

**Rossler v Voight**

2020 NY Slip Op 31950(U)

June 15, 2020

Supreme Court, New York County

Docket Number: 162412/15

Judge: Joan A. Madden

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SUPREME COURT OF THE STATE OF NEW YORK  
COUNTY OF NEW YORK, IAS PART 11

----- X Index No.: 162412/15

CAROLE ROSSLER, as the Administrator of the Estate  
of FRED ROSSLER, deceased and CAROLE  
ROSSLER,

Plaintiff,

-against-

LOUIS P. VOIGHT and THE MEMORIAL SLOAN-  
KETTERING CANCER CENTER,

Defendants,

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JOAN A. MADDEN, J.:

Defendants Louis P. Voigt, M.D. (“Dr. Voigt”) s/h/a as Louis P. Voight, and The Memorial Sloan-Kettering Cancer Center (“Memorial”) move for summary judgment dismissing the complaint against them. Plaintiff opposes the motion.

**BACKGROUND<sup>1</sup>**

This action arises out of allegations as to care and treatment of then 77- year-old, Fred Rossler (“Mr. Rossler” or “decedent”), at Memorial from his admission on January 5, 2015 to his death on January 18, 2015. Mr. Rossler was treated for kidney cancer in 1998. He had a kidney transplant in 2013, and was required to take anti- rejection drugs including Mycophenolate and Tacrolimus. In December 2014, Mr. Rossler had a liver biopsy at Boca Raton Regional Hospital in Florida (hereinafter “Boca Raton Hospital”), and was subsequently diagnosed with a metastatic germ cell tumor. Mr. Rossler, who lived in Florida with his wife, plaintiff Carole Rossler (“Mrs. Rossler” or “plaintiff”), traveled to New York on January 2, 2015 for a January 8, 2015 appointment at Memorial.

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<sup>1</sup> Unless otherwise noted, the facts in this section are based on the undisputed factual recitations in the expert affirmations submitted by the parties and the relevant medical records.

On January 5, 2015, Mr. Rossler was admitted to Memorial's Urgent Care Center ("UCC") and subsequently transferred to the Intensive Care Unit ("ICU") due to dehydration, decreased appetite, vomiting, pitting edema in his bilateral lower extremities and possible aspiration pneumonia, with underlying metastatic cancer. During his admission at Memorial, Mr. Rossler was treated by Dr. Voigt, a Critical Care attending. While in the ICU, Mr. Rossler received daily hydrocortisone as part of his immunosuppressive regimen for worsening renal function and his prior kidney transplant.

On January 6, 2015, the ICU attending, Dr. Kaye Hale discussed with plaintiff and her children Mr. Rossler's overall poor prognosis. Later that night, Mr. Rossler was intubated due to respiratory distress. On January 7, 2015, following consultations with renal services, decedent was treated with intravenous Tacrolimus and empiric high dose steroids, to reduce the risk of rejecting his transplanted kidney. On January 8, 2015, Dr. Hale and two other members of the ICU staff called a meeting and informed the family that Mr. Rossler had pneumonia and urged the family to sign a do not resuscitate order. Dr. Anna Varghese, a Memorial oncologist, recommended comfort care. The family refused to sign the do not resuscitate order or to accept supportive measures and informed Memorial that it should do everything possible to help Mr. Rossler recover. On January 12, 2015, Mr. Rossler recovered from pneumonia and was extubated.

On January 13, 2015, Dr. Hale noted that Mr. Rossler's active issues included delirium, acute respiratory insufficiency, debilitated state, severe malnutrition, moderate-to-severe aortic stenosis, chronic atrial fibrillation, abnormal liver function tests (likely from adenocarcinoma of the liver), and acute kidney injury in the setting of renal allograft. Mr. Rossler failed a swallowing test, necessitating continued tube feedings. The plan was to obtain a PET/CT scan the next day to assess the extent of his newly diagnosed liver cancer. Dr. Voigt noted that Mr. Rossler's condition was critical and his prognosis remained guarded.

By the morning of January 14, 2015, Mr. Rossler was suffering from acute respiratory failure, septic shock, delirium, hepatic failure and renal failure, and was reintubated. On January 15, 2015, a meeting was held at Memorial with Mr. Rossler's family, which was attended by Dr. Voigt, and other health care providers. Dr. Voigt provided the family with a review of Mr. Rossler's diagnoses, including progressive renal failure, respiratory failure and liver failure, and discussed his hospital course, condition, and plan of care. In response, the family requested that Mr. Rossler be transferred by air ambulance to Boca Rotan Hospital where Mr. Rossler's nephrologist advised he would treat Mr. Rossler upon his return to Florida.

In order to transport Mr. Rossler in his medical condition, Dr. Voigt consulted with the Interventional Radiology (IR) service regarding the possible placement of a tunneled hemodialysis catheter ("dialysis catheter" or "catheter") so that Mr. Rossler could be transported to Florida. The IR service declined due to Mr. Rossler's condition but subsequently agreed that placement of a vascular dialysis catheter could be done for the narrow purpose of giving Mr. Rossler the best conditions for travel to Florida.

The record contains a consent form signed by plaintiff on behalf of Mr. Rossler on January 15, 2015, giving Dr. Voigt and two other physicians permission to insert a dialysis catheter which states that the physician "has explained to me why I need the proposed treatment, the risks involved, potential problems, the chances for success and the problems I might experience as I recover... alternatives to treatment and the risks and consequences of no treatment." The form further states that "I understand my doctor will be assisted by others and I consent to their participation in my care." Dr. Voigt testified that before the procedure to insert the catheter, he spoke to plaintiff about where the catheter was going to be placed, that it would probably be in the neck or subclavian vein, why it was being done, the alternatives of not doing it, and possible complications including: "during the insertion, there was 1 to 3 percent risk" of injuring the lungs and leading to a pneumothorax, with air leaking into the lung space, and that if

that were to happen, a chest tube would be needed to drain it. Bleeding complications, infection and malposition were also discussed. (Dr. Voigt EBT at 108-109). Plaintiff testified that Dr. Voigt told her that putting the dialysis catheter in “was not a big deal, just like a PICC line. [but that] he chooses not to do it...he had not done it in years... [and that] he wanted interventional radiology to put it in.” (Plaintiff’s EBT at 129-130).

Dr. Voigt and his fellow, Dr. Rakesh Vedde each made two unsuccessful attempts to insert a right internal jugular catheter under ultrasound guidance. Dr. Voigt then decided to attempt to insert the catheter at decedent’s right subclavian vein, and Dr. Voigt testified that he proceeded to perform a sonogram of the right subclavian vein which “showed that the vein was patent, and we said we will give that a shot and try there.” (Voigt EBT at 76, 84). Cannulation of the right subclavian vein was then attempted without ultrasound guidance. Dr. Vedde attempted to place the catheter into the subclavian vein and failed and Dr. Voigt also attempted and failed. A subsequent attempt by Dr. Voigt resulted in the placement of the catheter in the subclavian artery instead of the subclavian vein. During the attempted cannulation of the right subclavian vein, Mr. Rossler “starting waking up” and was “grimacing with pain,” and Dr. Voigt asked the nurse to provide additional pain medication. (Voigt EBT at 77).

Following the erroneous placement of the catheter in the subclavian artery, Dr. Voigt asked for consults with IR and the Vascular Surgical Team from New York Presbyterian/Weil Cornell (“NYP”), and plaintiff was assured that the error would be corrected. A chest radiograph was conducted and revealed that Mr. Rossler had a pneumothorax as a result of the faulty insertion of the catheter which injured and collapsed Mr. Rossler’s lung with “air leaking into the long space” and thoracic surgery was performed to insert a right chest tube to re-expand his lung. On January 17, 2015, Memorial’s medical team and NYP’s Vascular Surgical Team jointly decided that Mr. Rossler was not a surgical candidate for placement of a vascular stent. On

January 18, 2015, Mr. Rossler sustained a wide complex tachycardia. His death certificate lists cardiac arrest and liver metastasis as the cause of death.

In this action, plaintiff asserts claims for medical malpractice, negligent hiring and supervision, lack of informed consent and wrongful death. Plaintiff has abandoned her negligent hiring and supervision claims. With respect to the medical malpractice claim, she alleges that Dr. Voigt, negligently and improperly inserted a right dialysis catheter into Mr. Rossler's subclavian artery instead of the subclavian vein, deviated from accepted standards of vascular and surgical care by performing a central venous catheterization ("CVC") procedure without ultrasound guidance, and failed to take proper and adequate steps to avoid lung collapse and the presence of air and fluid in Mr. Rossler's chest, resulting in the need for a chest tube to drain air and blood and causing a drop in blood pressure; and that Dr. Voigt lacked the skills and experience needed to place the catheter. It is also alleged that defendants deviated from the standard of care in failing to give Mr. Rossler anti-rejection medications, including Mycophenolate and by belatedly administering Tacrolimus. With respect to causation, it is alleged that the negligence in performing the catheter placement prevented Mr. Rossler from receiving life sustaining dialysis treatment and hastened his death, as did the failure to administer the anti-rejection medication. Plaintiff further alleges that the improperly inserted catheter substantially and unnecessarily increased Mr. Rossler's pain and suffering. Plaintiff also alleges that defendants failed to obtain informed consent as plaintiff was not informed that Dr. Voigt would be performing the CVC procedure or of the alternative of having the procedure performed by an individual with expertise in inserting the dialysis catheter, and that these failures proximately caused decedent's injuries and hastened his death.

Defendants now move for summary judgment, arguing that none of the care they provided or failed to provide was a proximate cause of decedent's injuries or death since decedent had multiple co-morbidities and was in multi system organ failure. Defendants also

maintain that the various unsuccessful attempts and the ultimate misplacement of the dialysis catheter were not the result of any medical negligence, but rather of the known risks of the procedure that occurred due to the critically ill and deteriorating condition of decedent. With respect to the claim for lack of informed consent, defendants argue that based on the consent form signed by plaintiff prior to the CVC procedure which expressly consents to Dr. Voigt's performance of the procedure, this claim is unavailing.<sup>2</sup>

In support of their motion, defendants submit the affirmation of Marc J. Shapiro, M.D., a physician licensed to practice medicine in the State of New York, who is Board Certified in Surgery with a Special Certification in Surgical Critical Care. Dr. Shapiro states that his opinions, which are stated with a reasonable degree of medical certainty, are based on his review of the allegations in the Bills of Particulars, Memorial's records concerning Mr. Rossler, the deposition transcripts, and his years of experience in Critical Care.

With regard to the plaintiff's allegations that during the CVC procedure Dr. Voigt negligently placed a right dialysis catheter into decedent's right subclavian artery, rather than the vein, Dr. Shapiro opines that Dr. Voigt "properly attempted to insert a dialysis catheter into Mr. Rossler's right internal jugular vein under ultrasound guidance [and that]... these attempts were unsuccessful due to the poor condition of Mr. Rossler's veins caused by his overall critical and deteriorating condition due to his multi-system organ failure and septic shock." After this attempt was unsuccessful, "[i]n his sound clinical judgment and in accordance with the standards of care, Dr. Voigt decided to then attempt placement of the dialysis catheter into Mr. Rossler's right subclavian vein." Dr. Shapiro opines that "the various unsuccessful attempts and ultimate

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<sup>2</sup> While the Bill of Particulars includes additional departures, as these departures are not addressed by plaintiffs' expert, they are deemed abandoned and will not be considered by the court.

misplacement was not the result of any medical negligence or poor technique, but rather was a known risk of the procedure that occurred in this instance due to Mr. Rossler's critically ill and deteriorating condition."

As to allegations that in connection with this attempt, Dr. Voigt departed from the standard of care by not using ultrasound guidance, Dr. Shapiro opines that "[d]ue to the location of the right subclavian vein, the standard of care did not require use of ultrasound guidance to place a dialysis catheter into the subclavian vein because the ultrasound high-frequency sound waves cannot penetrate through bone."

As for allegations that Mr. Rossler suffered from a pneumothorax as a result of defendants' negligence, Dr. Shapiro opines that "a pneumothorax is a known risk of the procedure that can occur in the absence of negligence ... [and that] the pneumothorax developed absent any negligence by Dr. Voigt or Memorial, as there is absolutely no evidence that the procedure was performed in a careless manner."

With regard to allegations that Dr. Voigt lacked the training and experience to insert the catheter, Dr. Shapiro opines that as "the evidence demonstrates that Dr. Voigt has placed approximately 60 to 100 dialysis catheters in the ICU and has been practicing for approximately 19 years ... Dr. Voigt possessed the requisite skill and experience to both place dialysis catheters into right internal jugular and right subclavian veins, as well as to supervise Fellows during the placement of same."

Dr. Shapiro also opines that Mr. Rossler's death was attributable to, or hastened by, misplacement of the dialysis catheter and the pneumothorax that resolved with appropriate treatment. In this connection, he opines that Mr. Rossler's "death was caused by his multi-system organ failure and septic shock related to his underlying diseased state which led to

cardiac arrest, all of which had been present on his admission to Memorial... ten days prior to the catheter placement, [noting that] the death certificate for Mr. Rossler lists the cause of death as cardiac arrest and liver metastasis.”

With regard to allegations that that defendants departed from the standard of care in failing to administrator Mr. Rossler’s anti-rejection medications, Tacrolimus and Mycophenolate, in light of his prior kidney transplant, Dr. Shapiro states that “[u]pon [Mr. Rossler’s] arrival to the ICU on January 5, 2015, Mr. Rossler was evaluated by the Renal Service who placed Mr. Rossler on daily hydrocortisone (steroid) in light of his immunosuppressive regimen, his worsening renal function of his prior kidney transplant [and that] [i]n addition to Tacrolimus and Mycophenolate, steroids are often used as anti-rejection medications for patients with kidney transplants.” He opines that “[i]t was within the sound clinical judgment and in accordance with the standard of care to administer a steroid to Mr. Rossler to prevent rejection of his allograft kidney transplant. Moreover, on January 7, 2015, Tacrolimus was resumed.” Dr. Shapiro also opines that “[t]he evidence shows that between the time that Mr. Rossler arrived at Memorial’s UCC and throughout his admission, the Defendants were aware of his renal condition, he was properly and timely consulted by the Renal Service, and the appropriate medications were administered.” With respect to causation, he opines that “there is no evidence in the record to suggest that between Mr. Rossler's arrival to the UCC on January 5, 2015 and the time when Tacrolimus was resumed, that Mr. Rossler's renal function was otherwise compromised in any way.”

As for the claim of lack of informed consent Dr. Shapiro opines that “[t]he evidence demonstrates that plaintiff was properly informed about the risks of the procedure, which

included misplacement of the catheter, as well as the risk of pneumothorax [and] [p]laintiff was also aware that the only alternative was no treatment.”

In opposition to the motion, plaintiff submits the affidavit of James B. Alexander M.D., who is licensed to practice medicine in New Jersey. He is board certified by the American Board of Surgery in General Surgery and Vascular Surgery and holds certifications from the American Registry of Diagnostic Medical Sonographers as a Registered Vascular Technologist and as a Registered Physician in Vascular Interpretation. He states that his opinions are based on his review of the relevant medical records, the pleadings, Bills of Particulars and deposition transcripts as well as the affirmation of defendants’ expert, Dr. Shapiro, and the summary judgment submissions of defendants.

Based on his review of the above materials and his education and training, Dr. Alexander opines that “there is no question that [Dr] Voigt committed a clear medical error in ‘mistakenly’ and ‘accidentally’ placing a large dialysis catheter into [decedent’s] subclavian artery instead of into his subclavian vein, thereby significantly reducing [Mr. Rossler’s] chances of survival.” He further opines that as “[a] result of this medical error and of [Dr.] Voigt’s failure to exercise adequate skill and experience in performing the CVC procedure correctly, dialysis treatment was not administered to decedent then or at any time thereafter.”

With regard to Dr. Voigt’s attempt to cannulate the vein without ultrasound guidance, Dr. Alexander opines that such an attempt “significantly and detrimentally raises the risk of complications, including arterial puncture for which reason reliance on ultrasound guidance for CVC procedures is not only recommended but, today, is also essential. Accordingly, failure to place such a catheter under ultrasound guidance - either today or in 2015 - amounts to a clear deviation from accepted standards of vascular and surgical care [and that]... [t]he use of

ultrasound in real-time ... not only decreases cannulation time but also significantly decreases the likelihood of many of the feared complications [and that] [Dr] Voigt used a landmark-guided or 'blind' approach which is known to dramatically increase the rate of serious and life-threatening complications, including arterial cannulation, pneumothorax and hematoma formation. Such complications could easily have been avoided had ultrasound been used. "

As for Dr. Shapiro's opinion that ultrasound is not the standard of care because the sound waves cannot penetrate bone, Dr. Alexander disagrees, and opines that "while at first glance, the subclavian vein seems difficult to visualize on ultrasound because it travels beneath the highly reflective clavicle bone, there is no question that failure to perform cannulation under ultrasound, even under the clavicle bone, materially increases the risk of serious and life-threatening complications.<sup>3</sup>"

Dr. Alexander next opines that Dr. Voigt lacked the medical experience and skill to perform the CVC procedure as evidenced by, *inter alia*, plaintiff's deposition testimony that Dr. Voigt admitted that he had not performed the CVC procedure in years; Dr. Voigt's failure to cannulate the correct vessel which is not a risk of the procedure; and that Dr. Voigt's inexperience is manifested by his deposition testimony which demonstrates his confusion "about the accepted standards of vascular and surgical care, particularly, the basic tenants of catheter insertion" (citing Dr. Voigt's EBT at 69-72; 80). Dr. Alexander also opines that "[f]aced with a clear inability to perform the procedure, instead of aborting altogether, Defendants should have

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<sup>3</sup> Dr. Alexander also opines that the Dr. Voigt's failure to attempt the CVC procedure through another access point, the femoral vein was also a departure. However, since as defendants argue, this departure is not included in the Bill of Particulars, it cannot be raised for the first time in plaintiff's expert affidavit. See Ruchames v. New York Presbyterian Hosp., 176 AD3d 602, 603 (1<sup>st</sup> Dept 2019). In any event, plaintiff's expert's opinion in this regard is conclusory and speculative. Id

called in someone skilled and experienced to perform the procedure [and that][such] [f]ailure to call for help was... a flagrant departure.” Dr. Alexander also opines that given Mr. Rossler’s weakened state that the procedure “should have been performed by a vascular surgeon or specialist [who] would have had the greatest level of skill to perform [the] procedure.”

With respect to the allegations that anti-rejection medications were inadequately provided, Dr. Alexander opines that “Memorial failed to properly administer anti-rejection medications to decedent as required... [and that] Tacrolimus was resumed too late and Mycophenolate was never resumed at all. Instead, Memorial chose to administer steroids despite the fact that decedent had been taking Tacrolimus and Mycophenolate since his transplant, without complications.” He further opines that “Mycophenolate works in tandem with Tacrolimus and the omission of one can seriously affect the patient’s ability to thwart kidney rejection. Indeed, missing a single dose or suddenly stopping administration of Mycophenolate may significantly worsen a patient’s condition and make an otherwise healthy person seriously ill.” In this connection, Dr. Alexander disagrees with Dr. Shapiro’s opinion that the delay in administering Tacrolimus did not compromise Mr. Rossler’s renal function, and notes that Dr. Shapiro did not specifically deny that Mycophenolate was needed, and opines that the failure to provide anti-rejection medications from the time of Mr. Rossler’s admission “was casually related to the worsening of decedent’s condition, needless pain and suffering, inability to receive life sustaining dialytic treatment and his untimely and accelerated death.”

As for the lack of informed consent claim, Dr. Alexander opines that Dr. Voigt “did not obtain informed consent for the CVC procedure [and that] ... while Dr. Shapiro mentions risks of the procedure, he cannot expect that reasonable patients would have consented to risks of the procedure when the physician admitted that he was not experienced in catheter insertion and

chose not to perform the procedure himself.” He also opines that he disagrees with Dr. Shapiro that the “only alternative” to catheter insertion that was performed by Dr. Voigt was “no treatment” and that “plaintiff could have asked for the procedure to be performed by someone with more skill and experience in performing catheter procedures... provided she would have been aware of the risk that an artery could be mistakenly cannulated instead of a vein (she was not) and provided [Dr. Voigt] would have told her that he would perform the procedure himself (he did not).” In this connection, Dr. Alexander cites plaintiff’s testimony that she was under the impression that procedure would be performed by someone in IR particular as Dr. Voigt told her that he did not do the procedure and wanted someone in IR to perform it. (See Plaintiff’s EBT at 130).

In reply, defendants argue that plaintiff’s expert affidavit is conclusory and contrary to the record; that the record shows that Dr. Voigt possessed the skill and experience to insert the catheter; that the wrongful death is subject to dismissal as Mr. Rossler’s death cannot be attributed to the alleged negligence; and that as plaintiff signed a form consenting to Dr. Voigt’s performance of the procedure, plaintiff’s testimony that she believed that a Dr. Voigt was not going to insert the catheter is insufficient to raise an issue of fact as to the lack of informed consent claim.<sup>4</sup>

## DISCUSSION

### Medical Malpractice and Wrongful Death Claims

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<sup>4</sup> Defendants also argue that plaintiff’s opposition should not be considered as it was served and filed after the deadline provided in the parties’ stipulation, which was so-ordered by the court. This argument is unavailing as defendants have not shown any prejudice resulting from the plaintiff’s belated submission of her opposition, particularly as the time to reply was extended by the court. See Morgan v. Candia, 69 AD3d 500, 500 (1<sup>st</sup> Dept 2010) (holding that “court properly accepted plaintiff’s untimely papers in opposition to defendants’ motion [for summary judgment] as defendants did not suffer any prejudice.”)

A defendant moving for summary judgment in a medical malpractice action must make a prima facie showing of entitlement to judgment as a matter of law by showing “that in treating the plaintiff there was no departure from good and accepted medical practice or that any departure was not the proximate cause of the injuries alleged.” Roques v. Nobel, 73 AD3d 204, 206 (1<sup>st</sup> Dept 2010). To satisfy this burden, a defendant must present expert opinion testimony that is supported by the facts in the record and addresses the essential allegations in the Bill of Particulars. Id. “When medical malpractice forms the basis of a wrongful death action, in establishing that he/she did not proximately cause the injuries alleged to have caused plaintiff’s death, a defendant establishes prima facie entitlement to summary judgment as to the wrongful death action as well.” Id. (internal citations omitted).

The expert opinion relied on by a defendant must be based on the facts in the record or those personally known to the expert. Defense expert opinion should specify “in what way” a patient’s treatment was proper and “elucidate the standard of care.” Ocasio-Gary v. Lawrence Hosp., 69 AD3d 403, 404 (1<sup>st</sup> Dept 2010). A defendant’s expert opinion must also “explain what defendant did and why.” Id. quoting Wasserman v. Carella, 307 AD2d 225, 226 [1<sup>st</sup> Dept 2003]).

Here, defendants have met their burden with respect to the allegations of malpractice related to the insertion of the dialysis catheter based on their expert’s opinion, which is adequately supported by the record, that (i) Dr. Voigt, who possessed the requisite skill and experience to insert the catheter, acted in accordance with the applicable standard of care when he attempted to insert the catheter in the right internal jugular vein under ultrasound guidance, and then in decedent’s right subclavian vein, without ultrasound guidance based on the location of the vein under the clavicle bone, (ii) Dr. Voigt’s erroneous placement of the catheter in the subclavian artery and the resulting pneumothorax are known risks of the procedure, (iii) the

unsuccessful attempts at insertion of the catheter were due to Mr. Rossler's critically ill and deteriorating condition, his septic shock and his underlying co-morbidities, and not any negligence by defendants; (iv) Mr. Rossler's death was in no way attributable to, or hastened by, the misplacement of the catheter or by the pneumothorax.

As for the alleged departure in failing to administer Mr. Rossler's anti-rejection medications, that is Tracrolimus and Mycophenolate, defendants have made a prima facie showing that there was no departure in this regard based on their expert's opinion that at the time Mr. Rossler was admitted to the ICU it was within the standard of care to place Mr. Rossler on a steroid to prevent the rejection of a kidney, and when Tracrolimus was resumed two days later there was no damage to his renal function.

As defendants have met their burden, to survive summary judgment, plaintiff must "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, 324-325 (1986). Specifically, in a medical malpractice action, this requires that a plaintiff opposing a defendant's summary judgment motion to "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... 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 defendant['s]... summary judgment motion." Id.

In addition, a plaintiff's expert's opinion "must demonstrate the requisite nexus between the malpractice allegedly committed and the harm suffered." Dallas-Stephenson v. Waisman, 39 AD3d 303, 307 (1<sup>st</sup> Dept 2007) (internal citations and quotations omitted). If "the expert's

ultimate assertions are speculative or unsupported by any evidentiary foundation... the opinion should be given no probative force and is insufficient to withstand summary judgment.” Diaz v. Downtown Hospital, 99 NY2d 542, 544 (2002). On the other hand, summary judgment is not proper where “conflicting opinions of the parties’ experts raise triable issues of fact.” Boston v. Weissbart, 62 AD3d 517, 518 (1<sup>st</sup> Dept 2009).

Here, plaintiff has controverted defendants’ showing with regard to her allegations related to the CVC procedure based on her expert’s opinion that (i) the failure to use ultrasound guidance to access the subclavian vein was a departure resulting in the erroneously canalization of the subclavian artery, (ii) the misplacement of the catheter in the subclavian artery was the result of negligence, and (iii) the catheter’s misplacement was a substantial factor in causing various complications including pneumothorax and hematoma formation and Mr. Rossler’s pain and suffering. As for defendants’ argument the erroneous insertion of the catheter and resultant complications were risks of the procedure, as plaintiff raises issues of fact as to whether the procedure was performed negligently, summary judgment is not warranted on this ground. See Bengston v. Wang, 41 AD3d 625, 626 (2d Dept 2007)(while defendant met his burden by showing that the injury suffered by plaintiff was “a known risk of the procedure that occurs in the absence of malpractice... plaintiff raise a triable issue of fact by submitting the affirmation of an expert who opined that... defendant was negligent [in performing the procedure]”).

On the other hand, plaintiff’s expert’s opinion fails to raise issues of fact as to whether Dr. Voigt lacked the medical experience and skill to perform the CVC procedure, particularly as the record shows that he was a critical care physician who had been practicing medicine for nearly twenty years. See generally Toth v. Community Hospital at Glen Cove, 22 NY2d 255, 262 (1968) (noting that “in measuring a doctor’s performance in malpractice cases, the doctor is

required to possess “that reasonable degree of learning and skill ... ordinarily possessed by physicians and surgeons in the locality where he practices”). That said, however, plaintiff raises factual question as to whether it was a departure from the standard of care for Dr. Voigt not to seek assistance from a specialist after he was unable to place the dialysis catheter, and whether this departure was a proximate cause of plaintiff’s injuries. See Hawkins v. Brooklyn-Caledonian Hosp., 239 AD2d 549 (2d Dept 1997), lv dismissed 91 NY2d 887 (1998)(denying motion to set aside the verdict in favor of patient in action alleging failure of physician to obtain assistance before asserting subclavian catheter which was improperly inserted and broke off inside patient’s body).

As for the allegations related to defendants’ failure to provide plaintiff with adequate anti-rejection medications upon his admission, even assuming *arguendo* that such failure constituted a departure from the standard of care, as plaintiff’s expert fails to substantiate his conclusion that such failure harmed decedent’s renal function or otherwise caused injury to plaintiff, such allegations do not provide a basis for defendants’ liability. See DeFillipio v. New York Downtown Hospital, 10 AD3d 521, 523 (1<sup>st</sup> Dept 2004) (summary judgment properly granted in defendant’s favor when “plaintiff failed to present a non-speculative basis for a finding that any act or omission of the medical defendants was the proximate cause of any injury to him”).

With respect to the wrongful death claim, it must be dismissed as plaintiff has failed to submit sufficient evidence to raise a triable issue of fact as to any causal connection between the alleged departures related to the CVC procedure and the death of plaintiff’s decedent. Specifically, while plaintiff’s expert opines that the departures, including the medical errors made in connection with inserting the dialysis catheter “reduced decedent’s chances for survival”

and “accelerated his untimely death,” he provides no substantiation for this conclusion. See Concepcion ex rel. Conception v. City of New York, 139 AD3d 606 (1<sup>st</sup> Dept 2016)(defendant was entitled to summary judgment where the opinions of plaintiffs’ experts that the defendant caused decedent’s death from compartment syndrome while performing surgery to treat leg injury and internal bleeding were speculative and unsupported by the record); Udoye v. Westchester-Bronx-OB/GYN, P.C., 126 AD3d 653 (1<sup>st</sup> Dept 2015)(affirming trial court’s grant of summary judgment where there was no basis for the opinion of plaintiff’s expert that any departure from the standard of care by defendants obstetricians caused the decedent’s death from viral myocarditis six weeks after she gave birth); compare Roques v. Nobel, 73 AD3d at 207 (denying defendant’s motion for summary judgment when “plaintiff’s expert’s opinion, based upon his review of the decedent’s medical records, as well as pertinent medical literature, clinical studies and his own experience, raised factual issues as to whether defendants’ treatment of the decedent caused or substantially contributed to his death plaintiff.”)

#### Lack of Informed Consent

Plaintiff’s lack of informed consent claim is based on allegations that defendants failed to obtain informed consent to the CVC procedure as plaintiff was not informed that Dr. Voigt would be performing the CVC procedure and/or the alternative of the procedure being performed by an individual with expertise in inserting dialysis catheters.

Lack of informed consent means the failure of the person providing the professional treatment or diagnosis to disclose to the patient such alternatives thereto and the reasonably foreseeable risks and benefits involved as a reasonable medical ... practitioner under similar circumstances would have disclosed, in a manner permitting the patient to make a knowledgeable evaluation” (Public Health Law § 2805-d[1]. To prevail on a claim for lack of informed consent “it must ... be established that a reasonably prudent person in the patient’s

position would not have undergone the treatment ... if [he] had been fully informed and that the lack of informed consent is a proximate cause of the injury or condition for which recovery is sought” (Public Health Law § 2805–d[3] ).

A defendant moving for summary judgment on a lack of informed consent claim must demonstrate that a plaintiff was informed of any foreseeable risks, benefits, or alternatives of the treatment rendered. Koi Hou Chan v. Yeung, 66 AD3d 642, 643 (2d Dept 2009); see also, Smith v. Cattani, 2 AD3d 259, 260 (1<sup>st</sup> Dept 2003)(defendant entitled to summary judgment where “documentary evidence establishes that before each of plaintiff’s seven surgeries, defendant notified him of the reasonably foreseeable risks and benefits of the surgery, as well as alternatives to the proposed treatment”).

Here, defendants have met this burden based on their expert’s opinion that plaintiff was adequately informed of the foreseeable risks and benefits of the procedure and that without the procedure, decedent could not be transported to Florida, which opinion is supported by the consent form signed by plaintiff, and Dr. Voigt’s deposition testimony.

When the evidence is sufficient to meet defendants’ burden, a plaintiff must demonstrate that (1) the defendant doctor failed to fully apprise her of the reasonably foreseeable risks of the procedure, (2) a reasonable person in plaintiff’s position, fully informed, would have opted against the procedure, (3) the lack of informed consent was a proximate cause of a plaintiff’s injuries. Orphan v. Pilnik, 15 NY3d 907, 908 (2010), citing Public Health Law § 2805–d (1)(3); see Eppel v. Fredericks, 203 AD2d 152 (1st Dept.1994). “Expert medical testimony is required to prove the insufficiency of the information disclosed to the plaintiff.” Orphan v. Pilnik, 15 NY3d at 908.

Here, plaintiff's expert's opinion that the consent provided was insufficient as plaintiff testified that she was unaware that Dr. Voigt would be inserting the catheter, and that she was not informed of the alternative of having someone with expertise perform the procedure, is insufficient to raise an issue of fact since plaintiff signed a form consenting to Dr. Voigt's performance of the procedure. Moreover, as informed consent does not require disclosure of qualifications of professionals providing treatment, the plaintiff's claim cannot be based on any alleged failure by defendants to inform plaintiff as to Dr. Voigt's qualifications to perform the procedure, or that the procedure could have been performed by a specialist with expertise in inserting catheters. See Johnson v. Jacobowitz, 65 AD3d 610, 614 (2d Dept 2009), lv denied 14 NY3d 710 (2010)(trial court properly precluded plaintiff from introducing evidence that defendant "did not have the proper credentials to perform the [subject] procedure, since informed consent does not require disclosure of the qualifications of personnel providing the professional treatment"); Zimmerman by Zimmerman v. New York City Health and Hospitals Corp., 91 AD2d 290 (1<sup>st</sup> Dept 1983)(holding that it was improper for trial court in jury interrogatories to suggest that it was negligent to fail to explicitly state surgeon's training and experience since these factors cannot be considered in determining if consent is properly given).

Accordingly, defendants' motion for summary judgment dismissing plaintiff's claim for lack of informed consent is granted.

### **CONCLUSION**

In view of the above, it is

ORDERED that defendants' motion for summary judgment is granted to the extent of dismissing plaintiff's claims for negligent supervision and retention, wrongful death, and lack of informed consent and plaintiff's malpractice claim insofar as it is based on allegations that Dr.

Voigt lacked the skill and experience to perform the CVC procedure and that defendants failed to provide decedent with adequate anti-rejection medications and is otherwise denied; and it is further

ORDERED that that the pre-trial conference shall be held remotely on July 23, 2020, at 2:15 pm and the parties shall contact the court at [SFC-PART11@nycourts.gov](mailto:SFC-PART11@nycourts.gov) to set up the conference call with the court; and it is further

ORDERED that pursuant to CPLR 2103(e) a copy of this order may be filed and served.

DATED: June 15, 2020

Joan  
Madden  
J.S.C.

Digitally signed by Joan Madden  
DN: c=US, o=NY County Supreme  
Court, cn=NYS Courts, cn=Joan Madden,  
e=jmadden@nycourts.gov  
Reason: I am the author of this document  
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