At an IAS Part 36 of the Supreme Court of the State of New York, held in and for the County of Kings, at the Courthouse, at 360 Adams Street, Brooklyn, New York, on the 2nd day of January, 2020.

PRESENT:

HON. BERNARD J. GRAHAM,
Justice.

----------X

AUREA MIRANDA-VAZQUEZ, ADMINISTRATRIX OF THE ESTATE OF PEDRO ANGEL ZAVALA, DECEASED, AND AUREA MIRANDA-VAZQUEZ, INDIVIDUALLY,
PLAINTIFF,

-AGAINST-

Index No. 513455/16

ROBERT LEE DAVIS, M.D., GALINA GLINIK, M.D., AND NYU LUTHERAN MEDICAL CENTER,
DEFENDANTS,

----------X

The following papers numbered 1 to 7 read herein:

	Papers Numbered
Notice of Motion/Order to Show Cause/ Petition/Cross Motion and Affidavits (Affirmations) Annexed	1-3
Opposing Affidavits (Affirmations)	4-6
Reply Affidavits (Affirmations)	7
Affidavit (Affirmation)	
Other Papers	

Upon the foregoing papers in this medical malpractice and wrongful death action, defendants Robert Lee Davis, M.D. (Dr. Davis), Galina Glinik, M.D. (Dr. Glinik), and NYU Lutheran Medical Center (NYU or the hospital) move, pursuant to CPLR 3212, for summary judgment dismissing the complaint of plaintiff Aurea Miranda-Vazquez, Administratrix of

the Estate of Pedro Angel Zavala, deceased, and Aurea Miranda-Vazquez, Individually (plaintiff).

Background Facts and Procedural History

On February 14, 2016[1], plaintiff's decedent Pedro Angel-Zavala (decedent) appeared at NYU's emergency room complaining of nausea and abdominal pain. Upon arriving at the ER, decedent gave his medical history, which included the removal of his right kidney five years earlier. Thereafter, decedent was admitted to NYU, and on February 16, an endoscopic retrograde cholangio-pancreatography (ERCP) was performed, which revealed gall stones. Subsequently, another procedure was performed in which decedent's bile duct was swept with a balloon and a large amount of dark bile and sludge was removed. Following these procedures, it was recommended that decedent undergo a laparoscopic cholecystectomy (i.e., gallbladder removal), and surgery was scheduled for February 18.

On February 18, decedent was brought to NYU's operating room for the scheduled surgery, which was to be performed by Dr. Davis. With respect to the operation itself, the surgical notes, which were dictated by Dr. Davis, state as follows:

> "An umbilical incision was made with a 15 blade scalpel with dissection down to the fascia under control with Kelly clams. The fascia was entered and stay sutures placed in the fascia. The Hasson cannula was inserted. The abdomen was insufflated to 15 mm Hg. The abdomen was inspected and no trauma due to Hasson entry noted. There were extensive adhesions near the trocar site which were sharply lysed. Additional trocars were placed under direct laparoscopic visualization. The gallbladder was grasped at the fundus and the infudibulum retracted up over the edge of the liver and

[1]Unless otherwise stated, all dates set forth in the facts took place in 2016.

> moved towards the abdominal sidewall exposing the hepatobiliary triangle. The cystic duct and artery were identified and dissected free. The cystic duct was clipped and divided. The posterior branch of the cystic artery was then carefully clipped and divided. Gallbladder was taken off the bed with electrocautery and pulled from the umbilicus. The abdomen was inflated and inspected. Hemostasis was verified. Clip placement was inspected and clip position was confirmed. Trocars removed and hemostasis was verified. The abdomen was deflated. Vicryl was used to close the fascia and Monocryl used to close the skin. The patient tolerated the procedure well. There were no complications. All sponge and needle counts were correct."

At his deposition, Dr. Davis confirmed the accuracy of these records with certain exceptions. In particular, the surgical notes indicate that the adhesions, which were the result of decedent's previous surgery to remove his kidney, were lysed (i.e., removed) after the Hasson trocar was placed, but before the additional trocar ports were placed. However, at his deposition, Dr. Davis testified that this sequence of events was incorrect. Specifically, Dr. Davis testified that a second trocar port, which was used to provide access for the surgical camera, was placed under decedent's breast bone before the adhesions were lysed. Dr. Davis further testified that two additional lateral trocar ports were placed to provide access for surgical tools. Finally, Dr. Davis testified that he removed the adhesions through the lateral ports using a grasper and scissors while viewing his work through the camera. When asked why the surgical notes indicated that the adhesions were removed before the additional ports were placed, Dr. Davis stated, "I can't answer. That's just the way I dictated it." Although not mentioned in the surgical notes, Dr. Davis also testified that after making

the initial umbilical incision, he performed a "finger sweep" to make sure that there was nothing that would obstruct the placement of the Hasson trocar.

On February 19, decedent was admitted to the surgical ICU for sepsis with low blood pressure, increased heart rate, elevated temperature, and elevated white blood cell count. On the same day, Dr. Davis went on vacation and decedent's care was managed by Dr. Glinik. On February 19, a CT angiogram of the chest was taken and revealed no pulmonary embolism. In addition, a CT of the abdomen and pelvis was taken and showed no gross abnormalities, with a small post-operative collection in the gallbladder fossa. On February 20, decedent was placed on the antibiotics Cefepime, Vancomycin, and Flagyl. On February 22, a urine test showed decedent to have an elevated white blood cell count (WBC) of 14.3. On February 23, decedent's WBC was 13.6 and the plan was to continue him on antibiotics with the final doses to be administered that day. On this day, decedent was also advanced to a full liquid diet and downgraded to the surgical floor.

On February 25, decedent's WBC was measured at 18.6 and an abdominal CT was ordered. Decedent's medical records indicate that the CT revealed a "[s]mall contained leak" from the small intestine, a "[n]ew approximately 8 x 2 collection in the right abdomen," and a "[n]ew small collection measuring 3.5 cm in the pelvis." Based upon this CT scan, Dr. Glinik performed exploratory laparoscopic surgery and discovered a 5 mm perforation of decedent's small intestine. Dr. Glinik repaired the perforation using sutures and performed an abdominal "washout" with saline. Following surgery, decedent was readmitted to NYU's

surgical ICU. At her deposition, Dr. Glinik testified that there were no abscesses in decedent's abdomen when she performed the surgery.

After the surgery, decedent was seen by an infectious disease physician, nonparty Jeanne Carey, M.D., who recommended a change in decedent's course of antibiotics. On February 27, Dr. Carey again examined decedent and it was noted that his increased heart rate had improved, he had adequate urine output, and was afebrile. However, decedent's WBC remained high at 19.9. On February 28, decedent's WBC continued to trend upward to 20.6 and Dr. Carey ordered a CT scan of decedent's abdomen and pelvis. The CT scan was performed the same day and indicated multiple enhancing loculated masses consistent with abscess formation.

On February 29, Dr. Davis returned from his vacation and examined decedent at 8:00 a.m. Dr. Davis's impression from the February 28 CT scan was that decedent had developed a hematoma that became infected. At 8:35 a.m., decedent's heart rate increased and his WBC increased to 24. As a result, fluid bolus therapy and antibiotics were administered. At 11:00 a.m., decedent's heart rate increased further and his blood pressure was low after being transferred from his bed to a chair. At 11:05 a.m., Dr. Davis determined that decedent was decompensating and becoming more unstable. At his deposition, Dr. Davis testified that he believed decedent was becoming more septic and needed surgery in order to drain the abscesses he believed were causing the sepsis. Dr. Davis also testified that he considered that decedent could have a pulmonary embolism based upon his rapid decompensation as

well as his hypoxia. When asked why decedent was not given anticoagulation medication in light of this possibility, Dr. Davis testified that this was not considered inasmuch as it would increase the risk of bleeding during the planned surgery.

At 12:45 p.m. on February 29, decedent was brought to the operating room. In this regard, the operative report states as follows:

> "The patient was taken to the operating room and placed on the table in a supine position. Prior to induction a left subclavian central line was placed at the request of the anesthesiologist. The procedure was performed without complication and CXR performed immediately after showed no pneumothorax. The abdomen was prepped and draped in the usual fashion. The looped PDS that was in the midline was incised and suture was removed. During the procedure the patient became increasingly hypoxic with saturations dropping to the low 80s. We performed a quick exploration of the abdomen which demonstrated no purulence or intestinal content and the previous intestinal repair was intact. Due to the patients increasing hypoxia we placed an Abthera device and left the abdomen open. We then repeated the chest xray which again showed no pneumothorax. Our working diagnosis at that time was a pulmonary embolism. We started a heparin infusion and prepared the patient to go directly to the CT Scan for a CTA of the chest to rule out a PE. The patient was then too unstable to move thus we contacted the Vascular surgeons who were in the OR suite to perform a pulmonary angio on the table. During this procedure the patient sustained a cardiac arrest and could not be revived."

Following decedent's death, the Office of Chief Medical Examiner, City of New York performed an autopsy. Among other things, the autopsy report indicates "blood clots occluding branches of the pulmonary artery, secondary and tertiary branches" as well as nonadherent blood clots present in the pelvic veins and in the deep veins of both legs. The

autopsy report lists the cause of death as "Deep venous thrombosis with pulmonary thromboemolism following laparotomy for repair of iatrogenic bowel injury during laparoscopic cholecystectomy for acute cholescystitis."

By summons and complaint dated August 3, 2016, plaintiff brought the instant action against Dr. Davis, Dr. Glinik, and NYU. The complaint alleges causes of action sounding in wrongful death and medical malpractice. In addition, plaintiff, who was decedent's wife, has asserted a derivative claim against the defendants. Discovery is now complete and the instant motion is before the court.

Claims Against Dr. Davis

Dr. Davis moves for summary judgment dismissing all claims against him. In so moving, Dr. Davis maintains that he did not depart from good and accepted standards of medical care in his performance of the laparoscopic cholecystectomy on February 18. Dr. Davis further maintains that he did not depart from good and accepted standards of medical care in his treatment of decedent on February 29, after his return from vacation. Finally, to the extent that his treatment of decedent did depart from accepted standards of medical care, Dr. Davis maintains that any such departures did not proximately cause decedent's injuries and death.

In support of his motion for summary judgment, Dr. Davis submits an expert affirmation by Fred M. Kimmelstiel, M.D., a physician duly licensed to practice medicine in the State of New York who is board certified in surgery. According to Dr. Kimmelstiel,

Dr. Davis appropriately and timely performed a laparoscopic cholecystectomy on decedent after an ERCP revealed gallstones. Dr. Kimmelstiel further avers that Dr. Davis was aware of decedent's prior surgical history and employed an appropriate approach to access the surgical field taking into account the fact that decedent's right kidney had previously been removed. Dr. Kimmelstiel also states that Dr. Davis appropriately employed a finger sweep during the placement of the trocars to insure that there was nothing impeding their placement. In addition, Dr. Kimmelstiel opines that Dr. Davis appropriately and properly removed the adhesions with surgical tools through the lateral ports while visualizing the procedure through the camera port. Dr. Kimmelstiel also maintains that, although the post operative report was dictated out of sequence, Dr. Davis' explanation at his deposition for this comports with generally accepted standards of medical practice.

With respect to Dr. Davis' treatment of decedent on February 29, Dr. Kimmelstiel avers that, given decedent's elevated WBC, elevated heart rate, and low blood pressure, it was within the standard of care for Dr. Davis to consider that decedent was going into septic shock from an abscess collection and that he needed urgently to go to the operating room. Dr. Kimmelstiel further opines that, when decedent decompensated on the operating table, it was appropriate for Dr. Davis to consider decedent was suffering from a pulmonary embolism and to call in a vascular surgeon. As a final matter, Dr. Kimmelstiel notes that almost all emboli come from arms or legs and that clots can migrate instantaneously from a patients' extremities to their lungs. Accordingly, Dr. Kimmelstiel avers that in this case, it

is more likely than not that decedent's clots were in his legs and migrated to his lungs. Dr. Kimmelstiel further avers that a physician cannot say to a reasonable degree of medical certainty that decedent would not have succumbed to this pulmonary embolism even if he had been operated on for this sooner than he was.

In opposition to Dr. Davis' motion for summary judgment, defendant maintains that there are numerous issues of fact regarding whether Dr. Davis departed from accepted standards of medical care in his treatment of decedent, and whether these departures caused decedent's injuries and death. In support of this contention, plaintiff submits an expert affidavit by a physician licensed to practice medicine in the State of New Jersey who is board certified in general surgery. In particular, plaintiff's expert opines that Dr. Davis was unaware of decedent's prior surgical history at the time he performed the laparoscopic gallbladder surgery, and that this lack of awareness was a departure from accepted standards of care. In support of this contention, plaintiff's expert notes that Dr. Davis testified at his deposition that he did not know what caused the adhesions in decedent's abdominal area. Plaintiff's expert further opines that this lack of awareness caused Dr. Davis to improperly insert the Hassan trocar in the umbilical area. According to plaintiff's expert, given the fact that decedent's right kidney had previously been removed, as well as decedent's obesity, the approach should have been to enter the abdomen through the upper left quadrant, away from the adhesions caused by the prior surgery by using a Veress-type needle or an optical trocar. Plaintiff's expert maintains that this departure on Dr. Davis' part proximately caused

decedent's injuries. Specifically, plaintiff's expert avers that the improper placement of the trocar by Dr. Davis caused the tear in decedent's small intestine, which led to the subsequent surgery performed by Dr. Glinik on February 25.

Plaintiff's expert also maintains that Dr. Davis departed from accepted standards of care by lysing the adhesions in decedent's abdomen before the port for the camera had been placed. In this regard, plaintiff's expert points to the surgical notes, which indicate that the adhesions were removed after the placement of the Hassan trocar and before the placement of the remaining ports, including the camera port. According to plaintiff's expert, this departure caused Dr. Davis to tear decedent's small intestine when he "blindly" removed the adhesions.

Plaintiff's expert further claims that Dr. Davis departed from accepted standards of care in performing a "finger sweep" in order to ensure that there was nothing to obstruct the placement of the Hassan trocar. In particular, plaintiff's expert maintains that, given decedent's prior surgical history and the presence of adhesions, a finger sweep was extremely dangerous inasmuch as the adhesions are dense and stronger than the bowel and sweeping the area with a finger could tear the bowel. According to plaintiff's expert, Dr. Davis should have employed "a far more accurate approach that includes visual inspection and placement of the trocars under direct vision," and his failure to do so was a departure that proximately caused the tear to decedent's small intestine.

In addition to Dr. Davis' alleged negligence in causing the tear to decedent's small intestine on February 18, plaintiff's expert opines that Dr. Davis departed from accepted standards of medical care in his treatment of decedent on February 29. In particular, plaintiff's expert avers that Dr. Davis misdiagnosed decedent with an evolving sepsis and otherwise failed to properly diagnose decedent with a pulmonary embolism in a timely manner. In support of this contention, plaintiff's expert notes that Dr. Davis admitted at his deposition that he considered the possibility of a pulmonary embolism on the morning of February 29 given the fact that decedent was decompensating and had hypoxia. According to plaintiff's expert, the proper standard of care under these circumstances would be further diagnostic tests such as a CT scan to rule out the possibility of a pulmonary embolism. Instead, Dr. Davis ordered that decedent, who was unstable, undergo emergency exploratory surgery for the treatment of sepsis. Plaintiff's expert contends that had proper diagnostic tests been ordered on the morning of February 29, there would have been ample time to treat the blood clot that caused the embolism through anticoagulation treatment.

The requisite elements of proof in a medical malpractice action are a deviation or departure from accepted standards of medical practice and evidence that such departure was a proximate cause of injury or damage (*Wiands v Albany Med Ctr.*, 29 AD3d 982, 983 [2006]; *Furey v Kraft*, 27 AD3d 416, 417-418 [2006]). "[A] defendant moving for summary

judgment must make a prima facie showing either that there was no departure from accepted medical practice, or that any departure was not a proximate cause of the patient's injuries" (*Matos v Khan*, 119 AD3d 909 [2014]). Once a defendant makes a prima facie showing of his or her entitlement to summary judgment, "the burden shifts to the party opposing the motion for summary judgment to produce evidentiary proof in admissible form sufficient to establish the existence of material issues of fact which require a trial of the action" (*Alvarez v Prospect Hosp.*, 68 NY2d 320, 324 [1986]). In a medical malpractice action, this means that "a plaintiff must submit a physician's affidavit of merit attesting to a departure from accepted practice and containing the attesting doctor's opinion that the defendant's omissions or departures were a competent producing cause of the injury" (*Domaradzki v Glen Cove Ob/Gyn Assocs.*, 242 AD2d 282 [1997]). Finally, conclusory allegations and hindsight reasoning contained in an expert affidavit submitted by a plaintiff do not constitute a basis for denying the summary judgment motion (*Kristal R. v Nichter*, 115 AD3d 409 [2014]; *Micciola v Sacchi*, 36 AD3d 869, 871 [2007]).

Turning first to the perforated small intestine injury sustained by decedent, Dr. Davis has failed to make a prima facie showing that he did not depart from accepted standards of medical care in performing the laparoscopic cholecystectomy on February 18. Dr. Davis has

further failed to make a prima facie showing that any departure on his part in performing this surgery did not proximately cause the tear to decedent's small intestine. In this regard, as previously noted, decedent's autopsy report lists his cause of death as a pulmonary embolism "following laparotomy for repair of iatrogenic bowel injury during laparoscopic cholecystectomy for acute cholecystitis." Thus, the autopsy report indicates that decedent sustained an inadvertent bowel injury during the gallbladder removal surgery performed by Dr. Davis on February 18, and that this injury was a cause of decedent's death. Notably, Dr. Kimmelstien does not dispute this finding in the autopsy report. Nor does Dr. Kimmelstien offer any explanation as to how such an injury could occur in the absence of departure on Dr. Davis' part. Indeed, Dr. Kimmelstien does not discuss the injury to decedent's small intestine except to note that Dr. Glinik repaired the tear on February 25, when she performed emergency surgery on decedent.

In any event, even if Dr. Davis had made a prima facie showing that the tear to decedent's small intestine was not caused by any departure on his part, plaintiff has raised a triable issue of fact in this regard. In particular, given the fact that decedent's right kidney had been removed five years earlier, thereby causing adhesions, plaintiff's expert has raised a triable issue of fact as to whether Dr. Davis' departed from accepted standards of care in placing the Hassan trocar in the umbilical area and as to whether this placement caused the tear to decedent's small intestine.

Turning to Dr. Davis' treatment of decedent on February 29, Dr. Davis has made a prima facie showing through his expert affirmation that such treatment did not depart from accepted standards of medical care. However, in opposition to this prima facie showing, plaintiff has raised a triable issue of fact as to whether Dr. Davis departed from accepted medical standards in failing to timely diagnose the pulmonary embolism. In particular, as noted above, plaintiff's expert opines that decedent exhibited symptoms of a pulmonary embolism on the morning of February 29 including hypoxia and rapid decompensation, and Dr. Davis testified that he considered the possibility of a pulmonary embolism at that time. Plaintiff's expert further opines that diagnostic tests including a CT scan should have been employed to rule out the possibility of an embolism rather than rush decedent into surgery and that had the pulmonary embolism been timely diagnosed on the morning of February 29, treatment including the administration of anticoagulation medicine would have prevented decedent's death several hours later. Under the circumstances, the issue of whether or not Dr. Davis departed from accepted standards in failing to timely diagnose decedent's pulmonary embolism, and whether this departure caused decedent's death, are for the jury to determine.

Claims Against Dr. Glinik

Dr. Glinik moves for summary judgment dismissing plaintiff's claims against her. In so moving, Dr. Glinik maintains that her care and treatment of decedent did not depart from accepted standards of medical practice and care. Dr. Glinik further contends that, to the

extent that her care and treatment of decedent did depart from accepted standards, any such departure did not proximately cause decedent's injuries. In support of these arguments, Dr. Glinik submits an expert affidavit by Dr. Kimmelstiel. In this regard, Dr. Kimmelstiel notes that the post operative CT scans taken of decedent's chest and abdomen on February 19 revealed no pulmonary embolism and no gross abnormalities. Dr. Kimmelstiel further notes that, between February 19 and February 24, decedent's condition improved with a decline in WBC, an advancement to a full liquid diet, and the transfer of decedent from the surgical ICU to the surgical floor. Under the circumstances, Dr. Kimmelstiel avers that Dr. Glinik's treatment of decedent during this time period did not depart from accepted standards as there was no reason to conduct additional diagnostic tests.

Dr. Kimmelstiel also maintains that Dr. Glinik's treatment of decedent did not depart from accepted standards of medical care with respect to the care she rendered on February 25. In particular, Dr. Kimmelstiel states that Dr. Glinik appropriately ordered an abdominal CT scan when decedent's WBC count trended upward to 18.6. Further, Dr. Kimmelstiel maintains that based upon this scan, Dr. Glinik correctly diagnosed decedent with a leak from the small intestine, and appropriately ordered exploratory laparoscopic surgery in order to repair the leak. In addition, Dr. Kimmelstiel avers that Dr. Glinik appropriately repaired the leak using sutures, which was confirmed by the autopsy report. According to Dr. Kimmelstiel, Dr. Glinik properly washed out the abdomen with saline after the repair. In this regard, Dr. Kimmelstien notes that, at her deposition, Dr. Glinik testified that no drain was

necessary as there were no abscesses. Finally, Dr. Kimmelstien states that Dr. Glinik's care of decedent following the February 25 surgery was proper inasmuch as decedent remained stable and only complained of mild tenderness around the incision sites, infectious disease consults were timely called, and an appropriate antibiotic regimen was implemented.

In opposition to Dr. Glinik's motion, plaintiff maintains that there are issues of fact regarding whether Dr. Glinik departed from accepted standards of medical care in her treatment of decedent, and that there are issues of fact as to whether these departures proximately caused decedent's injuries. In support of these arguments, plaintiff relies upon an affidavit from the same physician whom she relied upon in opposition to Dr. Davis' motion. In particular, plaintiff's expert maintains that Dr. Glinik departed from accepted standards in failing to order any diagnostic tests between the February 19 CT scan and the February 25 CT scan. According to plaintiff's expert, another CT scan should have been taken 24 hours after the February 19 CT scan as such a scan would have revealed the tear in decedent's small intestine. Plaintiff's expert also maintains that Dr. Glinik departed from accepted medical standards in failing to drain abscesses in decedent's abdomen during the February 25 surgery. In this regard, plaintiff's expert maintains that the CT scan taken prior to surgery on February 25 and the scan taken on February 28 reveal that the abscesses remained in the same location. Plaintiff's expert states that, had Dr. Glinik properly drained the abscesses, they would not have remained in the same areas. Plaintiff's expert further

states that, had the abscesses been properly drained, Dr. Davis would not have encountered a frozen abdomen when he performed surgery on decedent on February 29.

Dr. Glinik has made a prima facie showing that her treatment of decedent between February 19 and February 28 did not depart from accepted standards of medical care and treatment. In opposition to Dr. Glinik's prima facie showing, plaintiff has failed to raise a triable issue of fact regarding Dr. Glinik's treatment between February 19 and the February 25 CT scan. In particular, although plaintiff's expert maintains that Dr. Glinik should have ordered a CT scan 24 hours after the February 19 CT scan, the expert fails to point to anything in decedent's medical record supporting this claim. Specifically, the medical records indicate that decedent's condition was improving up until the time that his WBC increased on February 25. However, plaintiff has raised a triable issue of fact regarding whether Dr. Glinik departed from accepted standards in failing to adequately inspect decedent's abdomen during the February 25 surgery, and drain abscesses. In particular, although Dr. Glinik testified that there were no abscesses to drain, plaintiff's expert maintains that the February 25 and February 29 CT scans show that the same abscesses were present before and after the surgery on February 25. Furthermore, the February 25 CT scan revealed the presence of new collections in decedent's right abdomen and pelvis. Under the circumstances, the issue of whether or not Dr Glinik departed from accepted standards in failing to remove the alleged abscesses and whether this departure caused decedent's injuries is for the jury to determine.

Summary

In summary, defendants' motion for summary judgment dismissing plaintiff's complaint against them is denied.

This constitutes the decision and order of the court.

ENTER,

J. S. C.

HON. BERNARD J. GRAHAM