Roach v Wedderburn
2021 NY Slip Op 32028(U)
June 21, 2021
Supreme Court, Kings County
Docket Number: 500466/16
Judge: Ellen M. Spodek
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At an IAS Term, Part ~~36~~ 63 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 21st day of June, 2021.

PRESENT:

HON. ELLEN M. SPODEK,

Justice.

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ROBERT ROACH, AS ADMINISTRATOR OF THE ESTATE OF TARA ROACH, DECEASED AND ROBERT ROACH, INDIVIDUALLY,

Plaintiff(s),

- against

Index No. 500466/16

RAYMOND WEDDERBURN, M.D., MARIA CASTELLO RAMIREZ, M.D., JENNY Y. CAI, M.D., JANICE RISO, M.D., JASON CHU, M.D., CAROL HILFER,M.D. TOVA SEBAOUN, M.D., SEEMA KAMISETTI, D.O. AND ST. LUKE'S ROOSEVELT HOSPITAL CENTER,

Defendants.

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The following e-filed papers read herein:	NYSCEF Doc Nos.[1]
Notice of Motion, Affidavit +Affirmation and Annexed Exhibits	142-154
Opposing Affirmations and Annexed Exhibits	155-183
Reply Affirmation	184-185

Upon the foregoing papers in this medical malpractice action, defendants Raymond Wedderburn, M.D., Maria Castello-Ramirez, M.D., Jenny Y. Cai, M.D., Janice Riso, M.D., Jason Chu, M.D., Carol Hilfer, M.D., Tova Sebaoun, M.D., Seema Kamisetti, D.O. and Mount Sinai-St. Lukes's (MSSL) s/h/a "St. Luke's Roosevelt Hospital Center" move (in motion sequence [mot. seq.] four) for an order, pursuant to CPLR 3212, granting them summary judgment dismissing the complaint of plaintiff, Robert Roach, as administrator

[1] New York State Courts Electronic Filing Document Numbers

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of the estate of Tara Roach, deceased and Robert Roach (Mr. Roach), individually on the grounds that no material factual issues exist herein.

Factual Background and Procedural History

This case concerns the care and treatment of plaintiff's decedent, Tara Roach (Mrs. Roach or decedent), and arises from Mrs. Roach's treatment at MSSL from March 3, 2015, when she presented to the Emergency Department (ED) with a three-day history of abdominal pain, nausea, vomiting and obstipation (i.e. severe constipation), until March 19, 2015, when she died. Her prior medical history was significant for five prior abdominal surgeries including four cesarean sections. Other than anemia, she had no medical issues.

Before March 3, 2015, Tara Roach was a 44 year-old wife and mother of 4 children, 2 of whom were minors, who was employed at MSSL in building services. She had been married to Mr. Roach for just under 20 years. Upon admission as a patient at MSSL on March 3, 2015, Mrs. Roach was diagnosed with a small bowel obstruction caused by adhesions and needed emergent surgery. She did not recover well from her first surgery and needed two additional surgeries. During subsequent surgeries organs and a portion of her bowel were removed. Postoperatively she developed pneumonia, acute respiratory distress syndrome, septic shock and a stroke, which led to her death on March 19, 2015.

Plaintiff claims that defendants were negligent in their care and treatment of Mrs. Roach during her admission in that they failed to timely diagnose and treat a small bowel obstruction; failed to appreciate the presence of gastric contents on a CT scan; failed to adequately empty stomach contents resulting in an aspiration; failed to prevent an aspiration; negligently delayed the performance of surgery; negligently closed Mrs.

Roach's fascia (i.e. thin casing of connective tissue) despite her airway pressures and difficulties ventilating; caused and failed to timely diagnose and treat abdominal compartment syndrome; negligently prescribed and administered Nimbex; failed to timely diagnose and treat cerebral edema, stroke and multi-organ system failure; and ultimately caused Mrs. Roach's death.

Plaintiff commenced this action on January 13, 2016 with the filing of a summons and complaint. The complaint sets forth causes of action for medical malpractice, lack of informed consent, negligent credentialing, wrongful death and loss of services on behalf of Mr. Roach, individually. Issue was joined by the filing of answers on behalf of all defendants on April 14, 2016 and July 19, 2016. The bills of particulars allege that the medical malpractice occurred on March 3, 2015 through March 19, 2015 while Mrs. Roach was a patient at MSSL. Plaintiffs allege that defendants' malpractice caused Mrs. Roach to suffer multi-system organ failure, stroke, cerebral edema, multiple blood clots, bowel necrosis, abdominal compartment syndrome (ACS), aspiration, high intra-abdominal cavity pressures, elevated blood pressure, sepsis, septic shock, small bowel obstruction, ascites (i.e. fluid in the abdomen), dilated loops of bowel, hypotension (i.e. abnormally low blood pressure), tachycardia (i.e. abnormally rapid heart rate), respiratory distress, nausea, vomiting, abdominal pain, pain and suffering, anxiety, mental anguish, fear of impending death and ultimately her death on March 19, 2015.

The note of issue was filed on December 20, 2019, and an extension of defendants' time to move for summary judgment was granted to April 18, 2020. On March 20, 2020 an indefinite suspension of in-person court operations began due to the Covid-19 crisis.

After March 27, 2020 the court advised via e-mail that an extension of time to file the motion would be granted and extended the date to move for summary judgment to July 20, 2020.

Defendants deny all allegations of negligence and contend that the care which they provided to Mrs. Roach was consistent with good and accepted standards of medical care. They submit that Mrs. Roach presented to the hospital with a complex medical condition and, despite receiving good care, she deteriorated and died from her severe illness. Defendants maintain that they tried to save her life but were unsuccessful.

Supporting Arguments

Standard of Care

Defendants, in support of their motion, submit the affidavit of Eric Morley, M.D., an emergency medicine expert, the affirmation of Lawrence Schwartz, M.D., a radiology expert, the affirmation of Marc Kanchuger, M.D., an anesthesiology expert and the affirmation of Philip Barie, M.D., a surgery expert. Their affirmations specifically examine the care provided by each named defendant, as staff at MSSL and collectively; and they each find that all treatment was provided in accordance with the standard of care. Each of these experts opine to a reasonable degree of medical certainty that the attending defendants appreciated Mrs. Roach's prior medical history, symptoms and vital signs; monitored her condition during her admission and provided medical care consistent with the standard of care. Dr. Barie surmises that Mrs. Roach had a complex abdominal trauma, evidence of preexisting aspirate (i.e. breathing or drawing in harmful bodies such as food into the airway); and that the combination of these two conditions, plus surgery

overwhelmed her body leading to sepsis (i.e. life-threatening complication[s] of infection), septic shock and the need for vasopressors[2] due to cardiovascular collapse. These vasopressors caused bowel and organ ischemia (i.e. inadequate blood supply to an organ or body part, especially the heart muscles), and Mrs. Roach deteriorated and developed multi-system organ failure which resulted in her death.

Jason Chu, M.D.

Defendants maintain that Dr. Chu and MSSL staff in the ED treated Mrs. Roach in accordance with the standard of care. Dr. Chu testified that he was the attending ED physician assigned to Mrs. Roach when she presented to MSSL on March 3, 2015. Based upon her presentation, he formed a differential diagnosis that included acute gastroenteritis, abdominal pain from vomiting and possible small bowel obstruction. He ordered routine lab work and abdominal X rays to rule out a small bowel obstruction. When he learned that the X rays showed a possible small bowel obstruction, he ordered a CT scan right away to characterize the obstruction. Although the lab work was not markedly abnormal, he also ordered a surgical consult. Ultimately, it was the surgical attending physician's decision to take Mrs. Roach to the operating room (OR). The decision was based upon the CT scan findings which showed a high-grade small bowel obstruction indicating that Mrs. Roach's

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[2] These are drugs that induce vasoconstriction (i.e. involuntary constriction of blood vessels) thereby raising arterial blood pressure. Defendants submit they are required in patients such as Mrs. Roach who experience cardiovascular collapse with profoundly low blood pressure that does not respond to intravenous fluid. Excessive vasoconstriction in response to hypotension and vasopressors can produce inadequate blood flow to the extremities and other bodily parts/organs. Defendants maintain that this is a known risk of using such medication (*see* NYSCEF Doc No. 154, Dr. Barie's affirmation at ¶ 27, annexed as exhibit D to defendants' moving papers).

intestines were completely blocked. Once Mrs. Roach was admitted to surgery, Dr. Chu was no longer involved in her care.

Defendants specifically rely upon the affidavit of their emergency medicine expert, Dr. Morley (*see* NYSCEF Doc No. 151, Dr. Morley's affirmation, annexed as exhibit A to defendants' moving papers), who explains the role of an ED attending and affirms that Dr. Chu properly evaluated Mrs. Roach, properly admitted her to the hospital under the surgery service for further management, provided appropriate medical care in accordance with the standard of care and acted appropriately in all respects. Dr. Morley further opines that although Mrs. Roach appeared before Dr. Chu with no fever, and normal vital signs, Dr. Chu appropriately appreciated both that her abdomen bowel sounds were absent and her surgical history of four prior pelvic surgeries. Dr. Chu, according to Dr. Morley, appropriately ordered a plain film abdominal study, followed by a CT scan of the abdomen with contrast that was necessary to characterize a small bowel obstruction, which seemed likely. While Mrs. Roach was in the process of undergoing her CT scan, Dr. Chu also timely ordered a surgery consult says Dr. Morley. Surgery responded and began prepping Mrs. Roach for possible surgery. The CT scan result, provided over the phone to Dr. Chu, revealed a closed loop, high grade obstruction, and the need for emergent surgery to relieve the obstruction was confirmed. Dr Morley opines that the sequence of events and time lapse from the time that Dr. Chu called for surgical consult to the time that a surgeon responded, and, more broadly, between Mrs. Roach's admission to the ED and the surgery prep under Dr. Chu's supervision, was appropriate and within the standard of care for a busy metropolitan hospital such as MSSL.

Carol Hilfer, M.D.

Defendants submit that Dr. Hilfer and MSSL staff in the Radiology Department treated Mrs. Roach in accordance with the standard of care. Radiology expert Dr. Schwartz opines (*see* NYSCEF Doc No. 152, Dr. Schwartz's affirmation, annexed as exhibit B to defendants' moving papers) that Mrs. Roach's radiology findings as reported by Dr. Eng, Dr. Bashist and Dr. Hilfer specifically, and the radiology department generally, were proper in all respects. Dr. Schwartz is supportive of the coordination of the transfer of Mrs. Roach from the ED to the imaging locations as both timely and done in accordance with the standard of care and affirms that the intervals of time between testing were consistent with good care. Additionally, findings in each study were communicated to the ED physician, over the phone, before full results were dictated in a report. This shows, according to Dr. Schwartz, both conscientious appreciation of Mrs. Roach's findings, which were significant for a small bowel obstruction, and diligence in ensuring that results were conveyed to the ED staff as quickly as possible. Dr. Schwartz opines that Dr. Hilfer properly reviewed the CT scan images and concluded that the obstruction was a high-grade, small bowel obstruction in the lower abdomen/upper pelvis with small bowel loops twisting around presumed adhesions. Ascites (i.e. fluid in the abdomen) was present, but no obvious bowel ischemia was seen. Dr. Hilfer also noted that air space nodules were seen in the lower lungs consistent with possible aspiration pneumonia. This interpretation, Dr. Schwartz also opines, was accurate and made in accordance with the standard of care

as well as consistent with findings documented by Mrs. Roach's surgeons in conjunction with her March 3, 2015 surgery.

Tova Sebaoun, M.D. and Seema Kamisetti, D.O.

Defendants submit that Dr. Sebaoun, Dr. Kamisetti and MSSL staff in the Anesthesiology Department treated Mrs. Roach in accordance with the standard of care. Dr. Sebaoun was the attending anesthesiologist who provided anesthesia care to Mrs. Roach during her surgery on March 3, 2015. She was assisted by Dr. Kamisetti, a fourth-year resident, and this was the only surgery performed on Mrs. Roach where her anesthesia care was managed by this team. Dr. Sebaoun testified that she placed a nasogastric (i.e. NG) tube in Mrs. Roach preoperatively to empty the stomach contents, and also agreed with the radiology finding that Mrs. Roach had diffuse lung opacities preoperatively which could be consistent with aspiration pneumonia. She elected to do a rapid sequence induction due to the possibility of regurgitation and testified that Mrs. Roach had an episode of desaturation at the end of her surgery, which meant she was not breathing efficiently. After closure of the fascia at the end of the procedure, there was an increase in airway pressures.

Defendants' expert anesthesiologist, Dr. Kanchuger agrees (*see* NYSCEF Doc No. 153, Dr. Kanchuger's affirmation, annexed as exhibit C to defendants' moving papers) with Dr. Sebaoun, who testified that the imaging performed showed that Mrs. Roach likely had a developing pneumonia before her surgery on March 3, 2015. Dr. Kanchuger opines that Dr. Sebaoun and Dr. Kamisetti properly recommended and used General Anesthesia

(GA) for this procedure. It is Dr. Kanchuger's opinion that this was the most appropriate choice because of the likely complex nature of the planned procedure and since imaging had shown that Mrs. Roach's lungs already showed evidence of possible aspiration. Dr. Kanchuger opines that once GA with a cuffed endotracheal tube (ETT) was selected, Mrs. Roach's anesthesia team properly decided to initiate a rapid sequence induction. Dr. Kanchuger notes that it was at the end of the procedure, as anesthesia staff was entering the final stage of anesthesia and attempting to both reverse the neuromuscular block and prepare for extubation, that Mrs. Roach was unable to tolerate breathing on her own. Dr. Sebaoun, according to Dr. Kanchuger, properly assessed the strength of Mrs. Roach's respirations, the regular return of the gag reflex, the level of consciousness and the maintenance of the oxygen saturation rate with effort of breathing. Instead of extubating Mrs. Roach, given that she struggled to maintain oxygenation on room air, Dr. Sebaoun properly maintained Mrs. Roach's intubation and ventilation in Dr. Kanchuger's opinion. Mrs. Roach's oxygen saturation rate in fact improved after the decision to keep her intubated, and her blood pressure remained stable. Furthermore, Dr. Kamchuger concluded that Dr. Sebaoun properly emptied Mrs. Roach's stomach contents before Dr. Wedderburn performed Mrs. Roach's surgery, but it is also Dr. Kanchuger's opinion that even if Mrs. Roach's stomach contents were not completely emptied with the NG tube before the start of surgery that would not be a departure from the standard of care.

Raymond Wedderburn, M.D., Maria Castillo-Ramirez, M.D., Jenny Y. Cai, M.D. and Janice Riso, M.D.

Defendants maintain that Dr. Wedderburn, Dr. Castello-Ramirez, Dr. Cai, Dr. Riso and MSSL staff in the Surgical Intensive Care Unit (SICU) and Surgery Department treated Mrs. Roach in accordance with the standard of care. Dr. Castello-Ramirez, Dr. Cai and Dr. Riso were residents at the time they treated Mrs. Roach; they each provided care to her under the direction and in conjunction with surgical attending physician Dr. Wedderburn. He testified that MSSL is a teaching hospital and that he worked with a team of residents to manage patient care.

Mrs. Roach's first surgery was performed on March 3, 2015 by Dr. Wedderburn, who was assisted by Drs. Castello-Ramirez and Dr. Cai, as residents, to decompress a bowel obstruction. The surgical findings were significant for innumerable adhesions, which cause tissues and organs to stick together. A history of abdominal or pelvic surgery increases the likelihood of developing abdominal adhesions. In Mrs. Roach's case, she had four prior Cesarean section deliveries, and defendants' surgical expert, Dr. Barie opines that these were the cause of Mrs. Roach's adhesions (*see* NYSCEF Doc No. 154, Dr. Barie's affirmation, annexed as exhibit D to defendants' moving papers, *supra* at 4 and n 2). Some of Mrs. Roach's adhesions wrapped around her small bowel and caused it to twist in upon itself resulting in a closed loop obstruction. A closed-loop obstruction causes progressive accumulation of fluid and gas within the isolated loop thereby placing it at risk

for ischemia (i.e. loss of blood flow) that can result in tissue death. It is a serious finding associated with a significant risk of mortality.[3]

Dr. Barie opines that Dr. Wedderburn and his team timely located Mrs. Roach's closed loop obstruction, removed it, and the portion of the bowel that had been obstructed then appeared to regain viability (i.e. blood flow returned). Accordingly, during this first surgery on March 3, 2015, there was no need to resection a portion of dead or dying tissue as dead or dying bowel tissue was not removed. Dr. Barie also opines that Mrs. Roach was taken to surgery in a timely manner as there was no evidence that her obstruction had progressed to permanent bowel ischemia (i.e. permanent loss of blood flow). After relieving the obstruction, Mrs. Roach's surgical team inspected her entire bowel to ensure that peristalsis (i.e. normal contracting) had returned, which Dr. Wedderburn confirmed had occurred. It is Dr. Barie's opinion that the return of peristalsis proved that bowel function had been restored.

Defendants note plaintiff's criticism that Dr. Wedderburn's decision to close Mrs. Roach's abdomen at the conclusion of her surgery on March 3, 2015 constituted a departure from the standard of care. Plaintiff claims that, in light of increased airway pressure and decreased oxygen saturations, Mrs. Roach's fascia should have remained open and closure left for a later time. However, Dr. Wedderburn explained at his deposition that Mrs. Roach

[3] Dr. Wedderburn testified that, during the March 3, 2015 surgery, the team also observed ascites (i.e. fluid in the abdomen). Such finding in the presence of an intestinal obstruction, he explained, raises concern for ischemia, but, fortunately, the type of observed ascites was an indication that Mrs. Roach's bowel remained viable, and that there was no need then to remove any portion of the bowel (*see* NYSCEF Doc No. 150, Dr. Wedderburn tr at 826-829, annexed as an part of an appendix to defendants' moving papers).

was not a candidate for an "open abdomen" and that the increase in airway pressures and decrease in saturation were expected and not a basis to keep her abdomen open. He testified that although it was not entirely clear what caused the increase in airway pressures and desaturation upon concluding the surgery, those findings could have occurred because the surgery had just closed an abdomen with a distended bowel which causes the diaphragm to be pushed up and pressure raised. He explained in his deposition testimony that the findings are relevant to deciding whether or not the patient should be extubated (*id.* at 852-855).

Dr. Barie agrees with Dr. Wedderburn's treatment and his decision to proceed with fascial closure on March 3, 2015. Dr. Barie opines that indications for leaving the abdomen open after surgical management of a bowel obstruction exist when the obstruction is accompanied by bowel perforation with severe contamination of the peritoneal cavity (peritonitis). In these cases, there is a high likelihood of recurrent intra-abdominal sepsis and postoperative abscess formation. Under these types of circumstances, it may be desirable to leave the abdominal wall open and use negative pressure wound therapy in anticipation that there may be a need for repeated abdominal exploration and abdominal irrigation. Mrs. Roach, however, did not have a bowel perforation nor was the abdomen noted to be contaminated at the time of her initial surgery. The likelihood of her needing a further surgery to address her bowel or to wash out the abdomen was low. In addition, leaving the abdomen open is not without risk. A significant amount of fluid and protein can be lost through an open abdomen. Fistula formation and ventral hernia formations are

also known risks of an open abdomen. Therefore, it is Dr. Barie's opinion that Mrs. Roach was not a candidate for an open abdomen at the conclusion of her first abdominal surgery.

Dr. Barie also addresses the increase in Mrs. Roach's airway pressure and desaturation in oxygenation level at the conclusion of her March 3, 2015 surgery and observes that attempts were made to wean her off ventilatory support. He notes that Mrs. Roach had excessive secretions and a large emesis (i.e. regurgitation). Dr. Barie therefore opines that her slight increase in airway pressure was both normal and immaterial given the type of abdominal trauma she had endured, and that her oxygen desaturations were due to an ongoing pulmonary process that had been identified before the surgery. Dr. Barie further opines that Mrs. Roach's oxygen desaturation at the surgery's conclusion resulted from a worsening pneumonia, her overall difficulty handling the bowel obstruction and the inherent trauma of the surgical procedure. He also opines that these changes in respiratory status were expected given both her compromised state as well as the obstruction's severity and were not caused by intra-abdominal hypertension. Consequently, he additionally opines that Dr. Wedderburn's decision to close the wound and to keep her intubated was appropriate in all respects. Dr. Barie further maintains that Mrs. Roach's surgical team properly used a layered closure technique to close the wound at the end of surgery on March 3, 2015, and he finds no evidence to support concluding that the fascia was closed too tightly during the first surgery.

After completion of her first surgery, Mrs. Roach was transferred to the SICU where she was seen frequently by Dr. Wedderburn, Dr. Cai, Dr. Castello-Ramirez and Dr. Riso. Overnight from March 3, 2015 to March 4, 2015 and during the day on March 4, 2015,

Mrs. Roach was noted to be severely dehydrated. She received fluid resuscitation in response to several days of vomiting. The bowel being obstructed causes swelling and fluid to leak from the bowel, and Mrs. Roach had her stomach contents emptied by an NG tube before and during the surgery. In fact, she continued to make fluid during the surgery resulting in a large bilious regurgitation. All of these factors contribute to severe dehydration. Dr. Barie opines that SICU staff properly recognized Mrs. Roach's severe dehydration and instituted appropriate fluid challenge protocol to treat it.

On March 4, 2015, there was a concern that Mrs. Roach might be developing intra-abdominal hypertension (IAH). Dr. Cai and Dr. Riso both treated Mrs. Roach in the SICU and they collectively documented that she had either low or no urine output. Dr. Barie explains that bladder pressure is used as a measure to assess the intra-abdominal pressure (IAP), and intra-abdominal hypertension (IAH) is defined as sustained IAP. Dr. Barie opines that Mrs. Roach's physicians properly recognized the importance of gauging Mrs. Roach's IAH and administered a paralytic (i.e. a neuromuscular blocking agent) to accurately assess her IAP and rule out abdominal compartment syndrome (ACS).

Dr. Barie explains that ACS is an IAH-induced new organ dysfunction and is typically associated with an IAP greater than 25 mm Hg. To assess for ACS, Mrs. Roach was administered 10 mg of Nimbex, a muscle relaxation medication, because when the muscles are relaxed, it is possible to obtain a more accurate IAP reading. After administration of Nimbex, Mrs. Roach became hypertensive and tachycardic with a shaking seizure-like motion of all four extremities. The shaking resolved after six minutes, and labetalol was given to treat tachycardia and hypertension. Vital signs were stable

afterwards. Mrs. Roach received a dose of Naloxone and her symptoms reversed. Dr. Barie opines that Nimbex was the drug of choice to administer in this type of situation to accurately assess for ACS and evaluate whether surgery was needed to decompress Mrs. Roach's abdomen. Dr. Barie also opines that SICU staff properly consulted the Neurology Department when Mrs. Roach began to experience a seizure-like reaction; properly completed an adverse event form and updated Mrs. Roach's medical record to list Nimbex as an allergy. In addition, Dr. Barie opines that Nimbex's side effects were completely reversed with a dose of Naloxone.

Defendants reject plaintiff's argument that administering Nimbex was a departure from the standard of care, and stress Dr. Barie's opinion that there is no basis in the chart or the deposition testimony to support that contention; that defendants could not possibly have anticipated this adverse reaction; and that they reacted appropriately when it occurred. Moreover, Dr. Barie opines that neither Nimbex nor its administration could have been the cause of her seizure-like activity. Once Mrs. Roach recovered from her adverse reaction, she was administered Vecuronium as a second muscle relaxant. Her LAP was reassessed once the Vecuronium was administered. According to both Dr. Wedderburn and Dr. Barie, her IAP reading of 16 mm Hg was not dispositive of ACS, which can impair the function of nearly every organ system. Dr. Barie agrees that the decision to then continue to monitor Mrs. Roach overnight from March 4, 2015 to March 5, 2015 was proper and made in accordance with the standard of care.

On the morning of March 5, 2015, Mrs. Roach was reassessed by Dr. Wedderburn, who recognized that overnight she required increased vasopressor support, as she was

beginning to experience cardiovascular collapse. Blood cultures and respiratory cultures were positive for infection, and she was diagnosed with sepsis and septic shock. Her hypotension was profound, and Dr. Wedderburn prescribed high dose vasopressors to improve her blood pressure. He testified that he brought Mrs. Roach back to the OR on March 5, 2015 because she had deteriorated to a point with such a severe degree of multi-organ dysfunction that he wanted to take a second look. At the time, Mrs. Roach had no clinical evidence of ACS (*id.* at 1056-1059). In response to plaintiff's contention that Mrs. Roach developed ACS and should have been returned to the OR sooner, defendants maintain that Dr. Wedderburn properly ordered laboratory work and reassessment once the lab information was reported. Once Dr. Wedderburn rechecked Mrs. Roach and documented that her abdominal distention was worse and blood work showed that her lactic acidosis was worse, he then made the decision to return her to the OR for an exploratory laparotomy (i.e. a surgical incision into the abdominal cavity to examine abdominal organs and diagnose any problems). Dr. Barie opines that these defendants properly assessed Mrs. Roach's entire clinical picture, and the decision to return her to the OR on March 5, 2015 was timely and within the standard of care.

Mrs. Roach's second abdominal surgery was performed on the afternoon of March 5, 2015. Dr. Wedderburn was the attending surgeon, and he was assisted by Dr. Castello-Ramirez and Dr. Cai. Mrs. Roach was noted to have multiple new areas of ischemia, and these areas were removed. Her abdominal cavity was not closed, and, instead a wound VAC was placed. Dr. Barie confirms that this treatment is consistent with the standard of care in all respects. Mrs. Roach's surgical team, according to Dr. Barie, properly

recognized that a further surgery was likely and therefore, the decision to then keep her abdomen open was proper. According to Dr. Barie, although there was a finding of IAH made during this second surgery, there was no finding of ACS. The ischemia seen during this second surgery is a pattern more consistent with either a thromboembolic event (blood clot) or ischemia caused by the use of vasopressors, or both.

Dr. Wedderburn testified that he had no explanation for the underlying cause of the ischemia in several areas, but did note patchy ischemia in the abdomen and that the pressors could have contributed to such ischemia (*id.* at 1078-1082, *et seq.*). Dr. Barie negates ACS as causing such ischemia as he opines that ACS causes widespread ischemia, and the surgical team noted localized ischemia. Dr. Barie opines that the findings documented during Mrs. Roach's second surgery are consistent with vasopressor induced ischemia, which is a known risk (*see* n 2), and were unavoidable. The findings, Dr. Barie further observes, are also consistent with a possible embolic event, and it is not possible to distinguish between the two potential sources. Dr. Barie additionally opines that both events may occur in the absence of medical malpractice and that the findings observed during Mrs. Roach's second surgery are not causally related to any action or inaction on defendants' part herein.

Unfortunately, despite the second surgical intervention, Mrs. Roach continued to deteriorate significantly. On March 6, 2015, Dr. Wedderbum documented that Mrs. Roach had developed a fever with persistent acidosis, persistent mild coagulopathy and needed another second look laparotomy and possible related surgical procedures. Mrs. Roach was taken for a third exploratory laparotomy later that day, and the ensuing findings were

consistent with further progressive ischemia. According to Dr. Barie, there was no treatment or lack of treatment attributable to defendants that caused or contributed to this complication.

Mrs. Roach continued to deteriorate until her death on March 16, 2015. In response to plaintiff's allegations that defendants caused Mrs. Roach's cerebral edema and stroke, then failed to properly treat these conditions which led to multi-organ failure and death, Dr. Barie opines that Mrs. Roach went into septic shock during her MSSL admission, developed multi-system organ dysfunction, suffered a stroke and simply did not respond well to surgical or medical interventions. This situation, Dr. Barie submits, may occur in the absence of malpractice.

Informed Consent

Defendants submit that the cause of action for failure to obtain informed consent lacks merit and should be dismissed. It is well settled that in order to recover damages for a lack of informed consent claim pursuant to Public Health Law §2805-d [1] and [3], a plaintiff must establish that (1) the defendant physician failed to disclose the material risks, benefits, and alternatives to the contemplated medical procedure which a reasonable medical practitioner "under similar circumstances would have disclosed, in a manner permitting the patient to make a knowledgeable evaluation," (2) a reasonably prudent patient in the patient's position would not have undergone the procedure if he or she had been fully informed, and (3) the lack of informed consent proximately caused plaintiffs injuries (*see Gilmore v Mihail,* 174 AD3d 686, 688 [2d Dept 2019]; *Figueroa-Burgos v Bieniewicz,* 135 AD3d 810, 811-12 [2d Dept 2016]).

Dr. Schwartz and Dr. Barie opine that defendants obtained proper informed consent for all procedures they performed on Mrs. Roach, and that no reasonable patient would have refused the procedures defendants recommended as they were required in attempting to save Mrs. Roach's life. When Mrs. Roach was unable to provide informed consent, the procedures, the recommendation to perform them, the risks, benefits and alternatives were fully explained to her husband, Mr. Roach, who provided consent. Defendants maintain that plaintiffs will not be able to prove that a reasonable person, informed about the risks associated with the procedure would have opted against Mrs. Roach's surgical procedures (*see Orphan v Pilnik*, 15 NY3d 907, 909 [2010]) [summary judgment in favor of defendant warranted where the evidence did not establish that a fully informed reasonable person would have declined the procedure]; *Zapata v Buitriago*, 107 AD3d 977, 980 [2d Dept 2013] [summary judgment granted in favor of defendant who demonstrated that a reasonably prudent person in the injured plaintiff's position would not have declined to undergo the procedure at issue]). Hence, defendants maintain that plaintiffs' cause of action for lack of informed consent is baseless and should be dismissed.

Negligent Hiring and Supervision

Defendants maintain that plaintiff makes vague allegations that MSSL negligently hired, retained and supervised unskilled, improperly credentialed and incompetent employees; failed to properly screen employees; failed to promulgate and enforce good and accepted practices with regard to promulgating protocols and procedures; failed to adhere to those protocols and procedures; failed to properly coordinate care; failed to properly and

timely perform diagnostic tests and differential diagnoses; and failed to properly supervise and train employees. This vague and ambiguous claim of negligent hiring, training, and supervisory practices, defendants assert is unsupported by evidence and cannot be pursued under New York State case law.

Summary judgment must be granted, defendants reason, where the employer acts with reasonable care in hiring, retaining and supervising employees (*see Boadnaraine v City of New York and White Glove Placement. Inc.* 68 AD3d 1032, 1033 [2d Dept 2009]) [denial of summary judgment reversed where defendant established that its employee-nurse was a New York State licensed registered nurse in good standing assigned to work at Queens Hospital with favorable references]). Defendants maintain that there is no evidence that MSSL was negligent in relying on the credentials of the medical personnel (*see Kirkman v Astoria Gen. Hosp.,* 204 AD2d 401, 403 [2d Dept 1994], *lv denied* 84 NY2d 811 [1994], *rearg denied* 85 NY2d 858 [1995] [summary judgment based on claim of negligent hiring by security company improperly denied where security company conducted a routine but thorough pre-employment check into employee's background]). All of defendants' experts opine that there is no basis to support the claim that medical personnel were negligently credentialed, and that there is no merit to plaintiffs' allegations pertaining to failure to promulgate and adhere to policies, protocols and procedures.

Opposing Arguments

Standard of Care

Plaintiff and his experts, in opposition to the motion, disagree with the opinions of defendants' experts (e.g., *see* NYSCEF Doc No. 157 at 8-10, ¶ 11) and maintain that there

were numerous intraoperative and postoperative departures. His three expert physicians, one board-certified in critical care medicine, another board-certified in surgery and colon and rectal surgery and a third board-certified in anesthesiology, collectively set forth the departures, their reasons and basis for their opinions in great detail and to a reasonable degree of medical certainty in two affirmations and an affidavit (*see* NYSCEF Doc Nos. 156-158, annexed as exhibits A-C, respectively to plaintiff's opposition papers). For example, plaintiff and his anesthesiologist expert maintain that there were numerous departures on the part of the anesthesia team, including: the failure to recognize and address Mrs. Roach's risk of aspiration; the failure to properly place the NGT and empty the stomach; the failure to recognize that Mrs. Roach's NGT had stopped functioning and was out of position thereby causing Mrs. Roach's intraoperative aspiration; the failure to recognize that Mrs. Roach had aspirated; and the failure to either perform or ensure the performance of a bronchoscopy to visualize and remove any aspirated material (*see* NYSCEF Doc No. 158 at 10, ¶ 18; at 10-16, ¶¶ 19-29; at 21-22, ¶¶ 38-41). With respect to Dr. Sabaoun, plaintiff's expert also maintains that there was never an X ray performed to confirm the proper placement of the NGT tube (*id.* at 16-17, ¶ 30).

In addition, plaintiff's surgical expert asserts 22 surgical team departures including: defendants using an improper approach with a "very small incision" into the peritoneum and thus not fully viewing the bowel with greater abdomen exposure; failing to properly lyse (i.e. break apart) adhesions needed to free the *entire* small bowel; failing to evaluate and run the *entire* bowel (i.e. inspect it in its entirety to ensure that normal contracting, known as peristalsis, had returned); failing to milk (i.e. manually decompress) the contents

of the small bowel into the stomach and then remove the stomach contents via the NGT; failing to recognize the significantly increased IAP (intra-abdominal pressure)/IAH (intra-abdominal hypertension) or its effects on Mrs. Roach during surgery; failing to leave the abdomen open at the end of the March 3, 2015 procedure; failing postoperatively to recognize elevated IAP, IAH and, on March 4, 2015, bladder pressure through signs such as tachycardia (i.e. abnormally rapid heart rate), evolving hypotension (i.e. abnormally low blood pressure) and decreased urine output; failing postoperatively to timely reopen the abdomen to relieve the elevated IAP once the abdominal closure caused increased IAP, which pushed Mrs. Roach's diaphragm up towards her lungs, causing an elevation in her airway pressures, desaturation and aspiration; failing postoperatively to administer antibiotics covering intra-abdominal bacteria and bacteria that causes aspiration pneumonia; failing postoperatively to recognize the significance of Mrs. Roach's decreased APP (i.e. abdominal perfusion pressure) and resulting decreased abdominal perfusion (i.e. passage of blood or other fluid through the circulatory or other system) to abdominal organs and bowel; and overly aggressive fluid administration contributing postoperatively to her IAH-induced ischemia (i.e. inadequate blood supply), necrosis, edema, sepsis, etc. (*see* NYSCEF Doc No. 157 at 12-14, ¶ 14, et seq.).

Furthermore, plaintiff's critical care expert has also opined, to a reasonable degree of medical certainty, that defendants bear responsibility for 25 departures, many cited by plaintiff's other experts, in treating and caring for Mrs. Roach. These departures, according to plaintiff's critical care expert, were a proximate cause and substantial factor in her pain, suffering, injury and death and her clinical course from the time her abdomen was closed

at the end of the initial surgery on March 3, 2015 up until her death on March 19, 2015 (*see* NYSCEF Doc No. 156 at 8-10, ¶¶ 11-12). Plaintiffs critical care expert maintains that these departures, especially failing to diagnose and treat Mrs. Roach's elevated intra-abdominal pressure (IAP) and intra-abdomial hypertension (IAH) by timely surgical decompression, and not the vasopressors, caused the "cascade of complications" and clinical deterioration that followed (*id.* at 26-28, ¶¶ 49-51; at 59-61, ¶¶ 121-124). These complications and deterioration included developing sepsis, septic shock, cardiovascular collapse and ultimately her demise (*id.* at 59-65 at ¶¶ 121-134).

Plaintiff and his experts submit that the assertions and opinions made by defendants and their experts, in contrast, are without foundation in the record and are even contradicted by the record. Plaintiff contends in this regard that the affirmations of defendants' experts are either unsupported by the facts and the record or fail to address several key points, outlined above, and thus must be deemed wholly conclusory and speculative.

Plaintiff contends that defendants' entire argument must be rejected, and that the affirmation of defendants' surgical expert should be disregarded as his opinions, claims and arguments, as challenged above, are not based on this case's medical facts. Plaintiff likewise submits that the claims and opinions of defendants' anesthesiology expert should be disregarded concerning whether protocols were followed.

Plaintiff maintain that defendants and their experts, in any event, have failed to make a prima facie case showing entitlement to judgment as a matter of law as they have neither established the absence of departures from the standard of care nor established that any such departures did not cause Mrs. Roach's injuries. Plaintiff's experts have also each

opined, to a reasonable degree of medical certainty, that the departures enumerated in each of the expert's affirmations is and was a proximate cause of and substantial factor in Mrs. Roach's pain, suffering, injury and premature death.

In addition, plaintiff asserts that his experts' assertions and opinions show that numerous factual issues exist precluding summary judgment. For example, plaintiff's surgical expert rejects defendants' effort to stress the impact of vasopressors and notes they were administered *after* Mrs. Roach's condition had deteriorated, "her medical course was irreversible and her subsequent clinical course was unavaoidable . . ." (*see* NYSCEF Doc No. 157 at 57, ¶ 98).

Reply Argument

Defendants, in reply, note at the outset that plaintiff "does not oppose summary judgment . . . as to causes of action for lack of informed consent and negligent hiring, training and supervision of staff" (*see* NYSCEF Doc No. 184, counsel's reply affirmation at 2, ¶ 3). Defendants maintain that there were no departures in the treatment they rendered and no act or omission by them that proximately caused Mrs. Roach's development of aspiration, increased abdominal pressure, abdominal compartment syndrome (ACS), bowel necrosis, septic shock, cerebral hemorrhage, stroke, other injuries and death as plaintiff alleged. Defendants specifically note that on March 4, 2015, Mrs. Roach received her second dose of the antibiotic cefoxitin at 6:13 a.m and that the care provided to her by defendants at all times was within the standard of care; that Mrs. Roach was not a candidate for open abdomen management at the conclusion of her initial surgery on March 3, 2015; that her oxygen desaturation at the time of closure of her abdominal wound was due to her

preexisting aspiration pneumona, which implies that there was no intraoperative aspiration; that the decision to close her abdominal incision was appropriate in all respects; and that there was no contraindication to closing the abdomen at the conclusion of the initial surgery on March 3, 2015. Furthermore, defendants reiterate that Mrs. Roach's fluid resuscitation was appropriate in all respects; that she had her abdominal stomach contents emptied during the surgery; and that the administration of paralytics in this case was not a departure from the standard of care.

Defendants also maintain that Mrs. Roach was properly monitored; that the decision to monitor her instead of taking her back to the OR was proper and in accord with the standard of care; and that the decision to take her back to the OR on March 5, 2015 was timely and within the standard of care. Finally, defendants maintain that the March 5, 2015 surgical findings including ischemic necrosis and infarcted bowel (i.e. dead tissue caused by inadequate blood supply) necessitating resection, were unavoidable and not causally related to any action or inaction on their part. They submit that there could be no treatment, or lack thereof attributable to them that caused or contributed to the surgical findings on March 6, 2015. In summary, defendants reiterate that Mrs. Roach's cerebral edema and stroke, seizures, multi-organ failure, coma and death were not caused by them and that there was no additional treatment they could have provided to prevent the complications which occurred.

Discussion

Summary judgment is a drastic remedy and should be granted only when it is clear that no triable issues of fact exist (*see Alvarez v Prospect Hosp.*, 68 NY2d 320, 324 [1986]).

The moving party bears the burden of prima facie showing its entitlement to summary judgment as a matter of law by presenting evidence in admissible form demonstrating the absence of any material factual issues (*see* CPLR 3212 [b]; *Giuffrida v Citibank Corp.*, 100 NY2d 72, 81 [2003]). A failure to make that showing requires denying the motion, regardless of the adequacy of the opposing papers (*see Vega v Restani Constr. Corp.*, 18 NY3d 499, 503 [2012]; *Ayotte v Gervasio*, 81 NY2d 1062, 1063 [1993]). Once a movant makes a prima facie showing, the burden then shifts to the opposing party to produce sufficient evidentiary proof to establish the existence of material factual issues (*see Alvarez*, 68 NY2d at 324; *Zuckerman v City of New York*, 49 NY2d 557, 562-563 [1980]). Accordingly, issue-finding, rather than issue-determination, is the key in deciding a summary judgment motion (*see Sillman v Twentieth Century-Fox Film Corp.*, 3 NY2d 395, 404 [1957], *rearg denied* 3 NY2d 941 [1957]). "The court's function on a motion for summary judgment is to determine whether material factual issues exist, not resolve such issues" (*Ruiz v Griffin*, 71 AD3d 1112, 1115 [2d Dept 2010] [internal quotation marks and citations omitted]).

All evidence "must be viewed in the light most favorable to the non-moving party" (*see Vega*, 18 NY3d at 503 [internal quotation marks and citation omitted]). Denying the motion is necessary "where the facts are in dispute, where conflicting inferences may be drawn from the evidence, or where there are issues of credibility" (*Benetatos v Comerford*, 78 AD3d 750, 752 [2d Dept 2010] [internal quotation marks and citations omitted]; *see also Peerless Ins. Co. v Allied Bldg. Prods. Corp.*, 15 AD3d 373, 374 [2d Dept 2005] [denial of summary judgment required where "any doubt as to the existence of a triable

issue, or where the material issue of fact is arguable"] [internal quotation marks and citations omitted]).

A defendant seeking summary judgment in a medical malpractice action bears the initial burden of establishing either that there was no departure from the applicable standard of care, or that any alleged departure was not a proximate cause of the plaintiffs' injuries. To sustain their prima facie burden, defendants must address and rebut the malpractice allegations set forth in plaintiff's bill of particulars *(see E.K. v Tovar,* 185 AD3d 803, 805 [2d Dept 2020]; *Nelson v Lighter*, 179AD3d 933, 934 [2d Dept 2020], *Mathias v. Capuano,* 153 AD3d 698, 699 [2d Dept 2017]). In opposition, plaintiff must demonstrate a triable factual issue exists in those areas where defendant has met its initial burden (*see Michel v Long Is. Jewish Med. Ctr.,* 125 AD3d 945, 945 [2d Dept 2015], *lv denied* 26 NY3d 905 [2015]).

Here, defendants have demonstrated their prima facie entitlement to judgment as a matter of law through submission of deposition testimony, medical records and expert affirmations establishing that defendants did not depart from good and accepted medical practice and that, in any event, any alleged departures were not a proximate cause of Mrs. Roach's injuries or death (*see Prunty v Pastula*, 171 AD3d 1110, 1111 [2d Dept 2019]). For example, the medical records, deposition testimony, and affirmations of Emergency Medicine expert, Dr. Eric Morley and Radiology expert Dr. Lawrence Schwartz demonstrate that defendant Jason Chu, M.D. and defendant Carol Hilfer, M.D. did not depart from the standard of care, nor did their treatment cause or contribute to Mrs. Roach's injuries and death. These experts have addressed plaintiff's allegations in the bill of

particulars, defendants have thus met their burden of proof as to the claims asserted against Drs. Chu and Hilfer, and plaintiff has not shown a triable factual issue exists on the claims against those defendants.

However, as to Dr. Sebaoun and Dr. Wedderburn, contrary to their testimony, the expert affirmation of Dr. Kanchuger and Dr. Barie's expert affirmation, which maintains that Mrs. Roach's course was set by the time she presented herself in the ED, factual issues exist whether there were both departures from the standard of care and a casual connection between the alleged departures and her injuries (*Stukas v Streiter,* 83 AD3d 18, 30 [2d Dept 2011]).

Plaintiff and his experts have demonstrated that the above assertions and opinions made by defendants and their experts are either without foundation in the record or contradicted by the record (*see Kaplan v Hamilton Med. Assoc.,* 262 AD2d 609, 610 [2d Dept 1999] [expert's opinion must be based upon the specific facts supported by evidence in the record]). Here, plaintiff has submitted an affirmation or affidavit from three (3) board-certified physicians: a critical care medicine specialist, a surgeon and an anesthesiologist, each of whom has an active practice, is, respectively, fully familiar with the issues of critical care medicine, surgery and anesthesiology raised by this case, the accepted medical standards at the time in question and the applicable medical literature. Each has reviewed applicable records, testimony and evidence, including evidence and testimony not submitted by defendants, and utilized their knowledge, education, training, and experience in addressing the issues herein. Thus, the opinions of plaintiff's experts cannot be characterized as speculative, conclusory or hindsight reasoning (*see e.g.*

Anderson v Lamaute, 306 AD2d 232, 234 [2d Dept 2003] [holding the defendant's summary judgment motion was improperly granted because "the plaintiffs' expert recited ... facts in the medical record upon which the expert's opinion was based and opined that (the defendant's) deviations from good and accepted medical practice proximately caused (the) injuries"]).

Plaintiff's experts have disagreed with the opinions of defendants' experts, have each set forth, in great detail and to a reasonable degree of medical certainty, factual issues regarding defendants' departures in Mrs. Roach's care and medical treatment and have each also opined that departures enumerated in their expert affirmations were a proximate cause and substantial factor in this case. Indeed, according to plaintiff's surgical expert, the departures were a proximate cause and substantial factor in Mrs. Roach's pain, suffering, injury, death, and her entire hospital course, including her postoperative persistent tachycardia, decreased urine output/renal impairment, hypotension, increased IAP, IAH, decreased APP, bowel ischemia, bowel necrosis, sepsis, septic shock, multi-organ failure, edema, stroke, continued clinical deterioration and other medical problems (*see* NYSCEF Doc No. 157 at 61-62, ¶110).

The conflicting opinions of plaintiff's expert and defendants' experts present triable factual issues which cannot be resolved on this summary judgment motion (*see Many v Lossef,* 190 AD3d 721; 723 [2d Dept 2021]; *Kiernan v Arevalo-Valencia,* 184 AD3d 727,728 [2d Dept 2020]; *Joyner v Middletown Med., P.C.*, 183 AD3d 593, 594 [2d Dept 2020]; *Sheppard v Brookhaven Mem. Hosp. Med. Ctr.*, 171 AD3d 1234, 1235 [2d Dept 2019]).

These issues relate specifically to the standards of good and accepted practice that may not have been followed, for example, by Dr. Sebaoun, the anesthesiologist herein, as to placement of the NGT tube; the alleged failure to appreciate the presence of gastric contents on a CT scan; the alleged failure to adequately empty stomach contents resulting in an aspiration; the alleged failure to prevent an aspiration; the alleged failure to avoid negligently delaying performance of surgery; and the alleged failure to avoid the negligent closure of Mrs. Roach's fascia despite her airway pressures and difficulties ventilating. Likewise, numerous factual issues exist regarding Dr. Wedderburn, the surgeon herein, including, for example, as to decisions made regarding the initial surgical procedure on March 3, 2015 and his alleged failure to prescribe a postsurgical regimen of antibiotics in light of Mrs. Roach's significant history of prior abdominal surgeries; failure to timely diagnose and treat abdominal compartment syndrome; negligently prescribed and administered Nimbex; failure to timely diagnose and treat cerebral edema, stroke and multi-organ system failure, which ultimately caused Mrs. Roach's death.

However, it is well established that "[a] resident who assists a doctor during a medical procedure or care and treatment of a patient, and who does not exercise any independent judgment, cannot be held liable for malpractice so long as the attending doctor's directions did not so greatly deviate from normal practice that the resident should be liable for failing to intervene (*see Quille v New York City Health & Hosp. Corp.*, 152 AD3d 808, 809 [2d Dept 2017] [internal quotation marks and citation omitted]). Neither the medical records nor deposition testimony in this case provide a basis to conclude that the named residents herein exercised any independent judgment or encountered a situation

where they should have and failed to intervene. Drs. Castello-Ramirez, Cai, Kamisetti and Riso were all residents at the time they treated Mrs. Roach, and the record shows that that they acted and treated Mrs. Roach under the guidance of their respective attending physicians and did not independently act or treat Mrs. Roach. Therefore, those defendants have established that they are not liable herein.

In addition, defendants have established their unopposed entitlement to summary judgment dismissing plaintiff's lack of informed consent claim (*see Informed Consent*, *Orphan v Pilnik*, 15 NY3d at 909; and *Zapata v Buitriago*, 107 AD3d at 980, *supra* at 15-16).

Moreover, defendants have established their entitlement to summary judgment dismissing plaintiff's claims for negligent hiring, training, credentialing and supervision, especially considering that plaintiff also does not oppose defendants' motion in these regards and thus no factual issue exists regarding those causes of action (*see Negligent Hiring and Supervision, supra* at 16-17; *Simpson v Edghill*, 169 AD3d 738, 739 [2d Dept 2019] [Supreme Court should have granted unopposed branch of defendants' summary judgment motion to dismiss plaintiff's negligent hiring cause of action; defendants made prima facie showing that neither defendant nor any other employee acted outside scope of their employment in treating plaintiff; and plaintiff failed to raise triable factual issue]; *Henry v Sunrise Manor Ctr. for Nursing & Rehabilitation*, 147 AD3d 739, 741 [2d Dept 2017]; *Boadnaraine,* 68 AD3d at 1033; *Kirkman,* 204 AD2d at 403).

Plaintiff has established factual issues herein as to Drs. Sebaoun, Dr. Wedderburn and MSSL, sued herein as St. Luke's Roosevelt Hospital Center, based upon the submitted evidence and record. Accordingly, it is

ORDERED that defendants' summary judgment motion (mot. seq. four) as to Maria Castello-Ramirez, M.D., Jenny Y Cai, M.D., Janice Riso, M.D., Jason Chu, M.D., Carol Hilfer, M.D. and Seema Kamisetti, D.O., is granted. The motion is denied as to Drs. Sebaoun, Dr. Wedderburn and MSSL, sued herein as St. Luke's Roosevelt Hospital Center.

The foregoing constitutes the decision, order and judgment of the court.

E N T E R,

J. S. C.

KINGS COUNTY CLERK
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