

<b>Bayon v Saint Joseph's Med. Ctr.</b>
2021 NY Slip Op 33228(U)
September 9, 2021
Supreme Court, Westchester County
Docket Number: Index No. 65604/2017
Judge: Linda S. Jamieson
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Disp \_\_\_\_\_ Dec x Seq. Nos. 2-3 Type SJ

SUPREME COURT OF THE STATE OF NEW YORK  
COUNTY OF WESTCHESTER

**PRESENT: HON. LINDA S. JAMIESON**

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JOSE BAYON, as Executor of the Estate of  
MIRNA E. BAYON MARTINEZ a/k/a MIRA  
ESTHER BAYON-MARTINEZ,

Index No. 65604/2017

Plaintiff,

DECISION AND ORDER

-against-

SAINT JOSEPH'S MEDICAL CENTER and AKINO  
IRENE YAMASHITA, M.D., NEIL J. SAYEGH, M.D.  
a/k/a NAYAL J. SAYEGH, and YONKERS UROLOGY,  
P.C.,

Defendants.

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The following papers numbered 1 to 16 were read on these motions:

<u>Paper</u>	<u>Number</u>
Notice of Motion, Affirmations and Exhibits	1
Memorandum of Law	2
Statement of Material Facts	3
Notice of Motion, Affirmations and Exhibits <sup>1</sup>	4
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<sup>1</sup>In future, parties should not upload multiple copies of identical exhibits, but should merely refer to the exhibit number used by the first party to upload the same document.

Memorandum of Law in Opposition	10
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There are two motions for summary judgment before the Court. The first is filed by Defendants Dr. Nayal J. Sayegh and Yonkers Urology, P.C. (collectively, the "Sayegh defendants"). The second is filed by defendant Saint Joseph's Medical Center (the "hospital"). Plaintiff previously dismissed Dr. Yamashita from the action.

#### Background

Decedent had been having certain urological problems when she went to see the Sayegh defendants. After several consultations, they decided that decedent would have surgery performed by Dr. Sayegh at the hospital on an "ambulatory" basis. The plan was that decedent would stay in the hospital for approximately 23 hours. After that she would go home, returning to see the Sayegh defendants in the office on the third day after surgery, a Friday.

To clear her for the surgery, the Sayegh defendants gave decedent a list of instructions which included that she was to

stop any anticoagulants one week prior to the surgery. She was also to obtain clearance from her primary care doctor, Dr. Nasem James Sayegh (defendant Sayegh's brother) (the "primary care doctor"). Because of a history of two pulmonary embolisms, decedent took two different forms of anticoagulation medication (aspirin and Pradaxa), as prescribed by the primary care doctor and her cardiologists. The primary care doctor had decedent go to see her cardiologist for pre-surgery clearance as well. In the cardiologist's notes, she wrote "Recommend follow up with PMD [primary medical doctor] or pulmonary to manage perioperative [around the time of surgery] anticoagulation given pulmonary embolisms."

Decedent did stop the two anticoagulants for a week prior to the surgery. There is no dispute that Dr. Sayegh performed the surgery uneventfully. There is also no dispute that decedent suffered "minimal" blood loss during the surgery. Thereafter, however, decedent complained of pain. Dr. Sayegh requested that a hospitalist see her. The hospitalist, non-party Dr. Christopher Cotroneo, saw decedent and decided to admit her to the hospital for further observation. His notes from that day (the only day that he saw decedent) state that she had a history of pulmonary embolism (abbreviated as "PE") and that she "[h]ad a PE x 2 two years ago. The 2nd PE was when she was off anticoagulation. Plan: Pradaxa held for surgery. . . but should

be restarted as soon as possible when ok from surgical perspective." He also wrote that "Pradaxa on hold preop, will not start today. If ok with surgery would start tomorrow given [history of] PE x 2." The note did not mention aspirin, which decedent also took along with the Pradaxa.

The next day, non-party Dr. Rita Shah was the hospitalist treating decedent. Although decedent complained of abdominal pain, nausea and vomiting, she denied chest pain or shortness of breath. Nor was there swelling in her legs. Dr. Shah also wrote that "Pradaxa held for surgery. . . but should be restarted as soon as possible when ok from surgical perspective." Dr. Shah also ignored the aspirin. There is no evidence at that time that Dr. Shah tried to determine if decedent was "ok from surgical perspective."

The following day, a nurse removed the surgical packing. About an hour later, decedent complained of dizziness and nausea. Dr. Shah later saw decedent, and noted that she did not complain of chest pain or shortness of breath, and her legs were not swollen. Dr. Shah's note was similar to her note from the previous day, but also stated that "As per discussion with Dr. N. Sayegh, hold Pradaxa until seen by his office on Monday. . . . but should be restarted as soon as possible when ok from surgical perspective." The Sayegh defendants state categorically that decedent was supposed to see them on Friday, not Monday. Dr.

Sayegh also testified at his deposition that he **never** spoke to Dr. Shah at any time about anything involving decedent. Further, they point out that the note is not clear as to whether it refers to them or to decedent's primary care doctor - who is also Dr. N. Sayegh. Dr. Shah was never asked to clarify whether she meant that she had spoken to the primary care doctor or defendant Dr. Sayegh (which, as noted, he vehemently denies having done). There is no indication that Dr. Shah or anyone else at the hospital ever attempted to determine whether decedent was "ok from surgical perspective" in order to restart her two anticoagulants.

On Friday, as previously scheduled for an in-office visit, Dr. Sayegh saw decedent in the hospital and removed her catheter. He did not make any notes in her chart. Later that day, Dr. Shah saw her. Her notes from that visit are virtually identical to those from the two previous days. Again, no one at the hospital made any attempt to determine whether decedent should restart her anticoagulants.

That night, just after midnight, a nurse took decedent's vital signs. Both the Sayegh defendants' and plaintiff's experts agree that the vitals were alarming, with a blood pressure of 101/61, a pulse of 115 bpm, respirations of 24 bpm and oxygen

saturation on room air at 80%.<sup>2</sup> Notwithstanding these unusual numbers, the nurse did not alert a doctor or take any further steps. That morning at around eight a.m., hospital staff found decedent on the bathroom floor.

The hospitalist on duty, former defendant Dr. Yamashita, determined that decedent's oxygen saturation was then 77%, and gave her oxygen. Dr. Yamashita ordered a cardiology consultation, but soon after, the patient became unresponsive. Although Dr. Yamashita and the hospital staff administered lifesaving measures, decedent was pronounced dead at 9:12 a.m. by Dr. Yamashita.

The day after decedent's death, and two days since she had last seen her, Dr. Shah added another note to the file. She noted that decedent had a history of pulmonary embolism, and that restarting her "on Pradaxa vs Heparin gtt was addressed with surgeon during the course of this hospitalization; however, Dr. Sayegh noted that [decedent] had significant blood loss during surgery and recommended to hold an AC or Heparin gtt until she were to be seen in the office on 6/13/16." Again, as stated,

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<sup>2</sup>Given the pandemic, and the widespread discussions in the mainstream media about oxygen saturation rates, it is common knowledge that this is a very low and worrisome percentage. See *Carter v. Metro N. Assocs.*, 255 A.D.2d 251, 251, 680 N.Y.S.2d 239, 240 (1<sup>st</sup> Dept. 1998) ("A court may only apply judicial notice to matters of common and general knowledge, well established and authoritatively settled, not doubtful or uncertain. The test is whether sufficient notoriety attaches to the fact to make it proper to assume its existence without proof. The fact at issue must be generalized knowledge as is so notorious as not to be the subject of reasonable dispute.").

there is no evidence that Dr. Shah ever spoke to the Sayegh defendants (or, for that matter, any evidence that Dr. Shah ever spoke to the primary care doctor, also named Dr. Sayegh). There is also no basis for Dr. Shah's statement that decedent "had significant blood loss during surgery" since the evidence demonstrates that she actually had minimal blood loss.

#### Analysis

"In determining a motion for summary judgment, the court must view the evidence in the light most favorable to the nonmoving party. The function of the court on a motion for summary judgment is not to resolve issues of fact or determine matters of credibility, but merely to determine whether such issues exist. Summary judgment is a drastic remedy which should only be employed when there is no doubt as to the absence of triable issues. Generally, the elements of a cause of action sounding in negligence are: (1) the existence of a duty on the defendant's part as to the plaintiff; (2) a breach of this duty; and (3) an injury to the plaintiff as a result thereof. In order to establish the liability of a physician for medical malpractice, a plaintiff must prove that the physician deviated or departed from accepted community standards of practice, and that such departure was a proximate cause of the plaintiff's injuries." *Stukas v. Streiter*, 83 A.D.3d 18, 22-23, 918 N.Y.S.2d 176, 180 (2d Dept. 2011).

Here, the Sayegh defendants have established their prima facie burden. *Keesler v. Small*, 140 A.D.3d 1021, 1023, 35 N.Y.S.3d 356, 359 (2d Dept. 2016) (“In an action sounding in medical malpractice, a defendant moving for summary judgment must make a prima facie showing either that there was no departure from accepted medical practice, or that any departure was not a proximate cause of the patient’s injuries.”). Their expert, a board-licensed urologist, establishes, prima facie, that the Sayegh defendants appropriately diagnosed decedent’s urological problem, made the appropriate disclosures, obtained an informed consent, and had her obtain the appropriate pre-surgical clearances from her primary care doctor and cardiologist. Their expert also establishes that Dr. Sayegh performed the surgery competently, and that his post-surgery instructions were appropriate. He also finds that when decedent complained of pain, Dr. Sayegh appropriately sought the advice of a hospitalist. The expert then states that once decedent was admitted to the hospital, “Dr. Sayegh, as a urologist, would appropriately rely on the evaluation and anticipated treatment of Ms. Bayon-Martinez by the hospitalists. It was appropriate for Dr. Sayegh to expect the hospitalists to manage her day-to day medical care and render the appropriate treatment they saw fit.” The Sayegh defendants’ expert states that “Dr. Sayegh was responsible to follow her in the hospital from a urology

standpoint, as the consulting urologist. His responsibility to Ms. Bayon-Martinez was to make recommendations regarding urology care to the hospitalists and render urological care and treatment. . . ." He also states that "As to Plaintiff's claims regarding the management of Ms. Bayon-Martinez's blood thinning medication and development of deep vein thrombosis or pulmonary embolism, it is my opinion, to a reasonably degree of medical certainty, that Dr. Sayegh was not involved with the care and treatment related to this, nor did he have a duty to be, and this was consistent with the standard of care. Instead, it is my opinion that once the hospitalists admitted the patient to the hospital, it was the hospitalists' responsibility to manage Ms. Bayon-Martinez's Pradaxa and aspirin and to determine when such medication should be restarted." The expert states that it was the hospitalists' responsibility to "consult with the appropriate physicians in order to develop a plan to restart [decedent's] anticoagulation medication." He notes that the preoperative clearance also stated that the primary care doctor should be consulted about restarting Pradaxa after the surgery and that decedent should be on aspirin perioperatively." He further finds that there were "no contraindications to restarting her anticoagulation medication from a surgical perspective because the blood loss during surgery was minimal (50 ccs)," which was apparent from the chart. The Sayegh defendants' expert concludes

that since the hospitalists were managing decedent's care, it was their "responsibility to further investigate to determine whether her Pradaxa should be restarted, especially in light of their reiterated opinion that it should be restarted. At the very least, Dr. Shah should have ordered a consultation with a specialist such as a cardiologist to determine whether such medication could be restarted." Dr. Sayegh "is a urologist, and as such he does not diagnose or treat deep vein thrombosis or pulmonary embolism. He does not manage blood thinning medication. A physician is not required to treat outside their specialty, particularly when another physician is treating the patient, who is of the specialty that would manage the medication at issue or treat the suspected disease. Here, as soon as Ms. Bayon-Martinez was admitted, the hospitalists, provided by SJMC, took over her general medical care, including management of her medications." This suffices to establish the Sayegh defendants' prima facie burden. See *Parrilla v. Buccellato*, 95 A.D.3d 1091, 1092-93, 944 N.Y.S.2d 604, 605 (2d Dept. 2012) (Contrary to the plaintiff's contention, the appellant's responsibility for the decedent ended when his care was transferred to another attending physician.").

"Once this showing has been made, the burden shifts to the plaintiff to submit evidentiary facts or materials to rebut the defendant's prima facie showing, but only as to those elements on

which the defendant met the prima facie burden." *Uchitel v. Fleischer*, 137 A.D.3d 1111, 1112, 27 N.Y.S.3d 668, 669 (2d Dept. 2016). The Second Department has explained that "Although conflicting expert opinions may raise credibility issues which can only be resolved by a jury, expert opinions that are conclusory, speculative, or unsupported by the record are insufficient to raise triable issues of fact. In order not to be considered speculative or conclusory, expert opinions in opposition should address specific assertions made by the movant's experts, setting forth an explanation of the reasoning and relying on specifically cited evidence in the record. An expert opinion that is contradicted by the record cannot defeat summary judgment." *Wagner v. Parker*, 172 A.D.3d 954, 955, 100 N.Y.S.3d 280, 282 (2d Dept. 2019).

Plaintiffs submit to the Court expert reports from a board-certified urologist, Dr. Brodherson; a board-certified vascular surgeon, Dr. Weingarten, (who does not practice in New York); and a board-certified internist, Dr. Olin, (who practices in Connecticut, but has been on the faculty at Columbia for over 20 years). Dr. Olin's affirmation is telling. He states unequivocally that it was the hospitalists' responsibility to oversee decedent's medication, stating that the hospitalists failed to order consultations with any specialist or testing to see whether the blood thinners should be restarted. With respect

to Dr. Shah, "There is no medical explanation of what she believed urologist Dr. Neil Sayegh's rationale was for not wanting to restart anticoagulation therapy. . . . While hospitalists Dr. Shah and Dr. Cotroneo stated in their notes they were waiting for surgical authorization, they were required to treat this extremely high-risk patient." Moreover, Dr. Olin observed that there was no "note or reference in the chart to any postsurgical complications or bleeding that would make anticoagulation therapy contraindicated. In fact, based on her history, it was just the opposite - the therapy was required to have been started on admission and continued every day thereafter. Even assuming urologist Dr. Neil Sayegh had some objection or issue restarting anticoagulation, hospitalists Dr. Shah and Dr. Cotroneo were required to know the real and foreseeable dangers of this extremely high-risk patient being off anticoagulation for over a week, and of failing to resume anticoagulation. As the attendings in charge of her care, they had an independent obligation to act. If concerned or uncertain, they could have sought consultation with a vascular specialist, pulmonologist, cardiologist, or even a hematologist." Dr. Olin makes it quite clear that in his expert opinion, it was the hospitalists, not the Sayegh defendants, who were responsible for determining when to restart decedent's medications. Dr. Weingarten's affirmation is much of the same.

The affirmation of Dr. Brodherson, plaintiff's urologist, is filled with assumptions and misstatements. For example, he states that "the hospital chart notes **daily requests of urology** for clearance concerning the resumption of Pradaxa." (Emphasis added). In fact, there is no indication that anyone at the hospital ever contacted the Sayegh defendants to request information or clearance about the anticoagulants or anything else. Next, Dr. Brodherson states that "Urologist Dr. Neil Sayegh dangerously undercut the opinions of both hospitalists who were regularly seeing Mirna Bayon Martinez and had considered the correct treatment plan. Although urologist Dr. Neil Sayegh flatly believes that after the postoperative transfer he bore no patient responsibility, he then irresponsibly withheld the required anticoagulation that would have prevented her pain and suffering and death." The reality is that there is **no** evidence that Dr. Sayegh "undercut" the hospitalists' opinions, nor that he "withheld the required anticoagulation." Additionally, Dr. Brodherson states that the post-death note referred to "urologist Dr. Neil Sayegh," when instead the note did not make it clear to which Dr. Sayegh she was referring. These are just some of the multiple misstatements contained in his affirmation that make it insufficient to rebut the Sayegh defendants' prima facie showing. *Wagner*, 172 A.D.3d at 955, 100 N.Y.S.3d at 282 ("The expert affidavit proffered by the plaintiff relied upon facts that were

not supported by the record and, thus, was speculative and conclusory and insufficient to defeat the defendants' motion for summary judgment.").

Not only is this affirmation unreliable because of these serious mischaracterizations of the evidence, but Dr. Brodherson also fails to give a scientific basis for his statement that "As a surgeon, a urologist is required to be part of the management of anticoagulant therapy postoperatively." See *Tsitrin v. New York Cmty. Hosp.*, 154 A.D.3d 994, 996, 62 N.Y.S.3d 506, 509 (2d Dept. 2017). The records submitted to the Court make it clear that in this case, it was decedent's primary care doctor, cardiologist and/or pulmonologist who were responsible for prescribing her anticoagulation medications, not her urologist.<sup>3</sup>

The Court finds that plaintiff failed to rebut the Sayegh defendants' prima facie showing. *Pirri-Logan v. Pearl*, 192 A.D.3d 1149, 145 N.Y.S.3d 545, 548 (2d Dept. 2021). Accordingly, their motion for summary judgment is granted and they are dismissed from the action.

The same does not apply to the hospital. Putting aside all of the instances in which the hospitalists stated that they were waiting for decedent to be "ok from surgical perspective" to

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<sup>3</sup>To the extent that Drs. Brodherson and Weingarten state in their reports that Dr. Sayegh should have postponed the surgery, this is a new argument that was not spelled out in any of the multiple Bills of Particulars. For this reason, it must be rejected.

restart the anticoagulation, without actually seeking a "surgical perspective," there is another issue that the Court finds deeply troubling. That is decedent's alarming vital signs just after midnight on the day of her death. There is no dispute that these numbers were unusual; indeed, as noted, even a layperson knows these days that an 80% oxygen saturation is noteworthy. Yet the nurse who took these vital signs did not alert anyone or take any steps to treat decedent. Nine hours later, decedent was pronounced dead.

The hospital's expert completely omits the alarming vital signs just after midnight from his discussion of the facts. He simply fails to account for this evidence in his analysis. "Thus, the expert affirmation failed to eliminate all triable issues of fact as to whether the failure to monitor [decedent] during this period constituted a departure from good and accepted medical practice and whether [decedent's] respiratory distress and death were due to the lack of proper monitoring and timely treatment." *Macias v. Ferzli*, 131 A.D.3d 673, 676, 15 N.Y.S.3d 466, 470 (2d Dept. 2015). As a result, the Court finds that the hospital "failed to make a prima facie showing of [its] entitlement to judgment as a matter of law dismissing the cause of action alleging medical malpractice insofar as asserted against [it], since [it] failed to tender sufficient evidence to eliminate all triable issues of fact."

*Duncan v. E. Women's Ctr., Inc.*, 121 A.D.3d 831, 832, 994 N.Y.S.2d 658, 660 (2d Dept. 2014). "Since the defendant failed to meet its prima facie burden, we need not consider the sufficiency of the opposition papers" with respect to the hospital's motion. *Wesolowski v. St. Francis Hosp.*, 175 A.D.3d 1461, 1463, 108 N.Y.S.3d 180, 182 (2d Dept. 2019). The Court thus denies the motion for summary judgment filed by the hospital.

The parties are directed to appear for a Settlement Conference in the Settlement Conference Part, at a time to be scheduled by that Part.

The foregoing constitutes the decision and order of the Court.

Dated: White Plains, New York  
September 9, 2021



HON. LINDA S. JAMIESON  
Justice of the Supreme Court

To: Keith D. Silverstein & Associates, P.C.  
Attorneys for Plaintiff  
40 Fulton Street, 7<sup>th</sup> Floor  
New York, New York 1003

Heidell, Pittoni et al.  
Attorneys for Sayegh Defendants  
81 Main Street  
White Plains, New York 10601

Vouté, Lohrfink et al.  
Attorneys for the Hospital  
170 Hamilton Avenue  
White Plains, New York 10601