Wichmann v Evers
2021 NY Slip Op 33462(U)
June 30, 2021
Supreme Court, Orange County
Docket Number: Index No. EF003399-2019
Judge: Robert A. Onofry

SUPREME COURT-STATE OF NEW YORK
IAS PART-ORANGE COUNTY

Present: HON. ROBERT A. ONOFRY, J.S.C.

SUPREME COURT : ORANGE COUNTY

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ALICIA WICHMANN, AS EXECUTOR OF THE ESTATE OF MINNIE CONKLIN, DECEASED,

Plaintiff,

- against –

MARTIN EVERS M.D., TALAT HMOUD M.D., PETKO TATARSKI M.D. AND BON SECOURS COMMUNITY HOSPITAL,

Defendants.

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To commence the statutory time period 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.

Index No. EF003399-2019

DECISION AND ORDER

Motion Date: May 5, 2021

The following papers numbered 1 to 7 were read and considered on a motion by the Defendants Talat Hmoud, M.D. and Petko Tatarski, M.D., pursuant to CPLR 3212, for summary judgment dismissing the complaint insofar as asserted against them.

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Upon the foregoing papers, it is hereby,

ORDERED, that the motion is granted.

Introduction

On May 16, 2017, the decedent, Minnie Conklin, then 81years of age, died at the Defendant Bon Secours Community Hospital (hereinafter "Bon Secours") in Port Jervis, New York, in Orange County.

The Plaintiff Alicia Wichman, as executrix of her estate, commenced this action to

recover damages for medical malpractice against the Defendants Martin Evers M.D. (hereinafter "Dr. Evers"), Talat Hmoud M.D. (hereinafter "Dr. Hmoud"), Petko Tatarski M.D. (hereinafter "Dr. Tatarski") and Bon Secours.

In a bill of particulars, the Plaintiff alleges the following injuries, all of which are claimed to be permanent in nature and to have caused or contributed to the decedent's death– cardiac arrest; cardiomegaly [enlarged heart][1]; hypervolemia [too much fluid in the blood]; irregular heart rate; respiratory arrest and/or failure; edema [excess fluid trapped in a body's tissues]; irregular bowel; discomfort; sepsis and aggravation of sepsis [when the body's response to an infection damages its own tissues, which may cause organs to function poorly and abnormally]; and fear of imminent death.

Dr. Hmoud and Dr. Tatarski, an emergency room doctor and a hospitalist, respectively, initially examined and admitted the decedent to Bon Secours.

Dr. Evers, her primary care doctor, took over her care the morning after her admission.

The case has been settled as against the Dr. Evers and Bon Secours.

The remaining Defendants, Dr. Hmoud and Dr. Tatarski, move for summary judgment dismissing the complaint insofar as asserted against them.

The motion is granted.

Factual and Procedural Background

In the complaint, the Plaintiff alleges that the Defendants were negligent in lacking and/or failing to utilize requisite knowledge and skills for the care of the decedent's respiratory,

[1] All bracketed definitions found at https://www.mayoclinic.org.

infectious and cardiac issues; in failing to timely consult with a provider possessing such necessary knowledge and skills; in failing to adequately examine the patient; in failing to administer necessary medications; in failing to perform and/or properly interpret diagnostic studies; in failing to adequately monitor the patient; in failing to adequately respond to family members regarding the patisat's distress; in failing to adequately respond to the patient's calls and sounds of distress; in failing to timely and aggressively intervene in the patient's cardiac/respiratory crisis; in failing to timely implement physician orders; in failing to provide adequately skilled and trained nursing staff; in failing to promulgate and/or to enforce necessary https://www.mayoclinic.org/ protocols and procedures for patient monitoring and intervention; and were otherwise negligent, reckless and careless.

Dr. Hmoud and Dr. Tatarski move for summary judgment seeking dismissal of the complaint insofar as asserted against them.

In support of the motion insofar as it concerns Dr. Hmoud, the movants submit an affirmation from Rahul Sharma, M.D., MBA, FACEP.

Sharma asserts that he is licensed to practice medicine within the State of New York and is Board Certified in Emergency Medicine. He is currently a Professor and Chairman of the Department of Emergency Medicine at New York Presbyterian-Weill Cornell Medicine in New York.

Sharma avers that, based on his review of all relevant records and documents in the action, he can state, to a reasonable degree of medical certainty, as follows.

On May 14, 2017, the decedent presented to the emergency room at Bon Secours.

Dr. Hmoud was the emergency room physician who initially examined the decedent and

admitted her to the hospital.

The decedent was then treated by Dr. Tatarski, a hospitalist, until the following morning, when her care was transferred to the care of Dr. Evers, her primary care physician.

The decedent died on May 16, 2017, from cardiac arrest and sepsis.

Dr. Hmoud's care for the decedent was approximately 2.5 hours from her arrival to her admission. After she was admitted, Dr. Hmoud had no further interaction with her.

Sharma notes that the Plaintiff's allege that Dr. Hmoud failed to diagnose and treat the decedent's "hypervolemia [dehydration], heart failure and sepsis."

Further, there are theories of recovery based on the purported inadequacy of medication administration and improper "intravenous fluids," as well as the alleged failure to contact or consult with specialists in infectious disease and cardiology.

The relevant facts are as follows.

The decedent presented at the Emergency Room at 1:59 p.m. She complained of abdomen pain that had started 1to 2 hours prior. The intensity is not listed in the her charts, but she was not in acute distress according to Dr. Hmoud's testimony.

There were no obvious abnormalities noted in the examination.

Dr. Hmoud testified that his customary and usual practice with a new patient included inquiry into the chief complaint, the reason for appearance at the emergency room, review of the patient's past medical history, medication background and prior hospitalizations.

Dr. Hmoud ordered lab work. The decedent's electrolytes were normal, but her white blood count was elevated at 24.2.

Dr. Hmoud appropriately ordered a CT scan of the abdomen with IV contrast, which

revealed colitis of the descending colon and infrarenal abdominal aortic aneurysm increased in size compared to the prior examination, but without evidence of dissection or leakage.

Based on these laboratory results, the scans and his examination, Dr. Hmoud requested that the decedent be admitted to the hospital.

Sharma opines that this process of examination, history and admission fully conformed with all good and accepted standards of emergency department medical care.

Indeed, Sharma opines, the Plaintiff's allegation that Dr. Hmoud negligently failed to obtain heightened patient monitoring is misplaced. Rather, that the decedent required additional monitoring is precisely why Dr. Hmoud appropriately admitted her to the hospital.

Further, he opines, there is nothing in the record to indicate that, during Dr. Hmoud's treatment of the decedent, she had chest pain, palpitations, irregular heart rate or shortness of breath. Thus, the allegations that he failed to observe these signs and symptoms are without merit.

Dr. Hmoud also ordered a broad spectrum antibiotic – Invanz. This was due to the decedent's elevated white blood count, which is consistent with the presence of an infection. Given that the decedent had a history of sepsis, and could be going into septic shock, Dr. Hmoud prescribed Invanz to begin to treat any infection. Sharma opines that Invanz is an appropriate first line antibiotic for colitis, and that, until further cultures and tests were returned, it could be determined whether the decedent was in fact suffering from an infection that a broad-spectrum antibiotic like Invanz would not cover. Dr. Hmoud prescribed an antibiotic that would cover what he surmised her diagnosis to be. Accordingly, Sharma opines, there is no merit to the allegation that Dr. Hmoud's antibiotic treatment did not conform with the standard of care.

The Plaintiff also alleges a purported improper administration (or discontinuance) of the decedent's use of Lasix. However, Sharma asserts, the records and testimony reveal that Dr. Hmoud was not involved in any decisions relating to the same. Indeed, he opines, such a decision would not have been made during the initial 2.5 hour period the decedent was in the emergency room.

Further, Sharma opines, Dr. Hmoud did not order unnecessary and excessive IV fluids for the decedent. Rather, Dr. Hmoud started IV fluids after he received the report of an elevated white blood count, which could be from an infection. Further, the decedent had a history of sepsis, and he was concerned about her going into septic shock. Sharma opines that the decedent's history and signs of dehydration, as well as the likelihood of sepsis and the absence of bowel movements, were all indicative of the need for IV fluid administration. Further, the decedent was having abdominal pain, and required to some type of fluid replacement to avoid going into kidney failure and to prevent further dehydration. As she was "NPO" [nothing by mouth], she was not able to drink any fluids. Thus, Sharma opines, it was appropriate to administer IV fluids to hydrate the decedent.

The Plaintiff also alleges that Dr. Hmoud improperly failed to "timely consult with and refer" the decedent to specialists, including a cardiologist and an infectious disease specialist. However, Sharma opines, during the limited period of Dr. Hmoud's interaction with the decedent, her symptoms, history and medical condition did not represent signs or symptoms requiring cardiologic review. Rather, Dr. Hmoud's examination revealed that her heart rate was normal, with a regular rhythm and normal heart sounds, and that there was no gallop or friction

rub present. Thus, Sharma opines, referral to cardiology specialist was not medically indicated.

Dr. Hmoud found a tentative diagnosis of sepsis. Based on his examination and findings, his diagnosis was acute colitis. Sharma opines that, because the existence of sepsis was already considered, and an antibiotic medication prescribed, there is no basis for a claim of inadequate referral. Rather, he opines, based on the course of care and the decedent's condition, and based on the fact that she was already provided with an antibiotic regimen of medication, referral to infectious disease specialists was not medically indicated.

In sum, Sharma opines, based on all of the facts, there is no medical basis to find that Dr. Hmoud's care and treatment of the decedent caused or contributed to her death. Rather, she was being monitored, and her vital signs, breathing time, and oxygenation were all acceptable. She was not in any distress and was hemodynamically stable[2] at the time she was admitted to Bon Secours until Dr. Hmoud's care and treatment ceased. Thus, Sharma opines, to a reasonable degree of medical certainty, the decedent's medical course and outcome were not in any medically significant manner changed by any alleged malpractice claimed against Dr. Hmoud.

Rather, based on the very short (2.5 hour) period of emergency room involvement by Dr. Hmoud in the decedent's care, it was Sharma's opinion, to a reasonable degree of medical certainty, that the claim that any different conduct on the part of Dr. Hmoud would have somehow changed the course of the decedent's medical condition was pure speculation.

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[2] "Haemodynamic stability is the medical term used to describe a stable blood flow. If a person is hemodynamically stable, it means that he/she has a stable pumping heart and good circulation of blood."
https://indianexpress.com/article/lifestyle/health/haemodynamic-stable-meaning-signs-symptoms-6552730

In sum, Sharma avers, based on his review of the facts, it was his opinion, to a reasonable degree of medical certainty, that Dr. Hmoud did not depart from the relevant duty of care during the his "extremely limited involvement" in the care and treatment of the decedent, but rather, satisfied all applicable emergency room standards of care. Specifically, Sharma opines, in the absence of any evidence that the decedent's care was mismanaged in any manner by Dr. Hmoud, it was his opinion, to a reasonable degree of medical certainty, that the claim that any further or different testing, diagnosis or other care by Dr. Hmoud would have somehow changed the course of the decedent's medical condition and result were devoid of merit.

As to the branch of the motion as concerns Dr. Tatarski, the movants submit an affirmation from Jill Slater Waldman, M.D., SFHM.

Waldman asserts that she is licensed to practice medicine in New York and Connecticut, and is Board Certified in Internal Medicine. She is currently a Hospitalist at Yale New Haven Hospital.

Waldman avers that, based upon her review of the relevant medical records and the pleadings, she determined as follows.

Dr. Tatarski works at Bon Secours as a hospitalist. His duties involve admitting, following and discharging patients. He also admits patients belonging to private physicians, who then assume responsibility for the patient; usually the next morning.

Here, Dr. Tatarski was working a night shift and admitted the decedent. Her care was endorsed to her primary care physician less than 16 hours later.

Dr. Tatarski's began work on May 14, 2017, at 5:00 p.m. He went to the emergency room where Dr. Hmoud informed him that the decedent, an elderly lady, was complaining of severe

abdominal pain. Based on laboratory tests and a CT scan, it was determined that the decedent had acute colitis.

Dr. Tatarski admitted the decedent on behalf of her primary care physician, [former Defendant] Dr. Evers. Dr. Tatarski cared for the decedent until Dr. Evers took over the next morning.

Once assigned the decedent, Dr. Tatarski learned that she had severe abdominal pain, felt constipated and had received an enema prior to coming to the hospital. He reviewed her vitals and conducted a full physical exam. His pertinent findings included that she was in a significant amount of pain and had abdominal tenderness and suprapubic tenderness.

Waldman notes that the Plaintiff's allegations against Dr. Tatarski fall into three basic categories, to wit: that Dr. Tatarski failed to "diagnose ...decedent's hypervolemia, heart/failure and sepsis"; that he failed to "aggressively intervene in the management of the decedent's life-threatening conditions including hypervolemia, heart failure and sepsis"; that he failed to properly observe, record or assess the decedent's signs and symptoms of hypovolemia, sepsis and cardiac arrest.

Further, the Plaintiff alleges, there was inadequate treatment based on improper administration of medication, including "failing to timely administer aggressive diuresis," failing to "timely administering intravenous antibiotics," failing to "discontinue or adjust the administration of sodium chloride" and the alleged improper termination of Lasix use.

Finally, the Plaintiff alleges that Dr. Tatarski failed to "timely consult with and refer" the decedent to "a cardiologist and/or specialist in infectious disease...."

However, Waldman opines, to a reasonable degree medical certainty, none of the

allegations of malpractice by Dr. Tatarski are supported by the facts.

Waldman avers as follows.

Based on all of the information available, a treatment plan was designed to treat the decedent's for the diagnosis of acute colitis. Dr. Tatarski properly identified that the decedent had an elevated white blood count, and continued the administration of antibiotics (Invanz), which is an appropriate first line antibiotic for colitis. It was only after further cultures and tests were conducted could it be determined whether the decedent was in fact suffering from an infection that a broad-spectrum antibiotic like Invanz would not cover. Thus, she opines, Dr. Tatarski's conduct conformed to the standard of care.

Further, she opines, the extent and timing of administration of IV fluids conformed with all good and accepted standards. That is, the decedent's history and signs of dehydration, as well as the likelihood of sepsis and the absence of bowel movements, were all indicative of the need for IV fluid administration. She required some type of fluid replacement to avoid going into kidney failure and prevent further dehydration. As she was NPO, she was not able to imbibe fluids orally. Thus, Waldman opines, there is no merit to the allegation that Dr. Tatarski's administration of IV fluids did not conform with the standard of care.

Further, based on his assessment that the decedent seemed clinically dehydrated, Dr. Tatarski prescribed gentle hydration and dilaudid for pain. The decedent also arrived at the hospital with 17 medical conditions, which Dr. Tatarski continued to monitor. Appropriate medical care includes ensuring a patient is comfortable if he or she is experiencing pain. Accordingly, she opines, Dr. Tatarski properly prescribed dilaudid for the pain.

Further, Waldman notes, there is no indication that there were any complaint to the nurses

about the decedent requiring immediate attention. That is, there are no nursing notes stating that the decedent was decompensating or needed additional monitoring.

Thus, she opines, there is no merit to the allegation that Dr. Tatarski's monitoring did not conform with the standard of care.

Further, she notes, according to the medical records reviewed by Dr. Tatarski, the decedent was on the diuretic medication Lasix at home. Waldman opines that, due to the decedent's clinical dehydration and overall medical status, Dr. Tatarski properly determined that the decedent needed IV hydration. That is, under such circumstances, the temporary discontinuance of Lasix conformed with good and accepted medical practice. Moreover, she notes, it was Dr. Tatarski's expectation that the decedent would be reevaluated after 7:00 a.m. by her primary care physician (Dr. Evers), who would decide when and if it was appropriate to restart the Lasix. In fact, Dr. Evers assumed the role of the physician in charge of the patient's care and treatment at 7:00 a.m. on May 15, 2017.

Otherwise, she opines, the course of treatment prescribed by Dr. Tatarski was appropriate for the decedent's complaints, to wit: he started her on heparin, conforming with the accepted protocol for patients who are admitted to prevent the development of a deep vein thrombosis; he prescribed hydromorphone for her severe pain, and prescribed antibiotics and hydration to treat the colitis and leukocytosis. Waldman opines that there was no indication that the Plaintiff required plasma. Thus, she opines, not ordering plasma did not depart from good and accepted medical practice.

Indeed, she asserts, at the time of Dr. Tatarski's examination, the decedent was suffering from 17 conditions, and the issue which precipitating her admission to the hospital was acute

colitis. She opines that Dr. Tatarski appropriately considered sepsis in the diagnoses. Sepsis is defined as "life-threatening organ dysfunction caused by a dysregulated host response to infection." End organ damage is identified as an acute change in total Sequential [Sepsis-related] Organ Failure Assessment score (SOFA) 22. Based on the standard of care at the time of admission, she opines, the decedent did not meet the criteria for such a diagnosis. However, she notes, Dr.Tatarski nonetheless recognized the possibility that it could develop, which was consistent with good and accepted standards insofar as, at that time, he did not have all the criteria needed to determine definitively if she had sepsis.

Further, she opines, based on the records and testimony, there was no need for Dr. Tatarski to have ordered any additional studies, as all requisite tests and studies had been ordered.

In addition, she opines, Dr. Tatarski did not depart from good and accepted medical practice in failing to order consultations, including with cardiology and infectious diseases. Rather, she opines, during the time of his treatment, the decedent's symptoms, history and medical condition did not represent signs or symptoms requiring cardiologic or infectious disease review. Her vital signs were stable and she was not in any distress.

Further, she asserts, it is also important to note that, at all times during Dr. Tatarski's treatment, the existence of sepsis was already considered, and the decedent was in fact placed on antibiotic medication. Thus, she opines, referral to infectious disease specialists would be redundant and unnecessary. Rather, the appropriate initial interventions were arranged before Dr. Tatarski transferred the decedent's care to her primary care physician.

Indeed, she opines, in general, the care provided by Dr. Tatarski during the short period

he was responsible for the decedent was entirely consistent with good and accepted practices. Moreover, she notes, the decedent was hemodynamically stable when Dr. Tatarski's care and treatment ceased and Dr. Evers' treatment commenced, and her condition did not change until after she was in the care of Dr. Evers. It was only then that the decedent began to experience shortness of breath. Thus, Waldman opines, the decedent's medical course, and outcome, were not in any medically significant manner changed by virtue of the alleged malpractice claimed against Dr. Tatarski.

In sum, Waldman opines, the Plaintiff's allegations of negligence as against Dr. Tatarski on the basis of purportedly inadequate examination, testing, diagnosis, medication and care provided to the decedent all lack factual and medical merit.

In opposition to the motion, the Plaintiff submits an affirmation from Aymen Elfiky, M.D.

Elfiky asserts that he is a duly licensed in New York and Massachusetts, and holds various degrees. Currently, he is the faculty staff physician in medical oncology and internal medicine at Mount Auburn Hospital in Cambridge, Massachusetts.

Concerning the allegations at bar, Elfiky notes that Dr. Hmoud acknowledged the decedent's history of sepsis - which made her a high-risk patient - and started her on antibiotics. However, Elfiky opines, "[t]here is never a reason to assume that once a patient is started on antibiotics that they are, so to speak, 'in the clear'." Rather, he asserts, in a patient such as the decedent, the case remains urgent/emergent, given that an antibiotic does not have the immediate effect of countering an infection and the body's response to an active infection. During such a time, the patient can decompensate, which is what happened to the decedent.

Further, he opines, the antibiotic prescribed (Invanz) did not conform to the accepted standard of medical care. Rather, the decedent was a high-risk patient presenting with a systemic infection. At the time the Invanz was started, blood cultures had not been returned which would reveal a specific organism. In such a situation (a high risk patient with a systemic infection with an unidentified source), Elfiky opines, the standard of care requires a dual antibiotic to truly cover the broad spectrum of dangerous bacteria. This, he asserts, is because the initial hours in the ER, and how quickly the patient is started on the appropriate antibiotics, are the most critical to a patient's survival. Elfiky asserts that, while "Ivanz does cover a wide spectrum of invasive bacterial pathogens, it does NOT cover other important pathogens such as methicillin-resistant Staphylococcus aureus (MRSA), enterococci, Pseudomonas aeruginosa and Acinetobacter baumannii. Patients presenting to the ER with an infection such as that exhibited by the decedent should be started on Vancomycin to truly cover the whole spectrum of dangerous bacteria." Thus, he opines, it was a deviation from the accepted standard of medical care not to start the decedent on Vancomycin.

On a separate issue, he asserts, regarding fluid status and management, patients such as the decedent, who present to an emergency department with evidence of a systemic infection, are started on IV fluid hydration. Here, the decedent was started on IV fluids. "This was appropriate as far as it goes." However, Elfiky asserts, this does not negate the necessity of being cognizant of and monitoring for fluid overload. Here, he opines, there is no evidence that Dr. Hmoud monitored for fluid overload. Indeed, Elfiky asserts, this is especially important in the case of a patient such as the decedent, known to be on Lasix. Thus, he opines, Dr. Hmoud deviated from the accepted standard of medical care by failing to monitor the decedent for fluid overload.

Further, Elfiky asserts, a patient remains the responsibility of the ER department for as long as the patient remains physically in the department. This is true even if the patient is officially admitted to the hospital and assigned a bed. The ER department, including the physician, has a responsibility to continue caring for the patient and continuing to apply the standards of care up until the very minute the patient leaves - particularly where, as is the case here, the change in status of a patient is the direct result of actions undertaken by the ER physician.

As to Dr. Tatarski, Elfiky notes as follows.

Dr. Tatarski was the hospitalist who accepted the admission of the decedent from Dr. Hmoud on the evening of May 14, 2017. Dr. Tatarski admitted the patient on behalf of Dr. Evers, her primary care physician, who was to take over care the following morning at 7:00 a.m.

Upon examination of the decedent, Dr. Tatarski noted significant abdominal pain and diffuse tenderness. The laboratory and CT scan findings available to him were consistent with infectious colitis. Further, Dr. Tatarski was aware that the patient was prescribed Invanz. Elfiky opines that it was a deviation from the accepted standard of medical care for Dr. Tatarski not to have started another antibiotic as well *e.g.* Vancomycin, in addition to the Invanz. Indeed, Elfky opines, without additional culture results back, and in light of the critical window of opportunity for the proper administration of antibiotic treatment in patients with systemic infection, this should have been done. That is, it was incumbent on Dr. Tatarski to apply an expected broader knowledge of initially required antibiotics to give the decedent the combination of antibiotics that properly ensured a broad coverage of possible infections because a hospitalist such as Dr. Tatarski is held to a standard of care that encompasses a wide scope of care delivery, both acute

and chronic. Elfiky asserts that, noting generalized colitis on a CT Scan, as did Dr. Tatarski, does not allow for an assumption of usual/more common infectious bacteria. This, Elfiky opines, is specifically why the broad spectrum coverage with a combination of antibiotics in an acutely ill patient such as the decedent is the accepted standard of care.

With regard to medical management of fluids, he opines, the standard of care does not allow for interventions without continuing and vigilant reassessment of the interventions. This is particularly true in the case of a patient such as the decedent, who clearly had a systemic infection, with the possibility of septic shock. Importantly, he opines, because the decedent was not actually suffering from septic shock, the administration of IV fluids was initially appropriate. However, he opines, the unchecked administration of these fluids, particularly in decedent, who was normally on a diuretic, can, and in this case did, cause a fluid overload, leading to death. "For whatever reason, there was simply not proper monitoring. The lack of proper monitoring is counter to the accepted standard of care."

Further, he opines, Dr. Tatarski's discontinuance of the diuretic while at the same time allowing continuous IV hydration is "both short-sighted and contrary to the accepted standard of medical care." There should have been ongoing reassessment of the patient's fluid status on designated intervals, with checks for the lungs, jugular vein distension and checks of the legs for fluid retention. Based on these findings, a decision can be made whether to continue with fluids, stop fluids or even order a diuretic if necessary." Here, he asserts, there was no ongoing assessment.

In addition, he opines, Dr. Tatarski was clearly aware of and acknowledged the decedent's multiple co-morbid conditions. Thus, Elfiky opines, his failure to involve other sub-specialists,

in particular a cardiologist, does not conform with accepted medical practice. Rather, he asserts, the awareness of the decedent's complex medical history, including history of sepsis, mandated earlier intervention.

In sum, Elfiky opines, "the multiple deviations of Drs. Hmoud and Tatarski, as set forth above, caused [the decedent's] sepsis to increase, cause[d] her fluid overload, caused her to decompensate and ultimately led to the death of the decedent."

In reply, the movants submit an affirmation from counsel, Christina Accumanno.

Accumanno argues that, although the movants' motion papers address all of the allegations as against Drs. Hmoud and Tatarski, the Plaintiff's opposition fails to oppose, or even substantively address, the specific grounds upon which the movants' seek relief.

Regardless, she asserts, Elfiky's submission does not raise an issue of fact regarding causation as to either movant.

Indeed, she avers, it was not until the decedent was under the care of Dr. Evers that she began to decompensate, and it was another several days before she died.

Thus, Accumano asserts, even assuming, *arguendo*, that Dr. Hmoud and/or Dr. Tatarski were negligent, such negligence did not substantially impact the decedent's later medical complications.

At best, she argues, Elfiky's affirmation is conclusory and speculative.

For example, she asserts, Elfiky makes a "gratuitous" comment about assuming the patient was "in the clear" because antibiotics were prescribed. However, she notes, nowhere in the movant's papers or the record did anyone make any comment about the decedent being "in the clear" because she was on antibiotics. Rather, she asserts, Dr. Hmoud was appropriately

concerned about the decedent's condition, which is why he admitted her to the hospital.

Further, she argues, Elfiky fails to address the crucial fact that the decedent was stable at the end of Dr. Tatarski's shift and showed no signs or symptoms of deterioration.

In addition, she contends, Elfiky also asserts a deviation in the standard of care by commenting on the selection of Invanz as an antibiotic, citing various organisms that would not respond to this antibiotic. However, Accumano notes, Elfiky does not assert, and the record is devoid of any evidence, that the decedent was ultimately diagnosed with an organism that was not susceptible to Invanz. That is, there are no culture sensitivity reports in the Bon Secours record that indicate she was diagnosed with any of the pathogens mentioned by Elfiky. Thus, she argues, his claim that it was a deviation to not administer Vancomycin is entirely speculative.

Additionally, she notes, Elfinky claims that the decedent was not being monitored for fluid overload is not substantiated with the record. That is, he overlooks the fact that nursing staff continued to monitor the decedent and did not report any issues to the physicians. Otherwise, she notes, the Plaintiff's vital signs and her "input and outputs" were adequately monitored. Indeed, the decedent's lungs were clear when Dr. Evers' performed his assessment of the decedent at 7:12 a.m. the following morning, and she was stable at conclusion of Dr. Tatarski's shift.

Lastly, she argues, the claims that a cardiology consultation was necessary are completely without merit. Sharma notes that nothing in the record indicated that the decedent exhibited chest pain, palpitations, irregular heart rate or shortness of breath.

In addition, she notes, Waldman concurred, noting that there was nothing in the record which indicated symptoms that a cardiology consultation was required.

Further, she notes, Elfiky is a doctor in the field of "oncology" and "internal medicine." He did not assert that he has the credentials, background or training in specific disciplines of medicine relevant to the litigation at bar, to wit: emergency department and hospitalist care.

By contrast, the affidavits submitted by the movants are from a qualified emergency care specialist and a hospitalist.

In sum, she argues, the motion should be granted.

Discussion/Legal Analysis

On a cause of action alleging medical malpractice, a plaintiff must prove a deviation or departure from good and accepted standards of medical practice, and that such departure was a proximate cause of damages. *Goldberg v. Horowitz,* 73 A.D.3d 691 [2nd Dept. 2010]. In general, expert testimony is necessary to prove a deviation from accepted standards of medical care and to establish proximate cause. *Goldberg v. Horowitz,* 73 A.D.3d 691 [2nd Dept. 2010]. Because causation is often a difficult issue, a plaintiff need do no more than offer sufficient evidence from which a reasonable person might conclude that it was more probable than not that defendant's deviation was a substantial factor in causing the injury. *Goldberg v. Horowitz,* 73 A.D.3d 691 [2nd Dept. 2010]. A plaintiff's evidence of proximate cause may be found legally sufficient even if his or her expert is unable to quantify the extent to which defendant's act or omission decreased plaintiff's chance of a better outcome or increased the injury, as long as evidence is presented from which the jury may infer that defendant's conduct diminished plaintiff's chance of a better outcome or increased the injury. *Semel v. Guzman,* 84 A.D.3d 1054 [2nd Dept. 2011]; *Goldberg v. Horowitz,* 73 A.D.3d 691 [2nd Dept. 2010].

A defendant moving for summary judgment in a medical malpractice case must

demonstrate the absence of any material issues of fact with respect to at least one of these elements. *DiLorenzo v. Zaso*, 148 A.D.3d 1111 [2nd Dept 2017]. A defendant must establish, *prima facie*, either that there was no departure from good and accepted medical practice or that, if there were, the plaintiff was not injured thereby. *Contreras v. Adeyemi*, 102 A.D.3d 720, 958 N.Y.S.2d 430, (2nd Dept. 2013). The defendant is required to address the factual allegations set forth in the plaintiffs' bill of particulars with reference to the moving defendant's alleged acts of negligence and the injuries suffered with competent medical proof. Bare conclusory assertions by a defendant that he or she did not deviate from good and accepted medical practices, with no factual relationship to the alleged injury, does not establish that the cause of action has no merit so as to entitle defendants to summary judgment. *DiLorenzo v. Zaso*, 148 A.D.3d 1111 [2nd Dept 2017].

In opposing a motion for summary judgment in a medical malpractice case, a plaintiff needs only to rebut the moving defendant's prima facie showing. *DiLorenzo v. Zaso*, 148 A.D.3d 1111 [2nd Dept 2017].

Summary judgment is not appropriate in a medical malpractice action where the parties adduce conflicting medical expert opinions. *DiLorenzo v. Zaso*, 148 A.D.3d 1111 [2nd Dept 2017]. However, general and conclusory allegations of medical malpractice, unsupported by competent evidence tending to establish the essential elements of medical malpractice, are insufficient to defeat a defendant physician's summary judgment motion. Rather, the plaintiff's expert must specifically address the defense expert's allegations. *DiLorenzo v. Zaso*, 148 A.D.3d 1111 [2nd Dept 2017].

A medical expert need not be a specialist in a particular field in order to testify regarding

accepted practices in that field. *DiLorenzo v. Zaso*, 148 A.D.3d 1111 [2nd Dept 2017]. However, the witness must be possessed of the requisite skill, training, education, knowledge or experience from which it can be assumed that the opinion rendered is reliable. *DiLorenzo v. Zaso*, 148 A.D.3d 1111 [2nd Dept 2017]. Thus, where a physician opines outside his or her area of specialization, a foundation must be laid tending to support the reliability of the opinion rendered. Where no such foundation is laid, the expert's opinion is of no probative value. *DiLorenzo v. Zaso*, 148 A.D.3d 1111 [2nd Dept 2017].

Initially, it is noted, given that the action has been settled as against Dr. Evans, the record is not well developed as it concerns what occurred after the decedent's care was assumed by Dr. Evans at around 7:00 a.m. on May 15, 2017, until the decedent's death at around 2:00 p.m. on May 16, 2017.

Rather, given the respective positions of Drs. Hmoud and Tatarski, the record is focused on the period from the afternoon of May 14, 2017, when the decedent was admitted, until her care was taken over by Dr. Evers the following morning.

The details of how and when the decedent's condition deteriorated after such time, and her death, are not clear from the record.

Nonetheless, a determination can be made.

In support of the motion, Dr. Hmoud demonstrated a *prima facie* entitlement to judgment as a matter of law dismissing the complaint as against him.

Dr. Hmoud's direct care of the decedent was of short duration (approximately 2.5 hours).

Sharma's affidavit was sufficient to demonstrate, *prima facie*, that, during that period, all actions undertaken by Dr. Hmoud conformed with the standard of care, and that Dr. Hmoud was

not negligent in having failed to undertake any further or additional actions.

Dr. Tatarski's direct care of the decedent was for a longer period, to wit: from when he assumed her care around 5:00 p.m. on May 14, 2017, until Dr. Ever's took over her care the following morning at approximately 7:00 a.m.

Waldman's affidavit was sufficient to demonstrate, *prima facie*, that, during that period, all actions undertaken by Dr. Tatarski conformed with the standard of care, and that Dr. Tatarski was not negligent in having failed to undertake any further or additional actions.

Indeed, the Court notes, the affidavit of Waldman is sufficient to demonstrate, *prima facie*, that the decedent was stable when she came under the care of Dr. Evers, and that there were no apparent or emergent circumstances which warranted attention at that time.

Finally, the Court notes, the decedent was in the care of Dr. Evers for approximately 31 hours prior to her death.

In opposition, the Court finds that the Plaintiff failed to raise a triable issue of fact at to either Defendant.

Initially, as noted by the movants, the Plaintiff's proffered expert, Elfiky, does not purport to have any experience or expertise in either emergency medicine or as to hospitalists. Rather, his focus appears on oncology, which is not implicated by the facts.

Regardless, the Court agrees that Elfiky's submission is insufficient to raise a triable issue of fact, particularly as to causation. For example, although Elfiky opines that the movants departed from good and accepted practice when they failed to prescribe Vancomycin, rather than, or in addition to, Invanz, he does not provide a causative link as to the same. That is, he does not opine that the cause or a contributing factor to the decedent's deterioration and death was an

invasive bacterial pathogen, etc. that would been treated by Vancomycin, but was not by Invanz, and that the failure to prescribe Vancomycin at or near the time of the decedent's admission (rather than at some subsequent time) caused or contributed to such deterioration and death.

Indeed, the Court finds, in general, that Elfiky fails to provide a causative link to his allegations of departures. As has been noted, "[p]roof of negligence in the air, so to speak, will not do." *Palsgraf v. Long Island R.R. Co.*, 248 N.Y. 339; *see also, Rochlin v. Alamo*, 209 A.D.2d 499 [2nd Dept. 1994]. The negligence must be the proximate cause of a plaintiffs' injuries. *Rochlin v. Alamo*, 209 A.D.2d 499 [2nd Dept. 1994].

Accordingly, and for the reasons cited herein, it is hereby,

Ordered, that Defendants' summary judgment motion, which seeks dismissal of the complaint and causes of action asserted therein, is granted and the action dismissed.

The foregoing constitutes the Decision and Order of the court.

Dated: June 30, 2021
Goshen, New York

ENTER

HON. ROBERT A. ONOFRY, J.S.C.

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