy that was not diagnosed until 2014 and 2015. As plaintiff's expert explains, he has participated in the care and treatment of patients which various neurologic disorders including Parkinson's disease. The symptoms, according to plaintiff's expert, are gradual and are not of a sudden onset. Here, there was absolutely no evidence whatsoever that decedent suffered from any signs and symptoms of even early onset Parkinson's disease at the time of the surgery. Decedent reported an acute onset of his vocal cord symptoms immediately after the surgery. Therefore, according to plaintiff's expert, to a reasonable degree of medical certainty, it is improbable that decedent's vocal cord symptoms were as a result of anything other than vocal cord injury due to negligent premature extubation and reintubation by Dr. Garvin on October 1, 2012.

As a result of these departures, plaintiff's expert concludes that defendants' actions ran athwart of the applicable standard of care and were substantial factors in causing decedent's injuries. As such, plaintiff states that judgment in defendants' favor is unwarranted.

In reply, defendants' challenge plaintiff's expert affirmation and the conclusions drawn therefrom. Defendants state that plaintiff's expert affirmation is utterly bereft of facts or opinions rebutting defendants' expert affirmation. Defendants' further contend that the anonymous affirmation cites some departures, but fails to connect them causally with any injury. Defendants' also state that the affirmation criticizes a postoperative extubation as being contraindicated, but this improperly expands the scope of plaintiff's claims given that they never alleged a contraindicated extubation in the complaint, or the original bill of particulars or the amended bill of particulars. Moreover, defendants state that plaintiff's expert fails to rebut Dr. Benumof's articulation of the clinical diagnosis of synkinesis as the cause of the vocal cord injury and difficulty in swallowing. Defendants also articulate that plaintiff's expert's opinions on defendants having failed to obtain a proper informed consent are not properly before this court. In its totality, defendants' reply reiterates the arguments made in their moving papers, and renews the position that judgment in defendants' favor is warranted.

DISCUSSION

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*).

Here, defendants' submission of deposition transcripts, medical records and an expert affirmation based upon the same established a prima facie defense entitling defendants to summary judgment (*Balzola v Giese*, 107 AD3d 587 [1st Dept 2013]). To be sure, Dr. Benumof specifically provided that Dr.Garvin's visualization and management of decedent's larynx for both the initial pre-surgery intubation and the emergency post-surgery re-intubation, were well within the parameters of good and accepted medical practice. Additionally, Dr. Benumof states, within a reasonable degree of medical certainty, that nothing Dr. Garvin did, or did not do, proximately caused injury to decedent. As defendants' expert affirmation is predicated upon ample support within the record, defendants have shown that decedent was treated in full accord with good and accepted standards of medical care during his admission, and that there were no departures of care attributable to Dr. Garvin and HSS staff that proximately caused decedent's injuries.

In opposition to NYCHHC's prima facie showing, plaintiff raises triable issues of fact sufficient to preclude summary judgment. To be sure, plaintiff's expert highlights that decedent was at a higher risk of complications associated with general anesthesia than the general population in view of his significant past cardiac history. Because of decedent's medical history and respiratory compromise, plaintiff's expert states that contrary to defendants' assertions, decedent should have been intubated overnight. According to plaintiff's expert, had Dr. Garvin followed accepted standard of care and kept decedent intubated until the following morning as was planned, he would have reduced the probability of laryngeal edema which caused

stridor and respiratory distress and would have avoided the need for emergent reintubation. As a direct result of the reintubation in the presence of laryngeal edema, plaintiff's expert opines that decedent sustained bilateral vocal cord injury. Moreover, plaintiff's expert states that Dr. Garvin should have elicited more information with respect to decedent's prior radiation treatment, as such information is critical prior to proceeding with intubation. The failure to obtain it, plaintiff's expert surmises, constituted a departure from the accepted standard of care. Plaintiff's expert further expresses that it is improbable that decedent's vocal cord symptoms were as a result of anything other than vocal cord injury due to negligent premature extubation and reintubation by Dr. Garvin on October 1, 2012. As a result of the departures noted, plaintiff's expert concludes that Dr. Garvin's actions violated the applicable standard of care and proximately caused decedent's injuries. As such, plaintiff states that judgment in defendants' favor is unwarranted.

Defendants challenges to plaintiff's expert's anonymity and credentials are without merit. In the first instance, CPLR §3101(d) allows plaintiff to withhold the identity of plaintiff's expert. Second, plaintiff's expert is a board-certified anesthesiologist whose opines are all expressed to a reasonable degree of medical certainty and probability and are based upon his review of all of the pertinent medical records, parties contentions in the motion for summary judgment and based upon the expert's education, professional experience and training as an anesthesiologist. Moreover, plaintiff's expert sets forth that in his professional experience and training as an anesthesiologist, he has participated in elective and emergent intubations. Similarly, plaintiff's expert participated in intubations during various surgical procedures including orthopedic procedures. Plaintiff's expert has also participated in intubations of patients suffering from neurologic disorders including Parkinson's disease. Plaintiff's expert additionally states that he is aware of the signs and symptoms of Parkinson's disease at early and late onset having participated in the treatment of such patients. Based on the foregoing, it is apparent that plaintiff's expert is qualified to render his opinion with respect to the treatment rendered by Dr. Garvin to decedent. To be sure, plaintiff's expert's credentials do not place him within the ambit of medical professionals devoid of the requisite knowledge or experience to render an opinion outside of their discipline (*see Atkins v Beth Israel Health Servs.*, 133 AD3d 491 [1st Dept 2015]; *Mustello v Berg*, 44 AD3d 1018 [2d Dept 2007]).

Importantly, this is not a case where plaintiff's expert is practicing in an entirely different discipline from defendant's expert. Indeed, both experts are board-certified anesthesiologists. Even if plaintiff's expert was practicing in a different discipline, a medical expert need not be a specialist in a particular field in order to testify regarding accepted practice in that field (*Lopez v Gramuglia*, 133 AD3d 424 [1st Dept 2015]) so long as that medical expert provides a foundation that he or she possesses the requisite knowledge necessary to make a determination on the issues presented (*Limmer v Rosenfeld*, 92 AD3d 609 [1st Dept 2012]). Once such a foundation is laid, the issue of the expert's qualifications to render such an opinion is a question of weight for a jury resolve. Here, the court finds that plaintiff's expert's noted credentials and extensive experience within the field of anesthesiology provide the requisite foundation for him to opine on whether defendants' actions comported with the appropriate standard of care. As such, it is axiomatic that plaintiff's expert has provided a requisite foundation for his opinions.

Turning to plaintiff's expert's observations, it is notable that defendants' argument that decedent was appropriately dealt with during his admission to HSS is contravened by the content of plaintiff's expert

affirmation, which repeatedly takes aim at the fact that Dr. Garvin did not elicit proper pre-surgical information that may well have altered the outcome of his surgery and resulting vocal compromise. Because plaintiff's expert's opinion cannot be discounted as a matter of law, issue of fact remain that must be reconciled at trial. Indeed, the very fact that plaintiff's experts opinions differ from those proffered by defendant's expert illustrates the existence of issues of triable fact. To be sure, "[s]ummary judgment is not appropriate in a medical malpractice action where the parties adduce conflicting medical expert opinions" (*Elmes v. Yelon*, 140 A.D.3d 1009 [2d Dept 2016] [citations and internal quotation marks omitted]). Instead, the conflicts must be resolved by the fact finder (*id.*).

As summary judgment is not warranted as to Dr. Garvin, plaintiff's claims of vicarious liability with respect to HSS remain. Moreover, this court is unpersuaded by defendants' suggestion plaintiff's reintubation and lack of informed consent claims cannot be gleaned from the pleadings. At oral argument before the court on May 7, 2019, defendants took the position that plaintiff's supplemental bill of particulars was limited only to damages, and therefore should not have included the claims as presently alleged. Notably, as presently alleged, plaintiff's bill of particulars is replete with reference to Dr Garvin "negligently reintubated the plaintiff," "failed to administer paralytic prior to reintubation," and "failed to appreciate edema prior to extubation." Moreover, defendants' own moving papers reference the full scope of Dr. Garvin's intubation and reintubation processes, negating any suggestion, perceived or otherwise, that the allegations at issue are procedurally defective. Finally, the supplemental bill of particulars that the parties consented to at a conference before the court on September 25, 2018 was in no way limited by the language of this court's stipulation and order to plaintiff only expanding plaintiff's pleadings as to damages. As such, the court is unpersuaded by defendants' arguments to the contrary, and does not find procedural deficiencies in plaintiff's pleadings sufficient to warrant judgment in defendants' favor.

As the medical malpractice claims endure, so do plaintiff's claims for lack of informed consent and loss of consortium. The court has considered defendants' remaining arguments and finds them unavailing.

Accordingly, it is hereby

ORDERED that defendants' motion for summary judgment is denied in its entirety; and it is further

ORDERED that the parties are directed to appear for a conference before the court on December 17, 2019 at 9:30 AM at the courthouse located at 111 Centre Street, Room 1227 (Part 10).

This constitutes the decision and order of the court.

Dated: November 4, 2019

George J. Silver

HON. GEORGE J. SILVER