

**O'Brien v Ahmed**

2021 NY Slip Op 32072(U)

September 2, 2021

Supreme Court, Orange County

Docket Number: 002276-2015

Judge: Sandra B. Sciortino

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This opinion is uncorrected and not selected for official publication.

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

SUPREME COURT OF THE STATE OF NEW YORK  
COUNTY OF ORANGE

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**WILLIAM O'BRIEN,**  
Plaintiff,

**DECISION AND ORDER**  
**INDEX NO.: 002276-2015**  
**Motion Date: 6/28/21**  
**Sequence No. 4**

-against-

**FARUQ AHMED, M.D., PAUL J. SHANNON, M.D., ANNE SACKS-BERG, M.D., LONG ISLAND INFECTIOUS DISEASE ASSOCIATES, LLP, HUNTINGTON HOSPITAL ASSOCIATION OF THE NORTH SHORE-LONG ISLAND JEWISH HEALTH SYSTEM, INC., KIP L. BODI, M.D., and KIP L. BODI, PHYSICIAN, FACS, PLLC,**  
Defendants.

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**SCIORTINO, J.**

The following papers numbered 1 to 18 were considered in connection with defendants' motion to preclude the anticipated trial testimony of plaintiff's medical expert, or, alternatively, for a *Frye*<sup>1</sup> hearing:

<u>PAPERS</u>	<u>NUMBERED</u>
Notice of Motion/Affirmation (Lawless)/Expert Affirmation (Germano) with Exhibits/Exhibits B-L	1 - 14
Affirmation in Opposition (Fequiere)/Expert Affirmation (Charash) with Exhibits	15 - 16
Reply Affirmation (Lawless)/Expert Reply Affirmation (Germano)	17 - 18

**Background**

This medical malpractice action was commenced on or about March 27, 2015 by the filing of a Summons and Verified Complaint and Certificate of Merit. The action arises out of

<sup>1</sup>(*Frye v. United States*, 293 F. 1013 [D.C. Cir. 1923])

the allegedly negligent treatment of plaintiff by the defendants between October 25 and November 8, 2012. Plaintiff thereafter filed an Amended Verified Complaint on October 7, 2015. All defendants answered the Amended Complaint. The Note of Issue was filed on May 30, 2018.

The underlying facts of the action are not significantly disputed: On October 4, 2012, plaintiff, then 49 years old, underwent a vasectomy with former defendant Dr. Bodi. Plaintiff had a past medical history significant for, *inter alia*, obesity, hypertension, diabetes and obstructive sleep apnea. He had undergone an ablation for supraventricular tachycardia (SVT) eighteen years earlier and had done well thereafter. At his post-operative visit on October 24, 2012, plaintiff complained of testicular pain and swelling. Dr. Bodi prescribed an antibiotic; a sonogram was ordered and performed the following day. It was suspicious for infection.

Plaintiff went to Huntington on October 25, 2012, where he was diagnosed with a post-operative infection. He was administered the antibiotics Vancomycin and Rocephin and admitted. Blood work performed that evening showed a creatinine level of 0.84 (normal, 0.50-1.30). On October 26, 2012, plaintiff's creatinine level was 0.79, and on October 27, 2012, it was 0.85. Blood work performed on October 29, 2012 revealed a creatinine level of 1.19, which, though elevated from the previous readings, was still within the normal range. Due to Dr. Bodi's previously planned vacation, Dr. Shannon began covering plaintiff's care on October 28, 2012. On October 30, 2012, Dr. Shannon performed an incision and drainage procedure on plaintiff.

On November 1, 2012, plaintiff was evaluated by Dr. Sacks-Berg, an infectious disease specialist, who documented plaintiff's complaints of nausea and a fever. Blood work performed on that date, ordered by Dr. Ahmed, an internist, revealed that plaintiff's creatinine level was significantly elevated, at 3.23. Dr. Sacks-Berg discontinued Vancomycin and ordered a renal

ultrasound and a chest x-ray. It is apparently undisputed that plaintiff suffered an acute kidney injury (AKI) and consequent renal failure due to Vancomycin toxicity. He was diagnosed with pneumonia and hypoxia. During his hospitalization, plaintiff experienced episodes of intermittent or “paroxysmal” atrial fibrillation (aFib).

Plaintiff claims that his now-chronic or “persistent” aFib was caused by the AKI and hypoxic episode he experienced during his 2012 hospitalization.

By Notices of Motion filed on or about January 17, 2019, all defendants moved for summary judgment dismissing the complaint. The Dr. Bodi’s motion was unopposed in its entirety; the motions of the remaining defendants were opposed only with respect to the alleged failure to perform blood work from October 29-November 1, 2012. By Decision and Order dated January 15, 2019, the motions of defendants Shannon, Ahmed, Sacks-Berg, Long Island Infectious Disease Associates and Huntington Hospital were denied with respect to the claim of failure to order blood work and granted in all other respects. A trial was scheduled for May 11, 2020, but did not take place because of the COVID-19 restrictions then in place.

On or about February 23, 2021, plaintiff served a Second Amended Expert Witness Disclosure (Exhibit B) advising of his intent to call a cardiovascular expert to testify, *inter alia*, to the anatomy and physiology of the heart and cardiovascular system, the nature of congestive heart failure, aFib and SVT; the nature and characteristics of AKI and its complications, and treatment of these issues. The expert was also expected to testify as to the care and treatment of plaintiff by defendants, and the causal nexus between defendants’ departures from accepted standards of practice and plaintiff’s injuries. As relevant to the instant motion, plaintiff’s expert intends to conclude, with a reasonable degree of medical certainty, that plaintiff’s Vancomycin-

induced AKI and consequent renal failure resulted in the development of congestive heart failure and aFib, resulting in plaintiff's two cardiac catheter ablation procedures in 2013 and 2018.

### Motion to Preclude

By Notice of Motion originally filed March 19, 2021, defendants seek to preclude the testimony of plaintiff's expert witness on the basis of *Frye v. United States*, asserting that the anticipated opinion is not founded on generally accepted scientific principles, and is not supported by the scientific community or the medical literature. Rather, plaintiff's AFib is the result of chronic underlying health conditions, including long-standing obesity, uncontrolled hypertension and uncontrolled sleep apnea. Defendants point to plaintiff's medical records, showing obstructive sleep apnea (Exhibit E); chronic elevated blood pressure (Exhibit F); psychiatric history of bipolar disorder which further interfered with his sleep; cocaine use (Exhibit I); lower extremity edema, and poorly-controlled diabetes. (Exhibits J and K)

Defendants assert that plaintiff's expert's anticipated opinion, that the AKI and consequent renal failure caused the development of congestive heart failure, SVT, as well as the development of chronic persistent aFib constitutes a theory that is neither generally accepted in the fields of cardiology or cardiac electrophysiology and is without support in medical literature. New York law requires that plaintiff establish that his expert's opinion is generally accepted in the scientific community. Plaintiff is unable to do so.

In further support, defendants append the expert affirmation of Joseph Germano, D.O., board-certified in cardiac electrophysiology and cardiovascular disease. Dr. Germano provides a detailed medical history of plaintiff's treatment between 2012 and 2018, including his hospitalization at Huntington in October-November 2012. The anticipated testimony of plaintiff's expert will be that there is a causal link between the October 2012 hospitalization and

plaintiff's development of persistent atrial fibrillation. However, Dr. Germano opines that this "novel theory of causation" is not generally accepted in the fields of cardiology or cardiac electrophysiology. Nor is there any support in the medical literature for the theory that an acute, transient injury can cause chronic aFib. Dr. Germano further opines that plaintiff's persistent aFib is directly attributable to his underlying chronic health conditions, many of which are established risk factors for aFib: morbid obesity; obstructive sleep apnea with CPAP non-compliance; poorly-controlled hypertension leading to the development of left ventricular hypertrophy; poorly-controlled Diabetes Mellitus Type II; and alcohol and cocaine abuse. Given plaintiff's medical history, he was "highly predisposed" to developing aFib prior to his October 2012 hospitalization.

Dr. Germano also notes the distinctions between paroxysmal/intermittent aFib and persistent/chronic aFib. It is possible for acute short-term stressors, such as the complications experienced by plaintiff in October 2012, to precipitate paroxysmal aFib in patients who have a predisposition due to risk factors. But the exact cause or stressor of an individual's paroxysmal aFib cannot be stated with medical certainty. That said, there is no medical or scientific basis for the theory that a transient, resolved event can cause chronic and persistent aFib. Persistent aFib can only be caused by altered electrophysiological properties and altered structural properties of the atria, as well as pathophysiological mechanisms that damage atrial tissue over long periods of time. This occurs by prolonged and repeated exposure to defined risk factors, such as obesity, uncontrolled hypertension and obstructive sleep apnea. These are the factors that led to plaintiff's persistent aFib, and not any factor related to his October 2012 hospitalization. It is his opinion, to a reasonable degree of medical certainty that plaintiff's persistent aFib is directly attributable to his underlying medical conditions.

### Opposition

Plaintiff argues that no *Frye* hearing is required in this matter, because his theory of causation does not involve either novel principles or methodology. The purpose of a *Frye* evaluation is to guard against “junk science” being presented to a jury. However, even a novel theory of causation does not warrant a *Frye* hearing if it is premised on accepted principles or methodologies. Plaintiff’s theory is properly founded on generally-accepted scientific principles in the relevant field. Defendants’ motion is an improper attempt to attack the merit, weight and credibility of the theory, instead of its admissibility. The only determination to be made under *Frye* is whether the principles and/or methodologies upon which a theory of causation is premised have been generally accepted in the field. A proponent must show “consensus in the scientific community as to [the methodology’s] reliability.” It is not required that every proposed theory be detailed in medical literature—that would be impossible. The Court can require only that the premise be based on generally-accepted principles. Where there is no novel methodology at issue, the inquiry is really whether there is an appropriate foundation for the opinion. Plaintiff’s theory of causation is not novel. Plaintiff’s theory is premised on the generally-accepted medical principle of “AF begets AF”.

In further support, plaintiff appends the expert affirmation of Bruce D. Charash, M.D., board-certified in Internal Medicine, with a subspecialty in cardiovascular disease. Dr. Charash has practiced as a cardiologist for 30 years. His affirmation is based on the plaintiff’s Bill of Particulars; pertinent medical records; deposition testimony, and the expert affirmation of Dr. Germano, defendants’ expert. His opinions are additionally based on the literature he reviewed, including the literature appended to Dr. Germano’s affirmation. Dr. Charash also reviewed plaintiff’s medical history, including his hospitalization in October 2012, where he was

diagnosed with paroxysmal aFib and SVT. He notes that plaintiff's consulting cardiologist recorded a longstanding history of hypertension, with an ablation for treatment of SVT years earlier. However, plaintiff had no history of coronary artery disease; congestive heart failure; deep vein thrombosis, or pulmonary embolism.

Dr. Charash agrees with Dr. Germano that plaintiff had several risk factors, including morbid obesity, sleep apnea, hypertension and diabetes II; that he had complications during his admission to Huntington; that he had paroxysmal aFib for the first time during that admission; and that after discharge, he continued to have aFib episodes. Moreover, he agrees with Dr. Germano's statement that the acute injury plaintiff suffered while at Huntington can lead to paroxysmal aFib. He further agrees that persistent aFib will only exist where a patient has had prolonged and repeated exposure over long periods of time to defined risk factors.

The sole issue of contention is the causal relationship between paroxysmal aFib caused by an acute injury and the development of persistent aFib, directly attributable to the same conditions. Dr. Charash argues that there is support in the medical literature for the principle that once a patient experiences an initial instance of paroxysmal aFib, he is more likely to suffer recurrent and persistent episodes of aFib. The cause of plaintiff's initial onset of aFib can be traced back to defendants' negligence. Like Dr. Germano, Dr. Charash appends to his affirmation articles supporting his theory. He concludes that these articles establish that there is support in the medical community for the theory that once a patient experiences an episode of aFib, the risk of recurrence increases significantly and persistent aFib can develop for reasons other than the existence of risk factors.

### Reply

Defendants reiterate that Dr. Charash's conclusions are not generally accepted by the scientific community. Primarily, defendants note that Dr. Charash has training and experience in general cardiology, he is not an electrophysiologist. He does not claim that he has ever performed a cardiac ablation or that he received specialized training in the treatment of aFib. The literature which Dr. Charash claims supports his theory does not in fact support it. In fact, the articles confirm Dr. Germano's conclusion that persistent aFib results from the alteration of heart tissue over time due to prolonged and repeated damage from underlying health conditions. None of the literature provides a correlation between an acute stressor such as plaintiff's kidney injury with persistent aFib.

In his Reply Affirmation, Dr. Germano does not contest that paroxysmal aFib often leads to persistent aFib. But paroxysmal aFib is not an independent risk factor. Neither the literature nor the scientific community support such a theory. The "AF begets AF" argument refers to a pathway and not a causal link. He specifically points to multiple articles cited by Dr. Charash which support the conclusion that persistent aFib develops over time and in the presence of significant risk factors, including those which both experts agree plaintiff experienced. He concludes that there is no literature that states that an initial episode of aFib causes chronic aFib.

The Court has fully considered the submissions of the parties.

### Discussion

Defendants' motion to preclude is denied. Section 4515 of the CPLR provides that "upon *cross-examination* [an expert] may be required to specify the data and other criteria supporting the opinion." The statute does not support precluding the evidence, but rather, permitting defendants to cross-examine the expert regarding the basis of his opinion. (*Gaona-Garcia v.*

*Gould*, 31 Misc. 3d 1237(A) [Bronx Co. 2011]) While defendants assert that there is a lack of scientific support to warrant the opinion, they have not established that defendants' expert relied upon novel, unreliable or biased scientific methods or sources. (*id.*) If his testimony is ultimately admitted, defendants will be free to cross-examine Dr. Charash, to demonstrate their assertions to the jury, who will be free to accept or reject his testimony in whole or in part.

The application for a *Frye* hearing is granted. In order for scientific expert testimony to be admitted at trial, the procedure and results must be "generally accepted as reliable in the scientific community." (*Frye*, 293 F. at 1013; *People v. Williams*, 35 NY 3d 24, 37 [2020]; *Styles v. General Motors Corp.*, 20 AD3d 338, 341 [1<sup>st</sup> Dept 2005]) This is the precedent under which New York Courts are bound. (*Gaona-Garcia v. Gould*, 31 Misc. 3d 1237(A) [Bronx Co. 2011]) Although unanimity is not required, the proponent of the disputed evidence must show consensus in the scientific community as to the methodology's reliability." (*People v. Williams*, 35 NY 3d at 37; *Sean R. v. BMW of N. Am., LLC*, 26 NY 3d 801, 809 [2016]) A showing that an expert's opinion has "some support" is not sufficient to establish general acceptance. (*People v. Williams*, 35 NY 3d at 37) The burden of proving general acceptance of scientific principles, procedures or theories upon which expert testimony is based rests upon the party offering the disputed testimony. (*Ratner v. McNeil-PPC, Inc.*, 91 AD3d 63 [2d Dept 2011]; *Farrell v. Lichtenberger*, 194 AD3d 1013 [2d Dept 2021])

However, the Court's gatekeeping function under *Frye* does not require it to engage in its own independent review of a proposed expert's methodology and resultant conclusions. (*Gaona-Garcia*, 31 Misc. 3d at 1237(A); *see also, Marsh v. Smyth*, 12 AD3d 307, 310 [1<sup>st</sup> Dept 2004]) The Court's limited role is to determine whether the expert's deductions are based on principles that are sufficiently established to have gained general acceptance as reliable. (*Marsh*, 12 AD3d

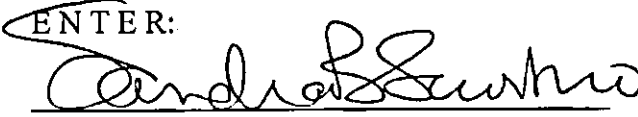
at 307-308) It is not necessary that the underlying support for the theory of causation consist of cases or studies considering circumstances exactly parallel to those under consideration to the litigation; “rather, it is sufficient if a synthesis of various studies or cases reasonably permits the conclusions reached by plaintiff’s expert.”

In the instant matter, the respective experts have cited some of the same literature to support their differing positions. Plaintiff correctly identifies the issue as one in which the causal nexus is the only disputed element of proof. Plaintiff relies on statistical studies showing the percentages of patients whose paroxysmal aFib developed into recurrent episodes, for the conclusion that “AF begets AF.” Defendants counter that plaintiff’s conclusions cherry-pick only the conclusions and ignore the underlying data that supports its theory that the underlying risk factors are the causative agent. The Court is not in a position to evaluate for itself which of the conclusions can be considered as more reliable. A *Frye* hearing is required to resolve this dispute. (See, *People v. Williams*, 35 NY 3d at 38; *Gaona-Garcia*, 33 Misc. 3d 1237(A)

The parties shall virtually appear for status conference on October 5, 2021 at 2:00 p.m. for the purpose of scheduling such a hearing. A Microsoft Teams link will be provided in advance of the conference date.

This decision shall constitute the order of the Court.

Dated: September 2, 2021  
Goshen, New York

ENTER:  
  
HON. SANDRA B. SCIORTINO

To: *Counsel of Record via NYSCEF*