| **Mattocks v Ellant** |
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| 2020 NY Slip Op 31626(U) |
| May 27, 2020 |
| Supreme Court, Kings County |
| Docket Number: 505506/16 |
| Judge: Ellen M. Spodek |
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At an IAS Term, Part 63 of the Supreme Court of the State of New York, held in and for the County of Kings, at the Courthouse, at Civic Center, Brooklyn, New York, on the 27th day of May, 2020.

P R E S E N T:

HON. ELLEN M. SPODEK,
Justice.

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CRYSTAL L. MATTOCKS, as Administrator of the Estate of RALPH CARTER, Deceased,

Plaintiff,

- against -

JONATHAN ELLANT, M.D., NEW YORK EYE AND EAR INFIRMARY, JOSEPH HUBERT PAUL, M.D., ALEXANDER SLOTWINER, M.D., NEW YORK METROPOLITAN HEART AND VASCULAR PROFESSIONAL CORPORATION, "JOHN DOE" and "JANE DOE," Names Being Fictitious and Unknown, the Parties Intended Being the Physicians, Residents, Nurses, Agents and/or Employees of the Respective Defendants who Treated the Plaintiff,

Defendants.

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**DECISION AND ORDER**

Index No. 505506/16

Motion Seq. Nos. 3, 5-7

| The following e-filed papers read herein: | Papers Numbered: |
|---|---|
| Notice of Motion, Affirmations (Affidavits), and Exhibits Annexed | 1-4 |
| Affirmations (Affidavits) in Opposition and Exhibits Annexed | 5-8 |
| Reply Affirmations and Exhibits Annexed | 9-12 |

In this action to recover damages for medical malpractice and lack of informed consent, defendants New York Eye and Ear Infirmary (NYEEI), Alexander Slotwiner, M.D. (Dr. Slotwiner), Jonathan Ellant, M.D. (Dr. Ellant), and Joseph Hubert Paul, M.D. (Dr. Paul), separately move, in sequence numbers 3, 5, 6, and 7, respectively, for an order, pursuant to CPLR 3212, granting summary judgment dismissing all claims insofar as asserted against such defendant. Plaintiff Crystal L. Mattocks, as administrator of the estate of Ralph Carter, deceased, opposes.

***Chronology of Events***

On Oct. 7, 2013, plaintiff's decedent, Ralph Carter (the patient), consulted with Dr. Ellant, an ophthalmologist in private practice, regarding cataract extractions. The patient, 69 years old at the time, disclosed on the medical history form which he filled out in Dr. Ellant's office, that (1) his only medications were multi-vitamins; (2) his medical history was significant for high blood pressure and arthritis; and (3) he drank alcohol "4 to 5 days per week." After examining the patient's eyes, Dr. Ellant recommended that the patient undergo cataract extractions in both eyes (the initial extraction to be performed in the left eye and the subsequent extraction to be performed in the right eye) at NYEEI where Dr. Ellant had operating privileges. Dr. Ellant gave the patient a NYEEI form entitled "Ambulatory Surgery Pre-Operative Medical Evaluation" to be utilized, when completed by the patient's primary care physician, as his medical clearance for the upcoming cataract extractions (the clearance form).

On Oct. 22nd, the patient brought the clearance form to his primary care physician, Dr. Paul, to complete. The patient requested, in addition to the medical clearance, that Dr. Paul perform a "complete exam" as he was "[c]oncerned about his alcohol use" and had not visited Dr. Paul for the preceding 15 months (Dr. Paul's records, pages 013-014). On physical examination, Dr. Paul found the patient to be hypertensive (blood pressure of 140 over 90) and obese (body mass index of 33.77). Dr. Paul also found the patient to have (1) a severely distended abdomen positive for ascites, (2) an enlarged liver and spleen, and (3) a pedal edema at 2+ (*id*. at page 014). The patient's labs, drawn on that date, were significant for (1) elevated liver enzymes, and (2) decreased platelets at 100 (normal 155-379) (*id*. at page 015). An EKG performed in Dr. Paul's office revealed A-

Fib (*id*. at pages 014-015). At the time, Dr. Paul declined to clear the patient and treated him for his A-Fib, noting that Coumadin (an anticoagulant) was not started "due to the history of alcohol abuse" (*id*. at page 015). Dr. Paul scheduled the patient's follow-up in one week and prescribed no medications (*id*. at page 016).

In the morning of Oct. 23rd, the patient presented to Dr. Slotwiner, a cardiologist, on referral from Dr. Paul. The patient's chief complaints, as documented by Dr. Slotwiner in his four-page office note, were (1) a shortness of breath for a period of almost six months which was improving with the reduced alcohol use, (2) an increased shortness of breath for the preceding two days, with dyspnea on exertion after he had walked half a block, (3) some lightheadedness for the preceding two weeks, and (4) a newly diagnosed A-Fib (Dr. Slotwiner's office note, pages 3-4). On physical examination, Dr. Slotwiner found the patient to be hypertensive (blood pressure of 160 over 80) and obese, with 1+ edema bilaterally (*id*. at page 4). Dr. Slotwiner noted that the patient's social history was significant for heavy alcohol use due to loneliness, with the patient "currently drink[ing] 1 pint a day, but was drinking as much as a Liter" (*id*.). Dr. Slotwiner attributed the patient's A-Fib, likely to be chronic, to his "heavy etoh [alcohol] use" (*id*.). Although the patient was "hemodynamically stable without active CHF [congestive heart failure] symptoms," his echocardiogram was significant for "severely reduced" ejection fraction of below 35% (*id*.; echocardiogram report, page 2 [observations]). Dr. Slotwiner's plan for the patient, as documented in his office note, stated in relevant part (with the abbreviations spelled out):

> "1. Metoprolol [a beta-blocker] 50 mg twice daily for [heart] rate control, [but] can increase [it] to every six hours as needed.
>
> 2. Aspirin [an antiplatelet agent] 325 mg once daily. [The patient is] [n]ot a great coumadin candidate because of falls risk and etoh [use].
>
> * * *
>
> 6. Tylenol for osteoarthritis pain[.]
>
> 7. Since he is currently [heart] rate controlled without congestive heart failure symptoms, he is medically stable for his planned cataract surgery and I would proceed as planned with beta-blockade for rate control since the benefits of surgery outweigh the risks at this time.
>
> 8. . . . [H]e will follow up with me in 1-2 weeks."

(Dr. Slotwiner's office note, page 4). Contrary to Dr. Slotwiner's instruction, the patient never followed up with him.

In the afternoon of Oct. 23rd, Dr. Slotwiner faxed to Dr. Paul his one-page "SOAP" note (an acronym for subjective, objective, assessment, and plan), as well as the EKG report (Dr. Paul's records, pages 022-024). Dr. Slotwiner's SOAP note reproduced, in its entirety, his plan for the patient, as quoted in relevant part above (*id*. at page 024).

In the morning of Oct. 29th, the patient returned to Dr. Paul to obtain medical clearance for his upcoming cataract extractions. The patient reported to Dr. Paul that (1) he had been seen by Dr. Slotwiner; (2) he was "started on Metoprolol"; and (3) "he [was] feeling fine," although his systolic blood pressure was elevated at 130 over 80 (Dr. Paul's records, page 019). Dr. Paul assessed the patient as suffering from (1) A-Fib, and (2) "Drug Abuse NEC [not elsewhere classified] - Unspec[ified]," meaning alcohol abuse

(*id*. at page 020). Dr. Paul's plan for the A-Fib, as prescribed by Dr. Slotwiner, was to continue the patient on metoprolol at 50 mg, one tablet to be taken twice per day (*id*.). Dr. Paul's plan for the other issues (categorized in Dr. Paul's office note as "Others") was for the patient to take: (1) terazosin (an anti-hypertension medication typically taken by men to reduce their enlarged prostate) at 1 mg, 1 capsule, once daily, and (2) aspirin at 325 mg, one tablet to be taken once daily, as prescribed by Dr. Slotwiner, albeit in the delayed-release formulation (*id*.). Dr. Paul directed the patient to return for a follow-up in four weeks (*id*. at page 021). Contrary to Dr. Paul's instruction, the patient never followed up with him.

In the afternoon of Oct. 29th, Dr. Paul completed, signed, and faxed the clearance form to NYEEI. The clearance form noted that the patient's medical history was significant for (1) hypertension, (2) cardiac arrhythmia, and (3) hepatic disease. The clearance form listed metoprolol 50 mg twice daily under the rubric of "Medications & Dosages," but omitted aspirin (as well as terazosin which is not at issue in this case) from that form. The clearance form further noted that the patient's A-Fib "[was] controlled with meds." The category of "Other Pertinent Findings" (meaning those which were not related to heart and lungs) listed "liver cirrhosis with ascites." The clearance form included as attachments Dr. Paul's Oct. 22nd lab report and Dr. Slotwiner's Oct. 23rd EKG report of the patient.

On the morning of Nov. 20th, the patient presented to NYEEI's ambulatory surgery unit for the cataract extraction in the left eye. As part of the pre-anesthesia assessment, the patient's home medications were listed as (1) metoprolol 50 mg twice daily, (2) the

enteric-coated aspirin 2 tablets daily as needed (no dosage specified), and (3) unspecified eye drops (NYEEI's records, PCS Assessment/Pre-Op Profile [Nov. 20th extraction], page 3). The "Preanesthetic Evaluation Form" for the Nov. 20th extraction indicated that (1) the patient took metoprolol in the morning of the extraction; (2) his medical history was significant for hypertension, A-Fib, and liver disease; and (3) he was hypertensive at 150 over 85. At 12:43 p.m., the anesthesia in the form of "Monitored Anesthesia Care (MAC)" was started (Anesthesia Report, Procedure Comments [Nov. 20th extraction]). MAC consisted of the topical anesthesia by eye drops administered by Dr. Ellant into the left eye and the intravenous sedation administered by the anesthesiologist. While under MAC, the patient remained capable of responding to tactile and verbal stimuli. At 1:22 p.m., the anesthesia ended. The cataract extraction in the left eye was successful. At 1:23 p.m., the patient was transferred to the Surgical Day Care where he was noted to be hypertensive with a blood-pressure reading of 169 over 93, and tachycardic with a heart-rate reading of 105 beats per minute, despite the intra-operative administration of beta-blockers metoprolol and labetalol at 12:57 p.m. and 1:20 p.m., respectively (Anesthesia Report, Procedure Comments [Nov. 20th extraction]; PCS Archive EChart Document [Nov. 20th extraction], page 5). At 1:30 p.m., the patient received a Tylenol for post-operative pain (Medication Record [Nov. 20th extraction]). At 1:46 p.m, a document entitled "Discharge Medication List" was completed by a NYEEI nurse. The Discharge Medication List instructed the patient to "continue taking the following medications," as follows:

| Drug | Instructions | Last Taken | Patient Comments |
|---|---|---|---|
| Metoprolol | 50 mg tablet twice per day | Nov. 20th at 8 a.m. | |
| *Aspirin (enteric coated)* | *2 tablets daily as needed for joint pain* | *Unknown* | *Off 2 weeks* |
| Eye drops | 1 drop into the left eye daily | Nov. 20th at 8 a.m. | |

(NYSCEF #189; part of the NYEEI records [abbreviations spelled out; emphasis added]).[1]

At 2:30 p.m. of the same day, the patient was discharged home (PCS Archive EChart Document [Nov. 20th extraction], page 6).

On Nov. 21st and again on Nov. 25th, the patient returned to Dr. Ellant for check-ups on the left eye. Both check-ups were uneventful.

On the morning of Dec. 4th, the patient returned to NYEEI's ambulatory surgery unit for the cataract extraction in the right eye. The original clearance form which Dr. Paul had submitted to NYEEI in connection with the Nov. 20th extraction was utilized for clearing the patient for the Dec. 4th extraction (Admitting Note & Pre-Surgical Orders, signed by Dr. Ellant on Nov. 25th). As was the case with the Nov. 20th extraction, the patient likewise underwent a pre-anesthesia assessment for the Dec. 4th extraction. As part of the pre-anesthesia assessment, his home medications were again listed as (1) metoprolol 50 mg twice daily, (2) the enteric-coated aspirin 2 tablets daily as needed (no dosage specified), and (3) unspecified eye drops (NYEEI's records, PCS Assessment/Pre-Op Profile [Dec. 4th extraction], page 3). The "Preanesthetic Evaluation Form" for the

[1] Although the parties disagree as to whether that notation indicated that the patient had been off aspirin *before* the first extraction (defendants' position) or that the patient would be off aspirin in the two weeks *after* the first extraction and before the second extraction (plaintiff's position), the parties' disagreement is not material to the resolution of the motions.

Dec. 4th extraction likewise indicated that (1) the patient took metoprolol on the morning of the extraction; (2) his medical history was significant for hypertension, A-Fib, liver disease, and was also further significant for arthritis and joint pain; and (3) he was hypertensive at 153 over 90. At 11:29 p.m., MAC was started. At 12:02 p.m., the anesthesia ended. The cataract extraction in the right eye was successful. At approximately 12:03 p.m., the patient was transferred to the Surgical Day Care where he was noted to be hypertensive with a

blood-pressure reading of 172 over 89, but with a normal heart rate of 80 beats per minute, following the intra-operative and concurrent administration of beta-blocker metoprolol and anti-emetic ondansetron at 11:40 a.m. (Anesthesia Report, Procedure Comments [Dec. 4th extraction]; PCS Archive EChart Document [Dec. 4th extraction], page 6). At 12:05 p.m., the patient received a Tylenol for post-operative pain (Patient Order Summary [Dec. 4th extraction], page 10).

At 12:20 p.m., while still in the Surgical Day Care, the patient displayed right-sided weakness (PCS Archive EChart Document [Dec. 4th extraction]). At 1:05 p.m., the patient was transferred to the nearby Beth Israel Hospital (Beth Israel) for a possible cerebrovascular accident (Patient Transfer Summary). On arrival at Beth Israel, the patient was alert but unable "to provide his history due to aphasia" (Discharge Summary, dated Dec. 20, 2013, part of Beth Israel's records). At presentation to Beth Israel, the patient exhibited a "new onset of [A-Fib] on the EKG and an "acute ischemic stroke" on the CT head scan. Thrombolysis, followed by thrombectomy, failed to resolve the stroke. After a prolonged hospitalization at Beth Israel, the patient was discharged to a nursing

home where he stayed for approximately five years until he died from unrelated causes on Sept. 25, 2018, while this action was pending (NYSCEF #88 [Certificate of Death]).

This action was commenced by the guardian of the patient's property and was continued by his daughter following his death. The complaint asserts two causes of action sounding in medical malpractice/negligence and lack of informed consent. The principal named defendants are Dr. Ellant, the eye surgeon; NYEEI, the hospital in which the cataract extractions were performed; Dr. Paul, the patient's internist who medically cleared him for the extractions; and Dr. Slotwiner, the cardiologist who cleared him for the extractions from the cardiac standpoint (collectively, defendants). The remaining named defendant, Metropolitan Heath and Vascular Professional Corporation, was dismissed from this action by stipulation.

***Discussion***

***Plaintiff's Informed Consent Claim***

Defendants have established their prima facie entitlement to judgment as a matter of law dismissing the cause of action alleging lack of informed consent as asserted against them by demonstrating, in the case of Dr. Paul and Dr. Slotwiner, that those defendants did not perform a procedure on the patient and, in the case of Dr. Ellant and NYEEI, that they properly obtained an informed consent from the patient. Further, Dr. Ellant's expert, Anurag Shrivastava, M.D. (Dr. Shrivastava), a physician licensed in the State of New York and board-certified in ophthalmology, opines that "stroke is not a risk of, nor is it caused by, cataract extraction. Therefore, it is not a risk that should have been disclosed to [the patient]" (Dr. Shrivastava Aff., dated June 26, 2019, ¶ 21). In

opposition, plaintiff has failed to rebut defendants' prima facie showing of entitlement to judgment as a matter of law, as her experts have not addressed that cause of action or specifically opposed that branch of defendants' motions (*see Bhim v Dourmashkin*, 123 AD3d 862, 865 [2d Dept 2014]). Accordingly, the branches of defendants' respective motions for summary judgment dismissing the cause of action alleging lack of informed consent insofar as asserted against them are granted.

***Plaintiff's Medical Malpractice Claim***

"A defendant moving for summary judgment in a medical malpractice action must demonstrate the absence of any material issues of fact with respect to at least one of the elements of a cause of action alleging medical malpractice: (1) whether the physician deviated or departed from accepted community standards of practice, or (2) that such a departure was a proximate cause of the plaintiff's injuries" (*Rosenthal v Alexander*, ___ AD3d ___, 2020 NY Slip Op 01101 [2d Dept 2020] [internal citation omitted]). "When a defendant in a medical malpractice action demonstrates the absence of any material issues of fact with respect to at least one of those elements, summary judgment dismissing the action should eventuate unless the plaintiff raises a triable issue of fact in opposition" (*Schwartz v Partridge*, 179 AD3d 963, 964 [2d Dept 2020] [internal citations omitted]).

*Dr. Ellant*

Dr. Ellant has established his prima facie entitlement to judgment as a matter of law dismissing the medical malpractice claim as against him through, among other

submissions, Dr. Shrivastava's expert affirmation. Dr. Shrivastava opines, in relevant part, that:

> "taking aspirin or not taking aspirin is not a contraindication to cataract extractions. A cataract extraction is a simple procedure and does not involve blood loss. Therefore, whether or not a primary care physician recommends aspirin does not and should not affect an ophthalmologist's decision to proceed with cataract extraction."

(Dr. Shrivastava Aff., ¶ 19).

In opposition to Dr. Ellant's prima facie showing, plaintiff has failed to raise a triable issue of fact. Plaintiff's expert affidavits in opposition to Dr. Ellant's motion – one by a physician licensed in the States of New York and Arizona and board-certified in ophthalmology and the other by a physician licensed in the States of Connecticut and Massachusetts and board-certified in anesthesiology – fail to rebut, or even address, the aforementioned opinion of Dr. Shrivastava on the subject of proximate cause. Thus, the affidavits of plaintiff's experts are insufficient to raise a triable issue of fact as to whether any deviation by Dr. Ellant from the accepted standard of care was a proximate cause of the patient's stroke. Accordingly, the branch of Dr. Ellant's motion for summary judgment dismissing the medical malpractice claims as against him is granted (*see e.g. Messeroux v Maimonides Med. Ctr.*, ___ AD3d ___, 2020 NY Slip Op 01487 [2d Dept 2020]).

*Dr. Paul and Dr. Slotwiner*

Dr. Paul and Dr. Slotwiner have established their prima facie entitlement to judgment as a matter of law dismissing all claims as against them through, among other

submissions, the expert affirmation of Philip M. Gelber, M.D. (Dr. Gelber), a physician licensed in the State of New York State and board-certified in internal medicine and cardiology, as to Dr. Paul, and the corrected expert affidavit of Henry S. Cabin, M.D. (Dr. Cabin), a physician licensed in the State of Connecticut and board-certified in internal medicine and cardiology, as to Dr. Slotwiner, respectively (NYSCEF #216). Like Dr. Shrivastava before them, both experts opine that "[c]ataract surgery is a low risk, low impact avascular surgery" (Dr. Gelber Aff., undated, ¶ 37), and that "[t]here was nothing about the surgery itself or the minimal anesthesia given which increased the patient's risk for stroke" (Dr. Cabin Aff., dated Oct. 28, 2019, page 12).

Plaintiff opposes Dr. Paul's motion with (1) the expert affidavit of a physician licensed in the State of Florida and board-certified in internal medicine and cardiology (plaintiff's expert cardiologist), and (2) the expert affidavit of a physician licensed in the State of Illinois and board-certified in internal medicine (plaintiff's expert internist). Separately, plaintiff opposes Dr. Slotwiner's motion with the same affidavit of her expert cardiologist. The affidavits of plaintiff's expert cardiologist and her expert internist contradict each other on the subject of proximate cause. On the one hand, both of these experts opine as to *Dr. Paul* that he was negligent in the manner in which he completed and returned the clearance form to NYEEI by failing to list *aspirin* on that form as one of the medications the patient was taking and by using an ambiguous abbreviation "meds" in describing the patient's medications on that form (Plaintiff's Expert Cardiologist Aff., ¶ 34 [iii]-[iv]; Plaintiff's Expert Internist, ¶ 24 [iii]-[iv]). On the other hand, plaintiff's

expert cardiologist opines as to *Dr. Slotwiner* that he was negligent by prescribing *aspirin* in the first place, instead of prescribing *Coumadin or Pradaxa* (Plaintiff's Expert Cardiologist Aff., ¶ 33 [i], [ii], [vi], [vii], [viii], [ix]). If Dr. Paul was at fault regarding *aspirin* after Dr. Slotwiner had advised him (Dr. Paul) of the aspirin prescription,

then Dr. Slotwiner could not have been negligent for failing to initially prescribe *Coumadin or Pradaxa*. Conversely, if Dr. Slotwiner was negligent in failing to initially prescribe *Coumadin or Pradaxa,* then Dr. Paul could not have been negligent in subsequently omitting *aspirin* from the clearance form and in using an ambiguous abbreviation "meds" on that form. In sum, plaintiff has offered two conflicting theories on the cause of the patient's stroke: *either* Dr. Paul failed to inform Dr. Ellant, the anesthesiologists, and NYEEI that the patient was on aspirin and to ensure that the patient was taking aspirin between the first and second extractions; *or* Dr. Slotwiner should have initially prescribed Coumadin or Pradaxa instead of aspirin. Whether the malpractice was committed with respect to *either* aspirin *or* Coumadin/Pradaxa depends on the correctness of plaintiff's expert opinions as to *only one* (but not both) of these medications. Inasmuch as the opinions of plaintiff's expert cardiologist and her expert internist contradict each other, they are insufficient to link the alleged departures to proximate cause (*see Barrocales v New York Methodist Hosp.*,122 AD3d 648, 649-650 [2d Dept 2014]; *Estate of Aviles v New York City Health & Hosp. Corp.*, 5 AD3d 432 [2d Dept 2004]; *Pozo v Somersel*, 2016 NY Slip Op 30702[U], *10-11 [Sup Ct, Bronx County 2016]). Moreover, plaintiff's choice of Dr. Slotwiner as a defendant and her

uninterrupted prosecution of her claims against him for his failure to prescribe the patient *Coumadin/Pradaxa* must necessarily exclude Dr. Paul's alleged liability for his subsequent omission regarding *aspirin*. Thus, plaintiff has failed to raise a triable issue of fact as to Dr. Paul on the issue of proximate cause. Accordingly, the branch of Dr. Paul's motion for an order granting him summary judgment dismissing the medical malpractice claim as against him is granted.

Putting aside the inconsistencies between the affidavits of plaintiff's expert internist and her expert cardiologist, the Court finds that the affidavit of plaintiff's expert cardiologist, standing on its own, fails to raise a triable issue of fact as to Dr. Slotwiner. The record indicates that Dr. Slotwiner's decision not to prescribe the patient Coumadin or Pradaxa at his first (and only) visit was not as cut and dry as plaintiff's expert cardiologist makes it out to be. Although the guidelines on managing A-Fib patients recommend thromboembolic therapy *generally*, the guidelines expressly exclude patients with *contraindications* (ACCF/AHA Practice Guidelines, Management of Patients with Atrial Fibrillation, *Circulation*, 2013; vol. 127, page 1918, § 1.1.2. [annexed to the affidavit of plaintiff's expert cardiologist]). Since the patient, by his own admission, drank alcohol to excess, Dr. Slotwiner was facing a dilemma when confronted with the patient's need for anticoagulation. Dr. Slotwiner could (and in the patient's case did) choose *not* to prescribe an anticoagulant (Coumadin or Pradaxa), realizing, as his pretrial testimony indicates, that the patient would be at risk for a thromboembolic event. In the alternative, Dr. Slotwiner could (as plaintiff's expert cardiologist opines he was required

to) prescribe an anticoagulant (either Coumadin or Pradaxa) to the patient at the first visit, albeit *without knowing* the likelihood of successful anticoagulation control or the risk of hemorrhagic events. Coumadin has several shortcomings, including bleeding and the inconvenience of regular blood testing and dose adjustments. Coumadin also has a narrow therapeutic window. Without a careful and frequent laboratory testing and dosage adjustment to maintain a normalized prothrombin clotting time ratio, a patient is at risk for blood clots if he or she is *under*-coagulated, and, conversely, is at risk for bleeding if he or she is *over*-coagulated. The then-available alternative to Coumadin – Pradaxa – had its own shortcomings at the time in question (October-December 2013), as follows: (1) no effective reversal agent or protocol for controlling bleeding in patients taking Pradaxa; (2) a twice-daily dosing frequency; and (3) a higher risk of gastrointestinal and other bleeding while on Pradaxa as compared to Coumadin.[2]

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[2] As was summarized in *Sellers v Boehringer Ingelheim Pharmaceuticals, Inc.* (881 F Supp 2d 992 [SD Ill 2012]), which was issued on July 25, 2012, or more than one year preceding Dr. Slotwiner's consultation of the patient:

"*The following events allegedly took place after Pradaxa was approved for use in the U.S. (October 19, 2010) but before or on or about the period when the plaintiff [in Sellers] was prescribed and injured by Pradaxa: (May/June 2011): . . . 932 Pradaxa-associated 'Serious Adverse Event' Medwatch reports were filed with the FDA, including reports of death and severe life threatening bleeding*. The additional events occurred after the plaintiff [in *Sellers*] was prescribed and injured by Pradaxa, including the following: (1) Officials in Japan imposed certain requirements for patients taking Pradaxa, including a "BOXED WARNING" regarding the risk of severe hemorrhages; and (2) two letters from physicians were published in the *New England Journal of Medicine* stating that the serious risks of Pradaxa, such as the lack of an effective reversal agent or protocol, are not fully appreciated by the medical community."

(*Id*. at 1012 n 5 [citations omitted; emphasis added]).

As the *Sellers* court explained:

"Presently [*i.e.*, as of July 25, 2012], there are at least 36 cases involving Pradaxa with substantially similar fact patterns and allegations ('Pradaxa Product Liability Cases') pending in fourteen different judicial districts in the United States. Of the 36 Pradaxa Product Liability Cases pending in federal court, 17 are on file in this judicial district and have been assigned to the undersigned judge."

(*Id*. at 997 [footnotes and citation omitted]). The plaintiff in *Sellers* "as a result of ingesting Pradaxa . . . suffered a severe gastrointestinal bleed causing her to be hospitalized . . . for a period of 5 days" (*id*. at 998).

As Dr. Cabin explains, Dr. Slotwiner, in prescribing the patient aspirin instead of Coumadin (or Pradaxa) for stroke prophylaxis, was justifiably concerned with the patient's comorbid conditions (liver disease, among others), risk of falls, compliance, and the lifestyle implications of his admitted alcohol addiction. Dr. Slotwiner, in addition to prescribing the patient metoprolol for heart-rate control and aspirin for stroke prophylaxis, emphasized the importance of substance abuse intervention (detoxification) which the patient acknowledged. Dr. Slotwiner cannot be held liable where, as here, "he . . . has considered his patient's best interest after careful evaluation" (*Bernard v Block*, 176 AD2d 843, 846 [2d Dept 1991]; *see also Nestorowich v Ricotta*, 97 NY2d 393, 398 [2002] ["a doctor is not liable in negligence merely because a treatment, which the doctor as a matter of professional judgment elected to pursue, proves ineffective"]).

A common theme running throughout the record is that the patient was concerned solely with having the cataract extractions performed. To that end, the patient visited Dr. Ellant for a total of five times: the initial office visit before his first extraction; his first extraction at NYEEI; two post-operative office visits to follow up on his first extraction; and his second extraction at NYEEI. Further, the patient requested (and received) from Dr. Ellant a specific (and a more expensive) type of the intraocular lens for which he had his personal lawyer arrange payment of Dr. Ellant's bill. In contrast to the time and effort he devoted to the cataract extractions, the patient visited Dr. Slotwiner only once and only because of Dr. Paul's referral for a cardiac clearance. The patient, in effect, used Dr. Slotwiner and Dr. Paul as the means to obtain the required medical clearance for his upcoming cataract extractions, with the intention of never again returning to see either of them.

In sum, plaintiff's cardiology expert has failed to raise a triable issue of fact in opposition to Dr. Slotwiner's prima facie showing on the departure and causation elements of the medical malpractice claim. The contention of plaintiff's cardiology expert (in ¶ 33 [iv] of his or her affidavit) that the patient required "ACE/ARB [anti-hypertensive] therapy for the newly diagnosed cardiomyopathy" cannot be considered because it is a new theory of liability which was raised for the first time in opposition to Dr. Slotwiner's motion and was not pleaded in the complaint or the bills of particulars (*see Bacalan v St. Vincent's Catholic Med. Ctrs. of NY*, 179 AD3d 989, 992 [2d Dept 2020]). Accordingly, the branch of Dr. Slotwiner's motion for an order granting him summary judgment dismissing the medical malpractice claim as against him is granted (*see e.g. Bowens v Koota*, 295 AD2d 384 [2d Dept 2002]).

*NYEEI*

Plaintiff's medical malpractice claim as against NYEEI and its anesthesiologists fails for the same reason it fails as against Dr. Paul; namely, the lack of proximate cause between the patient's stroke and the anesthesiologists' alleged failure to ensure that the patient had been taking aspirin. Inasmuch as plaintiff's expert cardiologist faults Dr. Slotwiner for prescribing aspirin in the first place, the patient's alleged failure to take aspirin is insufficient to raise a triable issue of fact on the subject of proximate cause. Accordingly, the branch of NYEEI's motion for summary judgment dismissing the medical malpractice claim as against it is granted.

Although not necessary to its holding, the Court addresses NYEEI's remaining contention (in ¶¶ 37-45 of its counsel's opening affirmation) that it cannot be vicariously liable for the alleged acts and omissions of the anesthesiologists because they were employed by East Manhattan Anesthesia Partners, P.L.L.C., rather than by NYEEI. Contrary to NYEEI's position, the anesthesiologists could have been potentially liable under the doctrine of apparent or ostensible agency (*see Keesler v Small*, 140 AD3d 1021, 1022-1023 [2d Dept 2016]; *Dragotta v Southampton Hosp.*, 39 AD3d 697, 699 [2d Dept 2007]). The Third Judicial Department's decision in *King v Mitchell* (31 AD3d 958 [2006]), which preceded the Second Judicial Department's decisions in *Kessler* and *Dragotta*, is not binding on this Court. In any event, *King* is distinguishable because the plaintiff in that case, unlike the patient here, was an employee of the hospital with which the anesthesiology group was affiliated and was aware that some physicians who treated patients at the hospital were not its employees but, rather, independent physicians with privileges to practice at the hospital (*see King*, 31 AD3d at 960).

***Conclusion***

Based on the foregoing and after oral argument, it is

ORDERED that the motions of defendants New York Eye and Ear Infirmary, Alexander Slotwiner, M.D., Jonathan Ellant, M.D., and Joseph Hubert Paul, M.D., in sequence numbers 3, 5, 6, and 7, respectively, for an order, pursuant to CPLR 3212, granting summary judgment dismissing all claims insofar as asserted against each such

defendant are *granted*, and the complaint is dismissed in its entirety as against each such defendant; and it is further

ORDERED that as the motion for summary judgment by New York Eye and Ear Infirmary has been granted, the claims as to the "John Doe" and "Jane Doe" defendants, are dismissed, and it is further

ORDERED that NYEEI's counsel is directed to electronically serve a copy of this decision and order with notice of entry on the other parties' respective counsel and to electronically file an affidavit of service thereof with the Kings County Clerk.

This constitutes the decision, order and judgment of the Court.

E N T E R,

J. S. C.