To commence the statutory time for appeals as of right (CPLR 5513 [a]), you are advised to serve a copy of this order, with notice of entry, upon all parties.

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF ORANGE

----------X

WYNELIA MARTINEZ, as Administrator of the Estate of WANDA RIVERA,

Plaintiffs,

-against-

ORANGE REGIONAL MEDICAL CENTER, SERGEY KOYFMAN, D.O., ENT AND ALLERGY ASSOCIATES, LLP, STEPHEN SOLOMON, M.D., RICHARD DAY, M.D., ORANGE ANSETHESIA SERVICES, P.C., NORTH AMERICAN PARTNERS IN ANESTHESIA, L.L.P.,

Defendants.

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DECISION AND ORDER
INDEX NO.: EF005621-2016
Motion Date: 02/22/2019
Sequence Nos. 3 - 5

SCIORTINO, J.

The following papers numbered 1 to 47 were read on the motion (Seq. #3) by defendants Sergey Koyfman, D.O. (Koyfman) and ENT and Allergy Associates, LLP (ENT) (collectively, the ENT defendants); the motion (Seq. #4) by defendant Orange Regional Medical Center (ORMC); and the motion (Seq. #5) by defendants Stephen Solomon, M.D (Solomon). and Richard Day, M.D. (Day), Orange Anesthesia Services, P.C. (OAS), and North American Partners in Anesthesia, L.L.P. (NAPA) (collectively, the Anesthesia defendants), each of which seeks an order granting summary judgment dismissing the complaint:

PAPERS	NUMBERED
(Seq. #3) Notice of Motion / Affirmation (Glazer) / Exhibits A - P	1 - 18
(Seq. #4) Notice of Motion / Affirmation (Thompson-Tinsley) / Exhibits A - H	19 - 28
(Seq. #5) Notice of Cross-Motion / Affirmation (Pomeraniec) / Exhibits A - H	29 - 38
Affirmation in Opposition (Futterman) / Exhibits A - E	39 - 44
(Seq. #3) Reply Affirmation (Lopes)	45

(Seq. #4) Reply Affirmation (Thompson-Tinsley) 46
(Seq. #5) Reply Affirmation (Pomeraniec) 47

Upon the foregoing papers, the motions are granted, and the complaint and all cross-claims are dismissed.

Factual Background[1]

This action for medical malpractice and wrongful death arises out of the care and treatment of plaintiff's decedent, Wanda Rivera (Rivera) by defendants between March 2014 and May 2015. Rivera first presented to ENT on March 25, 2014, complaining of difficulty swallowing. She was examined by Dr. Koyfman, who discovered a Reinke's polyp on her vocal cord. She was advised that the polyp would need to be removed, and that she would need to quit smoking cigarettes prior to the surgery. Rivera stated that she would try to quit smoking and return to schedule the surgery.

After Rivera missed her follow-up appointment, Dr. Koyfman sent her a letter dated May 8, 2014, requesting that she contact ENT to reschedule. Rivera next saw Koyfman on June 26, 2014, at which time it was noted that she had cut her smoking to two cigarettes per day. Surgery to remove the vocal cord polyp was scheduled for August 20, 2014. Pre-operative blood work was ordered.

Rivera missed another follow-up appointment and Koyfman sent a letter dated August 5, 2014, requesting that she contact ENT to reschedule. On August 6, ENT office staff sent Rivera the blood work order and pre-surgical packet. Rivera returned to ENT and was seen by Koyfman on August 14, 2014 ; complaints relating to her ears and hearing were addressed. It was decided that she would go forward with the surgery to remove the polyp on August 20, 2014. On August 18, 2014, ENT office staff left a telephone message for Rivera requesting that she advise them of where

[1]The facts contained herein are summarized from the various exhibits annexed to the parties' submissions.

her pre-operative blood work was done. Rivera did not appear for the scheduled surgery on August 20, 2014.

Rivera returned to ENT on September 8, 2014, when she was seen by another physician, non-party Dr. Phillip Massengill, who addressed concerns relating primarily to Rivera's ears and hearing. Dr. Massengill also performed a laryngoscopy and observed the polyp on Rivera's vocal cord. A laryngology referral was discussed, but Rivera declined same until such time that her ears and hearing improved. Rivera had a follow-up appointment with Dr. Massengill relating to her ears on September 15, 2014. She was advised to again follow up in one week. She did not do so. It appears that Koyfman was not notified that Rivera had returned to ENT and seen Dr. Massengill.

Rivera next presented to ENT on May 28, 2015, at which time Koyfman discovered that the vocal cord mass was now obstructing approximately 85 percent of her airway. He advised Rivera that she would need to undergo an awake tracheostomy that night in order to secure her airway. The tracheostomy was to be performed with Rivera awake because sedation could cause her airway to completely obstruct. Once the tracheostomy was performed and Rivera's airway was secured, she would undergo anesthesia prior to the surgery to remove the vocal cord polyp.

That evening, Rivera presented to ORMC. In the pre-operative room, an endoscopy was performed so the anesthesia team could observe the polyp. In the operating room, Koyfman discussed with the anesthesiologists, defendants Dr. Day and Dr. Solomon, that they would attempt an awake fiberoptic intubation. In the likely event that the fiberoptic intubation was unsuccessful, they would proceed with the awake tracheostomy.

Rivera was given minimal sedation, so as to keep her awake, and a topical anesthetic. Fiberoptic intubation was unsuccessful as the tube could not be routed around the polyp due to its

size. Rivera was re-positioned for the awake tracheostomy. After the necessary incision was made and a size 6 tracheotomy tube was inserted, Rivera became combative, and the operating room staff were not able to keep her still. Koyfman was unable to maintain the tube in place. The tube was removed and replaced with a size 5 tube, but Rivera still could not be ventilated. A larger tube was then placed, and ventilation was achieved.

During the period when Rivera was not ventilated, her blood pressure, heart rate, and oxygen saturation levels dropped. Epinepherine and atropine both were administered twice in a span of approximately ten minutes, after which her vital signs stabilized. Once she was stabilized, Koyfman noticed subcutaneous emphysema, and a chest x-ray was performed. A left pneumothorax was discovered, and Dr. Ilya L. Lantsberg, the attending physician in the Intensive Care Unit, placed a chest tube and reinflated the lung. Koyfman noted that Rivera appeared to have suffered a seizure and was treated for same by the ICU staff.

Due to the lack of ventilation during the attempted procedure, Rivera suffered an anoxic brain injury. She was evaluated by a neurologist who documented that she was not responsive to stimuli. When sedation was removed, she remained unresponsive. She was placed on palliative care and ultimately died on June 7, 2015.

Procedural History

Plaintiff commenced the action by filing a Summons and Verified Complaint on August 15, 2016. All defendants timely answered.

By Decision and Order dated April 18, 2017 (Seq. #1), plaintiff's motion for leave to file a late Notice of Medical Malpractice was granted, and plaintiff was directed to file the Notice on or before April 28, 2017. Plaintiff timely filed a Notice of Medical Malpractice pursuant to the terms

of that Order on April 25, 2017.

By Decision and Order dated October 12, 2017 (Seq. #2), the action was discontinued against Samaritan Medical Services, P.C. A Stipulation of Discontinuance as to that defendant had been circulated, but had not been fully executed, thus necessitating the motion. By Stipulation filed on November 14, 2018, the action was discontinued against Dr. Lantsberg. Note of Issue was filed on September 26, 2018.

The motion by the ENT defendants (Seq. #3) was timely filed on November 20, 2018. The motion by ORMC (Seq. #4) and the cross-motion by the Anesthesia defendants (Seq. #5) were timely filed on November 21, 2018. The motions, originally returnable on January 11, 2019, were adjourned on consent of all parties to February 22, 2019.

Motions for Summary Judgment

Sequence #3: Sergey Koyfman, D.O. and ENT and Allergy Associates, LLP

Plaintiff alleges various negligent acts and omissions on the part of Dr. Koyfman, and that ENT is vicariously liable for same. In moving for summary judgment, the ENT defendants assert that Koyfman did not depart from the applicable standard of care in his treatment of Ms. Rivera. They further contend that their care and treatment of Rivera was not a proximate cause of her injuries.

In support of their motion, the ENT defendants submit the expert affirmation of Babak Givi, M.D., board certified in surgery with a subspecialty in head and neck surgery. Dr. Givi opines, within a reasonable degree of medical certainty, that the ENT defendants did not depart from the standard of care in their treatment of Ms. Rivera. Dr. Givi further opines that the record contains no evidence that the ENT defendants caused or contributed to Rivera's injuries.

Dr. Givi states that the polyp on Rivera's vocal cord was one strongly associated with cigarette smoking. If a patient with such a polyp continues smoking, the polyp continues to grow. Dr. Givi thus opines that it was reasonable for Dr. Koyfman to recommend surgical removal only after Rivera stopped smoking.

Dr. Givi further opines that it was reasonable to first attempt the less invasive fiberoptic intubation prior to performing the awake tracheostomy. Rivera was then appropriately positioned and restrained for the tracheostomy. Dr. Givi states that there is no evidence that the tracheostomy tube was not placed in the trachea and, in fact, all evidence is consistent with placement in the trachea. When no end tidal CO2 was detected, it was reasonable for Dr. Koyfman to believe that the airway was obstructed, as this is a known risk, particularly when a patient does not remain still. Dr. Koyfman's use of suction and selection of substitute tubes also was reasonable.

Dr. Givi thus opines that Dr. Koyfman appropriately performed the awake tracheostomy under emergent conditions. There is no evidence of use of excessive force or too large of a tube, and no evidence that Koyfman negligently caused bleeding. Further, the standard of care does not require that blood suctioned during an emergency procedure be recorded or documented in the patient's chart. Dr. Givi concludes that there is no evidence that Koyfman departed from the standard of care in performing "heroic efforts to establish an airway in a patient with a severely compromised airway."

Dr. Givi opines that Rivera's failure to proceed with surgery in June 2014 and her continued smoking of cigarettes contributed to the outcome. Rather than performing an elective polypectomy on a patient under general anesthesia, Dr. Koyfman was required to perform an emergency awake tracheostomy as a result of the 85 percent obstruction of Rivera's airway. The difficulty ventilating

was a known risk and was not caused or contributed to by Koyfman. Rivera's hypoxia was the result of an airway obstruction which was not caused or contributed to by Koyfman. The pneumothorax likewise was not caused by Koyfman, but is a known risk of positive pressure ventilation in a patient with a history of smoking and emphysema. The ENT defendants thus conclude that their motion should be granted.

Sequence #4: Orange Regional Medical Center

Plaintiff alleges the following claims of direct liability against ORMC: (1) failure to supervise staff; (2) failure to promulgate proper rules, regulations, and policies; (3) failure to have staff timely and properly monitor Rivera's signs and symptoms; and (4) failure to have available a physician with expertise to address, consult, or treat Rivera's condition. Plaintiff also alleges that ORMC is vicariously liable for the alleged negligence of each of the defendant physicians.

In support of its motion, ORMC submits the expert affirmation of Steven M. Neustein, M.D., a licensed physician board certified in anesthesiology. Dr. Neustein opines, within a reasonable degree of medical certainty, that plaintiff's claims of direct liability against ORMC are without merit. Dr. Neustein further opines that plaintiff's claims of vicarious liability, based on the claimed negligence of the anesthesiologists, are without merit. Dr. Neustein opines that the care rendered by the anesthesiologists was in accordance with accepted standards, and that none of plaintiff's claims against ORMC were a substantial factor in causing Rivera's injuries.

Dr. Neustein opines that the treatment of Ms. Rivera concerns physicians' judgment and adherence to the applicable standards of care and not any specific hospital policies. Thus, the existence or absence of such written policies was not a substantial factor in causing Rivera's injuries. Further, the operating room was properly equipped with all standard required monitoring devices.

There were no instances of failure to monitor and record Rivera's signs and symptoms. There were, however, instances of Rivera's movement interfering with obtaining vital signs, which were appropriately addressed by hospital staff.

Dr. Neustein further opines that the record contains no evidence to support plaintiff's claim of failure to have available a physician with expertise to address, consult, or treat Rivera's condition. She was admitted to ORMC by her private otolaryngologist. Two qualified and properly trained anesthesiologists were involved in her care. When a pneumothorax was discovered, an intensivist was available and promptly responded. Dr. Neustein thus concludes that this claim is unfounded, and not a substantial factor in causing Rivera's injuries.

On the issue of vicarious liability for the claimed negligence of the anesthesiologists, Dr. Neustein opines that the anesthesiologists promptly assessed Rivera's airway and determined that intubation was not feasible. Their choice of sedation was in accordance with the standard of care. They promptly responded to changes in Rivera's vital signs.

Dr. Neustein further opines that the anesthesiologists' response to the discovery of a pneumothorax was appropriate as Rivera was stable at that time. Had she not been stable, either the surgeon or the anesthesiologist could have used a needle to decompress the pneumothorax. Under the circumstances, it was reasonable for the surgeon to call an intensivist to place a chest tube. Finally, when Rivera's vital signs changed, Dr. Solomon promptly administered epinepherine and atropine. No other emergency or critical care measures were required at that time. Dr. Neustein thus concludes that the care rendered to Rivera was in accordance with accepted standards of care and did not cause her injuries.

By the affirmation of their attorney, ORMC contends that it cannot be held vicariously liable

for the claimed negligence of the ENT defendants. Dr. Koyfman was Rivera's private physician, not an employee of ORMC. ORMC concludes that its motion should be granted, and all claims against it should be dismissed.

Sequence #5: Stephen Solomon, M.D., Richard Day, M.D., Orange Anesthesia Services, P.C. and North American Partners in Anesthesia, L.L.P.

The Anesthesiology defendants incorporate and adopt the arguments advanced on ORMC's motion for summary judgment and refer the Court to the affirmation of Dr. Neustein. They contend that the decision to discontinue attempts at fiberoptic intubation was a prudent judgment call, and they immediately relayed that decision to Koyfman. The choice of sedation was appropriate given the size of the polyp. Neither Dr. Day nor Dr. Solomon performed, nor were they responsible for performance of, any part of the awake tracheostomy; their responsibility was to monitor Rivera's vital signs, which they did appropriately. When her vital signs changed, Dr. Solomon promptly administered epinepherine and atropine. As the care rendered by them was at all times in accordance with accepted standards, and Rivera's injuries are unrelated to such care, the Anesthesiology defendants conclude that their motion should be granted.

Opposition[2]

In opposition to all three motions, plaintiff submits the affirmation of her attorney. Plaintiff does not oppose the cross-motion (Seq. #5) as it pertains to Dr. Day. Further, plaintiff concedes that ORMC can have no vicarious liability for the claimed negligence of Dr. Koyfman. Plaintiff's claims

[2]In response to all defendants' application, plaintiff's experts cite to the deposition testimony of non-party nurse Christine Mitchell in an attempt to raise issues of fact as to when bleeding occurred in Rivera's airway and whether it was Koyfman or one of the anesthesiologists who suctioned Rivera's airway. Neither of plaintiff's experts identifies any material issue to which such testimony may be relevant.

against Dr. Day, and her claims against ORMC of vicarious liability for the claimed negligence of Dr. Day and Dr. Koyfman are dismissed.

Plaintiff asserts that ENT is vicariously liable for Koyfman's negligence. Plaintiff further asserts that OAS and NAPA are vicariously liable for the negligence of Dr. Solomon, as well as that of non-party Dr. Visanee Darin. Finally, plaintiff asserts that ORMC is vicariously liable for the negligence of its agents, including Dr. Solomon and Dr. Darin.[3]

Plaintiff contends that a significant gap in the monitoring of Rivera's vital signs in the anesthesia record evidences a failure to properly monitor the patient. Further, plaintiff asserts that Dr. Koyfman failed to properly place the endotracheal tube in Rivera's trachea, and then failed to timely and properly remove and replace the misplaced tube. Plaintiff further asserts that Dr. Solomon failed to administer sufficient Versed to keep Rivera calm. Further, Dr. Solomon failed to immediately discuss with Koyfman the absence of end tidal carbon dioxide and to recommend replacement of the tracheotomy tube.

Plaintiff submits the affidavit of a board licensed general surgeon licensed to practice in the State of New Jersey. Plaintiff's surgeon opines that Dr. Koyfman departed from good and accepted medical practice when he failed to properly situate and secure the endotracheal tube into Rivera's trachea. The surgeon further opines that Dr. Koyfman also departed from the standard of care when he attempted to suction Rivera's airway and ventilate her through an improperly placed tube instead

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[3]The Court notes that Dr. Darin is not and has never been a named defendant and there has never been any claim asserted against this individual. The claim that OAS, NAPA, and ORMC are vicariously liable for Dr. Darin's actions, which plaintiff advanced for the first time in opposition to the within motions, is rejected. In any event, the record contains no evidence of what, if any, care and treatment Dr. Darin rendered to Ms. Rivera. There can be no finding of liability against any defendant relating to Dr. Darin's actions or inactions.

of immediately removing and replacing or repositioning the tube.

Plaintiff's surgeon opines that, in light of how uncomfortable Rivera was during the attempts at fiberoptic intubation, it should have been anticipated that she would become even more so during the attempted awake tracheostomy. The surgeon opines that the standard of care required that she be made as comfortable as possible for that event.

Plaintiff's surgeon opines, within a reasonable degree of medical certainty, that Dr. Koyfman misplaced the tracheal tube and that the tube only penetrated the pretrachial fascia. Had the tube been properly placed, end tidal carbon dioxide would have been appreciated immediately. The surgeon opines that Rivera was deprived of oxygen for approximately 15 minutes, which caused her anoxic brain injury. He further opines that the development of a pneumothorax was the result of the misplaced tube, which caused forced air to build up subcutaneously. Finally, he finds that the absence of end tidal CO2 was not caused by an obstructed airway as such an obstruction "would have been ruled out within seconds, or addressed within seconds."

Plaintiff additionally submits the affirmation of a board-certified anesthesiologist licensed to practice in the State of New York. The ansesthesiologist opines, within a reasonable degree of medical certainty, that Dr. Solomon departed from good and accepted practice by failing to administer sufficient Versed to keep Rivera calm; by failing to immediately discuss with Koyfman the reasons for the absence of end tidal CO2 and recommend repositioning of the endotracheal tube; by failing to timely and properly monitor Rivera's vital signs; and by failing to take timely and appropriate steps to ventilate Rivera.

On the issues of placement of the endotracheal tube, suctioning of Rivera's airway, administration of sedation to keep Rivera calm; the cause of the pneumothorax, and obstruction of

Rivera's airway, plaintiff's anesthesiologist recites, verbatim, the opinions stated in the affidavit of plaintiff's surgeon. The anesthesiologist further opines that, given Rivera's reaction to the attempts at fiberoptic intubation, it should have been anticipated that she would have a similar or even more significant reaction to the attempted awake tracheostomy. The anesthesiologist concludes that Dr. Solomon departed from good and accepted standards of medical care by failing to administer sufficient Versed to keep Rivera calm.

Reply (Sequence #3): Koyfman and ENT

The ENT defendants submit the affirmation of their attorney who contends that certain of plaintiff's claims must be dismissed as they were unopposed on the summary judgment motion. Those claims include: negligent failure to record the degree of obstruction; improper and negligent attempt to insert too large a tracheostomy tube; use of inappropriate force; causing bleeding and additional obstruction; failing to record the amount of suctioned blood; failing to timely respond to subcutaneous emphysema and pneumothorax; failing to timely take and act upon a chest x-ray; failing to timely place a chest tube; failing to provide appropriate emergency care; and lack of informed consent.

The ENT defendants contend that plaintiff's expert is a general surgeon, not an otolaryngologist, whose experience in performing awake tracheotomies is insufficiently stated. An expert offering an opinion in a field in which the expert is not a specialist must possess the requisite skill, training, education, knowledge or experience to demonstrate that the opinion is reliable. Because plaintiff's surgeon's affidavit fails to set forth such a foundation, the ENT defendants conclude that the affidavit is insufficient to defeat a motion for summary judgment.

In the event that the Court considers the affidavit, the ENT defendants submit that it remains

insufficient to defeat their motion as the surgeon's affidavit is speculative and conclusory, and misconstrues the medical records and deposition testimony. Plaintiff's surgeon ignores Dr. Koyfman's testimony that the endotracheal tube was placed in the trachea. He also ignores Dr. Solomon's testimony that Dr. Koyfman eventually placed the tube in the trachea or that whatever was blocking the tube was unblocked. In fact, the record contains no evidence that Koyfman misplaced the tube, and the medical records and testimony indicate that the absence of end tidal CO2 resulted from a blocked tube.

Plaintiff's surgeon does not refute that the series of events would have been the same in the event of a blocked tube. Further, plaintiff's surgeon ignores Dr. Solomon's testimony that the use of more than minimal sedation could have caused Rivera's airway to completely obstruct. The conclusory opinion that insufficient sedation was administered cannot defeat the motion as plaintiff's surgeon did not consider the risk of obstruction in determining how much sedation was appropriate. The ENT defendants conclude that plaintiff has failed to raise a triable issue of fact as to whether they departed from good and accepted standards of care in their treatment of Ms. Rivera.

The ENT defendants further contend that plaintiff has failed to raise a triable issue of fact as to proximate causation. On this issue, plaintiff's surgeon asserts only that Koyfman "caused additional anoxic injury... by failing to timely and properly withdraw the ET tube and attempt replacement within the trachea." As with the surgeon's opinions regarding Koyfman's alleged departures from the standard of care, this assertion is speculative and conclusory and relies on misconstrued testimony. In fact, the records and testimony all indicate that tube placement was not the cause of the anoxic event; rather, the event was caused by a blocked tube, a known risk. Plaintiff's surgeon offers no explanation as to how Koyfman caused additional anoxic injury. The

ENT defendants conclude that plaintiff has failed to raise a triable issue of fact.

Reply (Sequence #4): ORMC

ORMC submits the affirmation of its attorney who points out that plaintiff acknowledges that ORMC is not vicariously liable for the acts and omissions of Dr. Koyfman and that plaintiff does not oppose the motion as to Dr. Day. Further, plaintiff's opposition did not address any of the claims of direct liability against the hospital. ORMC concludes that the claims of direct liability, as well as the claims of vicarious liability related to the care and treatment rendered by Koyfman and Day must be dismissed.

ORMC further contends that the opinions of plaintiff's anesthesiologist as to the care and treatment rendered by Dr. Solomon are conclusory and speculative, and insufficient to defeat summary judgment. The anesthesiologist's affirmation contains only general allegations that are conclusory and unsubstantiated by competent evidence. The affirmation is based on hindsight reasoning and on the fallacy that Rivera's injuries could not have occurred in the absence of negligence on the part of the treating physicians.

ORMC submits that plaintiff's anesthesiologist alleges only three departures by the Anesthesiology defendants: failure to administer sufficient Versed; failure to promptly address the reasons for the absence of end tidal CO2 and to recommend repositioning of the tube, and failure to timely and appropriately monitor Rivera's vital signs or to take appropriate steps to ventilate Rivera. All other claims against ORMC thus are undefended and must be dismissed.

Plaintiff's anesthesiologist offers no opinion on what would constitute sufficient Versed to keep Rivera calm. Further, the opinion that a higher dose of sedation would have kept Rivera calm and would not have caused her compromised airway to obstruct is speculative and should be

disregarded. In addition, the record contains no factual basis for the claim that Solomon failed to promptly discuss with Koyfman the reasons for the absence of end tidal CO2. In fact, that opinion ignores both the hospital chart and the deposition testimony, which establish that Koyfman was aware of the absence of end tidal CO2 and took steps to remedy the situation. The opinion that the Anesthesiology defendants failed to monitor Rivera's vital signs or to take appropriate steps to ventilate her is likewise unsupported by the record. ORMC concludes that its motion should be granted.

Reply (Sequence #5): Solomon, Day, OAS and NAPA

The Anesthesiology defendants submit the affirmation of their attorney who points out that plaintiff does not oppose the cross-motion as it pertains to Dr. Day. All claims against Day should be dismissed. As to Dr. Solomon, his choice of sedation was appropriate. Plaintiff's anesthesiologist's opinion that a higher dose of Versed would have calmed Rivera without causing her airway to obstruct is speculative and specious.

The contention that Solomon should have advised Koyfman to remove and replace the endotracheal tube would require Solomon to direct the surgeon's performance of surgery which is outside an anesthesiologist's purview. Finally, the record reveals that Solomon properly monitored Rivera's vital signs, promptly notified Koyfman of the absence of end tidal CO2, and promptly administered atropine and epinepherine when Rivera's heart rate, blood pressure, and oxygen saturation dropped. The Anesthesiology defendants thus conclude that their motion should be granted.

The Court has fully considered the submissions of the parties.

Discussion

"A party moving for summary judgment must make a prima facie showing of entitlement to judgment as a matter of law, offering sufficient evidence to demonstrate the absence of any material issues of fact" (*Nash v. Port Wash. Union Free School Dist.*, 83 AD3d 136, 146 [2d Dept 2011]), *citing Alvarez v. Prospect Hosp.*, 68 NY2d 320, 324 [1986]). The function of the Court on such a motion is issue finding, and not issue determination (*Sillman v. Twentieth Century-Fox Film Corp.*, 3 NY2d 395 [1957]), and the Court is obliged to draw all reasonable inferences in favor of the non-moving party (*Rizzo v. Lincoln Diner Corp.*, 215 AD2d 546 [2d Dept 1995]). Where there is any doubt about the existence of a material and triable issue of fact, summary judgment must not be granted (*Anyanwu v. Johnson*, 276 AD2d 572 [2d Dept 2000]).

"On a motion for summary judgment, a defendant doctor has the burden of establishing the absence of any departure from good and accepted medical practice or that the plaintiff was not injured thereby" (*Murray v. Hirsch*, 58 AD3d 701, 702 [2d Dept 2009]). "A plaintiff, in opposition to a defendant physician's summary judgment motion, must submit evidentiary facts or materials to rebut the prima facie showing by the defendant physician that he was not negligent in treating plaintiff so as to demonstrate the existence of a triable issue of fact" (*Alvarez*, 68 NY2d at 324). "General allegations of medical malpractice, merely conclusory and unsupported by competent evidence tending to establish the essential elements of medical malpractice, are insufficient to defeat defendants physician's summary judgment motion (*id.* at 325).

In the matter at bar, each of the defendants has made the requisite prima facie showing of entitlement to judgment as a matter of law by submission of the various deposition transcripts, the medical records, and expert affirmations which refute by specific factual reference the claims

advanced by the plaintiff (*see id.*). The burden thus shifts to plaintiff to submit admissible proof sufficient to establish the existence of material issues of fact requiring a trial (*Zuckerman v. City of New York*, 49 NY2d 557 [1980]).

The ENT Defendants

In opposition to the motion by the ENT defendants, plaintiff submitted the affidavit of a general surgeon licensed to practice in the State of New Jersey. Plaintiff's surgeon states, "In the course of my career, I have had experience in performing awake tracheotomy upon patients in the hospital setting." Plaintiff's surgeon provides no further details as to his or her qualification to render an opinion on the standard of care applicable to Dr. Koyfman's treatment of Ms. Rivera, or Koyfman's alleged departures therefrom.

"While it is true that a medical expert need not be a specialist in a particular field in order to testify regarding accepted practices in that field.... the witness nonetheless should be possessed of the requisite skill, training, education, knowledge or experience from which it can be assumed that the opinion rendered is reliable" (*Behar v. Coren*, 21 AD3d 1045, 1046-47 [2d Dept 2005], *quoting Postlethwaite v. United Health Servs. Hosps.*, 5 AD3d 892, 895 [3d Dept 2004]). In the absence of any details as to plaintiff's surgeon's skill, training, knowledge or experience in treating patients with Rivera's particular condition, the Court is unable to assume that the opinion rendered is reliable. The affidavit is of no probative value.

In the absence of a reliable expert opinion to rebut the ENT defendants' prima facie showing, plaintiff has failed to raise a triable issue of fact. The motion (Seq. #3) by the ENT defendants is granted.

ORMC and the Anesthesiology Defendants

As the only remaining claims against ORMC are vicarious in nature, premised upon the alleged negligence of Dr. Solomon, the Court first must determine the motion by the Anesthesiology defendants. In opposition to that motion, plaintiff submitted the affirmation of a board-certified anesthesiologist licensed to practice in the State of New York. In this instance, plaintiff's expert is plainly qualified to render an opinion as to the standard of care binding the Anesthesiology defendants and their alleged departures therefrom.

Plaintiff's expert opines that the Anesthesiology defendants departed from good and accepted medical practice in four respects: by failing to administer sufficient sedation to make Rivera calm; by failing to immediately discuss with Dr. Koyfman the reasons for the absence of end tidal CO2 and to recommend repositioning of the endotracheal tube; by failing to timely and properly monitor Rivera's vital signs; and by failing to take timely and appropriate steps to ventilate Rivera.

Plaintiff's expert's opinions are speculative, conclusory, and unsubstantiated by competent evidence. With respect to the claim that Dr. Solomon failed to administer sufficient sedation to keep Rivera calm, plaintiff's expert offered no opinion as to how much sedation was appropriate and no opinion as to how much sedation could have been administered without causing Rivera's airway to obstruct. Further, plaintiff's expert "failed to state the specific facts or medical evidence relied upon in forming the opinion" (*Bendel v. Rapaj*, 101 AD3d 662, 664 [2d Dept 2012]).

The assertions that Solomon failed to immediately discuss with Koyfman the reasons for the absence of end tidal CO2 and to recommend repositioning of the tube, and that Solomon failed to take timely and appropriate steps to ventilate Rivera, are unsupported by competent evidence. The hospital record and the relevant deposition testimony clearly reflect an ongoing dialogue between Solomon and Koyfman regarding the absence of end tidal CO2 and Koyfman's removal and

replacement of the tube multiple times until ventilation was achieved.

The claim that Solomon failed to timely monitor Rivera's vital signs is likewise unsupported by competent evidence. The record reveals that, during the periods when vital signs were not recorded by the operating room equipment due to Rivera's excessive movement, Dr. Solomon continued to appreciate peripheral pulses. "It is well settled that an expert's opinion must be based on facts in the record or personally known to the witness, and that the expert may not assume facts not supported by the evidence in order to reach his or her conclusion" (*Erbstein v. Savasatit*, 274 AD2d 445, 446 [2d Dept 2000]).

Plaintiff's expert's speculative, conclusory, and unsubstantiated assertions are insufficient as a matter of law to raise a triable issue of fact. The Anesthesiology defendants' motion must be granted.

In the absence of a viable claim against the Anesthesiology defendants, plaintiff's claims of vicarious liability for the negligence of those defendants against ORMC cannot survive.

Accordingly, it is hereby ORDERED that the motion (Sequence #3) by defendants Sergey Koyfman, D.O. and ENT and Allergy Associates, LLP is granted; and it is further

ORDERED that the motion (Sequence #4) by defendant Orange Regional Medical Center is granted; and it is further

ORDERED that the motion (Sequence #5) by defendants Stephen Solomon, M.D., Richard Day, M.D., Orange Anesthesia Services, P.C., and North American Partners in Anesthesia, L.L.P.

is granted; and it is further

ORDERED that plaintiff's complaint, and defendants' respective cross-claims all are dismissed.

The foregoing constitutes the Decision and Order of the Court.

Dated: April 18, 2019
Goshen, New York

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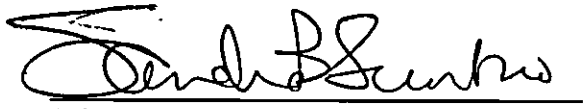

HON. SANDRA B. SCIORTINO, J.S.C.

TO: Counsel of Record
VIA NYSCEF