

Gordon v D'Souza

2022 NY Slip Op 30432(U)

February 4, 2022

Supreme Court, Kings County

Docket Number: Index No. 525849/18

Judge: Genine D. Edwards

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This opinion is uncorrected and not selected for official publication.

At an IAS Term, Part 80 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 4th day of February 2022.

P R E S E N T:

HON. GENINE D. EDWARDS,
Justice.

-----X

LINNETT GORDON, as Administrator of
the Estate of JERRY W. GORDON, Deceased,

Plaintiff,

-against-

LIONEL D’SOUZA, M.D., STONY BROOK
UNIVERSITY HOSPITAL GASTROENTEROLOGY
AND HEPATOLOGY, MICHAEL CLORES, M.D.,
JENNIFER LIU-BURDOWSKI, M.D., SALVATORE
DOCIMO, D.O., STONY BROOK SURGICAL
ASSOCIATES, UNIVERSITY FACULTY PRACTICE,
BARIATRIC AND METABOLIC WEIGHT LOSS CENTER,
AARON SASSON, M.D., and MUHAMMAD PERWAIZ, M.D.,

Defendants.

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DECISION, ORDER, AND JUDGMENT

Index No. 525849/18

Mot. Seq. No. 1-2

The following e-filed papers read herein:

NYSCEF Doc No.:

Notice of Motion, Affirmations, Memoranda of Law,
and Exhibits Annexed _____
Opposing Affidavits (Affirmations) and Exhibits Annexed _____
Reply Affirmations _____

83-100, 103-131
137-142, 144-149
152, 154

In this action to recover damages for medical malpractice, lack of informed consent, and wrongful death, defendant Lionel D’Souza, M.D. (“Dr. D’Souza”), individually, and defendants Salvatore Docimo, D.O. (“Dr. Docimo”), Aaron Sasson, M.D. (“Dr. Sasson”), Muhammad Perwaiz, M.D. (“Dr. Perwaiz”), and Stony Brook

Surgical Associates, University Faculty Practice (“Surgical Associates”), jointly, move, in each instance, for summary judgment dismissing the complaint of plaintiff Linnett Gordon, as the Administrator of the Estate of Jerry W. Gordon, deceased (“plaintiff”) (Seq. No. 1 and 2, respectively). Plaintiff opposes both motions insofar as they seek dismissal of the medical malpractice and wrongful death claims as against Drs. D’Souza, Docimo, and Sasson, as well as against Surgical Associates. Inasmuch as plaintiff does not expressly object to the dismissal of all claims as against Dr. Perwaiz,¹ nor objects to the dismissal of the informed consent claims as against the other moving defendants, all such claims are dismissed without further discussion.

Background

At 1:27 hours on August 20, 2017,² plaintiff’s decedent, Jerry W. Gordon (“patient”), was admitted, via the emergency room, to the medical intensive care unit (“MICU”) of nonparty Stony Brook University Hospital (“Stony Brook”)³ with the primary diagnosis of acute upper gastrointestinal (“GI”) bleeding that was likely

¹ See Plaintiff’s Counsel’s Affirmation in Opposition, ¶ 1 (NYSCEF Doc No. 137).

² Unless otherwise indicated, all year references are to 2017 and all time references are to the military time.

³ On January 11, 2019, plaintiff filed a claim in the Court of Claims against Stony Brook alleging, among other things, failure to perform surgery to control the patient’s UGIB. See Claim 132509 (Ct Cl) (“Court of Claims Action”) (NYSCEF Doc Nos. 1 [Claim] and 19 [Bill of Particulars] filed in the Court of Claims Action). On April 8, 2021, plaintiff as the claimant in the Court of Claims Action stipulated to its conditional dismissal, subject to its reactivation “in the event resolution of [this] Supreme Court action does not provide relief which [she] considers to be full.” See Stipulation of Conditional Dismissal (NYSCEF Doc No. 27 filed in the Court of Claims Action).

secondary to his two-day-old, hemostatically unclipped⁴ polypectomy of a sessile (flat) benign polyp in his duodenum (Patient's Chart at 2121 and 61).⁵ The patient, though relatively young at 54 years of age,⁶ was seriously ill: (1) his hemoglobin was critically low at 6.1; (2) his INR (a level of anticoagulation) was 2.1 (or approximately twice the level of normal for a patient who had not been taking an anticoagulant for the preceding seven days); (3) his pulse generally exceeded 100 beats per minute (tachycardia), and his systolic blood pressure was generally in the 90s or low 100s (a sign of hypotension that in combination with his tachycardia and his severe blood loss, suggested a potential for a cardiogenic shock); (4) he received several blood transfusions prior to the interhospital transfer; (5) his lung function and breathing were impaired by sarcoidosis for which (in addition to using an oxygen tank at home) he was taking several inhaler medications; (6) he was suffering from atrial fibrillation as well as from hypertension; (7) he was an insulin-dependent diabetic; and (8) he was obese with the body-mass index of 33.95.⁷

⁴ The endoscopy report for the August 18th polypectomy stated, in part, that the "polyp resection site [was] not amen[able] to [hemostatic] clipping[,] so edges and over the polypectomy site were all treated with APC." See Stony Brook's August 18th Endoscopy Record at 30, 31 (NYSCEF Doc No. 120). Mechanical hemostasis using endoclips is one form of controlling the polypectomy-site bleeding. Here, APC (or argon plasma coagulation) was used by the nonparty performing endoscopist to control the polypectomy-site bleeding.

⁵ Unless otherwise indicated, all references to the patient's chart at Stony Brook are to the 2,156-page-long version that was e-filed under NYSCEF Doc Nos. 122 through 129 (the "patient's chart").

⁶ The day after (August 21st), the patient turned 55.

⁷ As of August 18th, Stony Brook calculated the patient's body-mass index (BMI) at 33.95 on the basis of his weight and height of 110 kilograms and 180 centimeters, respectively. See Stony Brook's August 18th Endoscopy Record at 10.

The intensivists' goals were to resuscitate the patient, obtain a definitive control of his ongoing hemorrhage, treat his bleeding duodenum, and prevent the recurrence of bleeding. Whereas the goals of the intensivists were to resuscitate the patient with blood, fluids, and medications, the goals of the specialists (as selected and consulted by the intensivists) were to control the patient's bleeding, eliminate its underlying cause, and prevent its recurrence. There were two options to stop the patient's further bleeding. The non-operative (or minimally invasive) approach consisted of an esophagogastroduodenoscopy ("endoscopy") to be performed by the gastroenterology ("GE") service, and/or an embolization to be performed by the interventional radiology ("IR") service. The operative (or invasive) approach was open surgery to be performed by the surgical service to "oversee" the bleeding vessel. All three consulting specialties (GE, IR, and surgery) were on call and available to the intensivists at the time of the patient's admission to, and throughout his hospitalization at, Stony Brook. The intensivists, as the physicians in charge of the patient's overall care, determined *which* of the three specialties (GE, IR, and/or surgery) they wanted to call in to assist with their patient management, and equally important, *when* they needed to call on such specialists. As noted, the intensivists were concurrently resuscitating the patient with blood, fluids, and medications.

Gastroenterology was the first service that the intensivists turned to for bleeding control (Patient's Chart at 62). Approximately one hour post-admission, at 2:46 hours on August 20th, the since-dismissed defendant Michael Clores, D.O. ("Dr. Clores"), telephonically discussed the patient's condition with his attending, the moving defendant

Dr. D'Souza. That discussion culminated with the joint "plan [by the GE service] for [performing an] EGD in [the] AM to evaluate and treat [the patient's] post-polypectomy bleed" (Patient's Chart at 92). Approximately five hours later, in a note timed at 7:10 hours on August 20th, Dr. Clores reiterated the GE service's plan for performing an upper endoscopy on the patient on the morning of August 20th, and Dr. D'Souza so concurred in his note cosigned at 22:57 hours on that date (Patient's Chart at 45-46). Further, at 7:00 hours on August 20th, the patient consented, in writing, to an EGD to be performed by Dr. D'Souza (Patient's Chart at 2048). Paperwork aside, however, Dr. D'Souza actually performed the upper endoscopy on the patient at approximately 17:15 hours on August 20th (the "initial endoscopy"), or approximately 16 hours after the patient's acute presentation to Stony Brook (Patient's Chart 40 [anesthesiologist's note]).

During the initial endoscopy, Dr. D'Souza encountered a "visible" vessel in the patient's duodenum; more particularly, a ten-millimeter "oozing" ulcer.⁸ Despite, the initial endoscopy, however, the patient's duodenum continued to bleed.

At 2:30 hours in the early morning of August 21st, Dr. Clores was notified by an intensivist that the patient was severely bleeding (expulsion of bright red blood by rectum for a total of three times, followed by blood vomit), and that he was

⁸ According to the initial endoscopy report signed by Dr. D'Souza at 20:15 hours on August 20th:

"One non-obstructing cratered duodenal ulcer with a visible vessel with active [oo]zing was found in the first portion of the duodenum at the site of the recent [polypectomy]. The lesion was 10 mm in largest dimension. Coagulation for hemostasis using bipolar probe was successful."

(Patient's Chart at 1327-1328).

hemodynamically unstable (*i.e.*, that his systolic blood pressure, despite the ongoing resuscitation, had again fallen to the 90s) (Patient's Chart at 91, 60). Dr. Clores telephoned Dr. D'Souza with a plan to "repeat EGD in [the] AM" (*id.*). At 8:20 hours on August 21st, the patient consented, in writing, to a repeat endoscopy to be performed by Dr. D'Souza (Patient's Chart at 2049). Approximately four hours later, at 12:49 hours on August 21st, Dr. D'Souza performed a repeat upper endoscopy on the patient (the "repeat endoscopy") (Patient's Chart at 1321). During the repeat endoscopy, Dr. D'Souza encountered an eight-millimeter ulcer (located along the course of the same visible vessel that Dr. D'Souza treated on the initial endoscopy) which was then "spurting" blood (that is, actively discharging, rather than merely "oozing" it) (Patient's Chart at 1322). Dr. D'Souza treated the re-bleed with different modalities.⁹ Nonetheless, the repeat endoscopy, like its predecessor, failed to stop the patient from further bleeding in his duodenum.

At 1:11 hours on August 22nd, the patient, already resource-depleted from the two prior bleeding episodes, was bleeding again. Not only was he then hemodynamically unstable (his systolic blood pressure was fluctuating between 75 and 86), but he was also

⁹ According to the repeat endoscopy report signed by Dr. D'Souza at 12:49 hours on August 21st:

"Area was successfully injected with 3 mL of a 1:10,000 solution of epinephrine which resulted in transient slowing of the bleeding. A duodenoscope was used for improved visualization of the area. To stop active bleeding, two hemostatic clips were successfully placed . . . [;] however[,] ongoing oozing was seen. Coagulation for hemostasis using bipolar probe was then applied successfully. There was no bleeding seen at the end of the procedure."

(Patient's Chart at 1322-1324).

exhibiting signs of hypothermia (low body temperature), “shock liver,” and “hemorrhagic shock” (Patient’s Chart at 98). Yet, the intensivists did not call on the surgical service to take the patient’s case. Instead, the intensivists (by nonparty Joshua Samuel, M.D.) called the IR service for embolization, with a proviso that the intensivists would “consult general surgery also to evaluate [the] patient *if embolization [was] unsuccessful* and [for] further need for possible surgical intervention” (Patient’s Chart at 98 [Dr. Samuel’s note timed at 1:11 hours on August 22nd] [emphasis added]). Similarly, Dr. Clores’s successor, the since-dismissed defendant Jennifer Liu-Burdowski, M.D. (“Dr. Liu-Burdowski”), concurred with the intensivists’ recommendation that the IR (rather than the surgical) service should assist with further bleed control. *See* Patient’s Chart at 356 (“Dr. Liu-Burdowski’s note timed at 18:46 hours on August 21st [“If (the) patient (experiences) . . . (a) recurrent bleed, *(he) will need (an) IR evaluation for embolization. Maximum GI therapy has been attempted.*”] [emphasis added]).

Reflective of the intensivists’ and GI service’s respective recommendations, surgical resident, nonparty Kelsi Hirai, M.D. (“Dr. Hirai”), confirmed in her note, timed at 2:27 hours on August 22nd, that “surgery [was] aware” of the plan for the IR embolization (Patient’s Chart at 73, 80). Dr. Hirai so advised (by telephone) defendant Dr. Docimo who, while staying at home, was the on-call attending surgeon between 18:00 hours on August 21st and 6:00 hours on August 22nd (Patient’s Chart [Dr. Docimo’s note timed at 13:34 hours on August 23rd]; Dr. Docimo’s EBT tr at page 22, lines 4-13, page 23, lines 3-7; page 24, lines 17-20; page 25, line 24 to page 26, line 3; page 29, line 18 to page 30, line 2; page 35, lines 3-6).

At approximately 4:15 hours on August 22nd, the patient underwent an “empiric embolization of the proximal gastroepiploic artery back into the gastroduodenal artery” by an attending IR radiologist (Patient’s Chart at 1314-1315). By that time, the patient had received a total of ten units of packed red blood cells (“PRBC”) and was in the process of receiving his eleventh unit of PRBC (Patient’s Chart at 285 and 290 [note by resident Jerimarie Pasilliao, M.D., timed at 8:12 hours on August 22nd]; Patient’s Chart [Intake and Output] at 1583-1585).¹⁰

By note timed at 9:25 hours on August 22nd, attending intensivist nonparty Paul Richman, M.D. (“Dr. Richman”), sounded an alarm at the patient’s ever-worsening condition, despite the ongoing intensive resuscitation (an infusion of a total of eleven units of PRBS) and a total of three non-operative interventions for bleeding control (twice by the GE service and once by the IR service) (Patient’s Chart at 290-291 [Dr. Richman’s note]). By then, the patient had suffered an “acute kidney injury and shock liver due to [the] massive [GI] bleeding” (Patient’s Chart at 291). The patient’s white blood cell count was “high” at 31,800 (*id.*). The patient was “anuric” (passing little urine), with a Foley catheter having been placed in the morning of August 22nd (*id.* at 290). Further, the patient’s liver enzymes were elevated “in the setting of steatosis and probable shock liver” (Patient’s Chart at 278 [Dr. Richman’s note timed at 10:06 hours

¹⁰ Although some notations in the patient’s chart erroneously stated (and the plaintiff’s surgery expert so erroneously repeated in ¶ 15 of his/her affirmation) that the patient had received a total fourteen units of PRBC by 7:00 hours on August 22nd, the actual unit count, as stated in the Intake and Output section of the patient’s chart, indicated that he received a total of ten units of PRBC by 7:00 hours on August 22nd, and an additional (or the eleventh) unit between 7:00 and 15:00 hours on August 22nd. See Patient’s Chart (Intake and Output) at 1583-1585.

on August 23rd). Reflective of the patient's anuria, his total input for August 21st exceeded his output by 30 times (his input was 10709 ml versus his output of 350 ml for that day). As a result, the patient gained 22.7 pounds in weight between August 21st and 22nd (his weight increased from 251.2 pounds to 277.9 pounds in that 24-hour interval), with an additional 9.4 pound weight gain on August 23rd to reach the total weight of 287.3 pounds (*id.* at 47 and 315).

In light of the suspected acute kidney injury, the intensivists turned to the nephrology service for assistance, while the involvement of the GE and surgical services petered out (Patient's Chart at 279-285 [Dr. Richman's and his resident's, Dr. Pasilio's, notes]; at 47-52 [nephrology service's notes]). Between August 22nd and 25th, defendant Dr. D'Souza and his resident Dr. Lee-Burdowski followed the patient (Patient's Chart at 112-115). Dr. D'Souza stopped seeing the patient after August 25th when he went off service. Further, at approximately 17:00 hours on August 22nd, and again at approximately 16:00 hours on August 23rd, defendant Dr. Sasson (who ultimately succeeded Dr. Docimo as the on-call surgeon) saw the patient either alone or with his resident, Michael Hung, D.O. ("Dr. Hung") (Patient's Chart at 63, 72, and 167 [Dr. Hung's notes]). Dr. Sasson concurred with the intensivists' plan to continue transfusing the patient to reach the "goal" hemoglobin (Patient's Chart at 72 and 167 [Dr. Hung's notes]). Dr. Sasson did not see the patient after 16:00 hours on August 23rd when he went off service.

Despite the nephrology service's active participation in the patient's care, the latter's renal function continued to decline. By note timed at 10:00 hours on August 26th,

attending intensivist Dr. Richman expressed his concerns that: (1) the patient had been “completely anuric overnight”; (2) the patient “received 2 doses [of] Lasix [a diuretic] without result”; (3) the patient’s already elevated creatinine level at 1.9 further increased to 3.1; and (4) the patient appeared “more icteric [jaundiced],” his abdomen was “more distended and tense,” and he had “ascites [excess abdominal fluid] on ultrasound” (Patient’s Chart at 241). Dr. Richman opined that the patient probably had suffered from “acute tubular necrosis and post-shock liver with progressive biliary [cirrhosis] and ascites” (*id.*).

At 12:12 hours on August 26th, a non-contrast CT scan of the patient’s abdomen and pelvis revealed disturbing findings: (1) “new large abdominopelvic ascites”; (2) “suggestion of pancolitis”; (3) “moderate anasarca” (full-body edema); and (4) “bibasilar nodular opacities which may be infectious” (Patient’s Chart at 1308-1309).

At 9:24 hours on the following day, August 27th, the patient underwent a repeat non-contrast CT scan of his abdomen and pelvis. The repeat CT scan found: (1) a “redemonstration of pancolitis”; (2) a “mild dilatation of proximal small bowel loops with probable wall thickening representing nonspecific enteritis and possible ileus”; (3) a “relatively stable moderate to large abdominopelvic simple fluid attenuating ascites”; and (4) the previously documented “bibasilar nodular opacities” (Patient’s Chart at 1306-1307).

Also on August 27th, the patient underwent two sessions of paracentesis (removal of the peritoneal fluid) (one session in the morning, and the other session in the afternoon). The removed fluid grew *E. coli* bacteria. Despite the subsequent infusion of

multiple antibiotics to fight the infection (as well as of multiple pressors to keep the patient's heart pumping in order to sustain the increased circulatory load), he died in the morning of August 31st without even starting on his first dialysis. The certificate of his death listed "cardiac failure" as the immediate cause of his death (with the onset of thirty minutes before his death) due to, or as a consequence of, "septic shock" and "bacterial peritonitis" (in each instance, with the onset of two days before his death).

The patient's sister, as the administrator of his estate, brought this action against, among others: (1) attending gastroenterologist Dr. D'Souza; (2) attending surgeons Dr. Docimo and Dr. Sasson; and (3) Surgical Associates as the surgeons' employer (collectively with Dr. Docimo and Dr. Sasson, the "surgery practice defendants"). The plaintiff's claims, as limited by way of her opposition papers, sound in medical malpractice and wrongful death. After discovery was completed and a note of issue was filed, the instant motions were served. On November 5, 2021, this Court heard oral argument and reserved decision.

Discussion

In the medical malpractice context, "[a] defendant physician seeking summary judgment . . . bears the initial burden of establishing, prima facie, *either* that there was no departure from good and accepted medical practice *or* that any alleged departure did not proximately cause the plaintiff's injuries." *Bowe v. Brooklyn United Methodist Church Home*, 150 A.D.3d 1067, 56 N.Y.S.3d 180 (2d Dept., 2017) (emphasis added). The opposing parties, in turn, "must demonstrate the existence of a triable issue of fact as to the elements on which the defendant has met his or her initial burden." *Id.* Where

a defendant physician makes a prima facie showing *on both elements*, “the burden shifts to the plaintiff to rebut the defendant’s showing by raising a triable issue of fact as to *both* the departure element and the causation element.” *Stukas v. Streiter*, 83 A.D.3d 18, 918 N.Y.S.2d 176 (2d Dept., 2011) (emphasis added).

Dr. D’Souza’s Motion

Dr. D’Souza, by way of the affirmation of his expert, Steven Rubin, M.D., a board-certified gastroenterologist (“Dr. Rubin”), made a prima facie showing that he did not depart from the accepted standard of care. Specifically, Dr. Rubin opined that Dr. D’Souza: (1) properly performed the initial and repeat endoscopies; (2) appropriately relied on the IR service for embolization to stop further bleeding; and (3) was not required, on his own, to summon the surgical service which, with the intensivists’ efforts, had already been consulted on the patient’s case. *See* Dr. Rubin’s Affirmation, ¶¶ 5-6 and 8 (NYSCEF Doc No. 86). Dr. Rubin further opined that none of Dr. D’Souza’s alleged acts or omissions proximately caused the patient’s injuries and death. *Id.*, ¶ 9. Thus, the burden shifted to the plaintiff to raise a triable issue of fact as to: (1) whether Dr. D’Souza departed from good and accepted medical practice (the “departure element”); and (2) if so, whether such departures were a proximate cause of the patient’s injuries and death (the “causation element”). *See Reustle v. Petraco*, 155 A.D.3d 658, 63 N.Y.S.3d 111 (2d Dept., 2017).

In opposition, plaintiff failed to raise a triable issue of fact warranting denial of summary judgment to Dr. D’Souza. The problem with plaintiff’s expert opposition is two-fold. First and less importantly, plaintiff’s GE expert confined the scope of

Dr. D'Souza's claimed departures to a single instance; namely, Dr. D'Souza's allegedly untimely performance of the *initial* endoscopy. See Physician Affidavit, ¶¶ 15-20 (NYSCEF Doc No. 138). Plaintiff's GE expert failed to controvert (or even address) Dr. Rubin's expert opinion regarding: (1) the timeliness of the repeat endoscopy; (2) Dr. D'Souza's reliance on the IR service for embolization to stop further bleeding; and (3) Dr. D'Souza's reliance on the intensivists to summon the surgical service.¹¹

Second, and more importantly, plaintiff's GE expert "defer[red] to the affirmation of the plaintiff's expert in surgery as to the *specific consequences* of failing to timely address" the patient's bleeding. *Id.*, ¶ 17 (emphasis added). There are contradictions, however, between the contentions of plaintiff's GE expert and those of her expert surgeon in that regard. According to plaintiff's expert surgeon, the patient's bleeding was "surgical" in nature; in other words, that it required an immediate surgical intervention in light of its severity. See Physician Affirmation, ¶ 21 (NYSCEF Doc No. 139). Consequently, plaintiff's expert surgeon opined that Dr. D'Souza's performance of the initial endoscopy was "ill-advised and futile" (*id.*); in other words, that it was unnecessary, *irrespective* of its timing. Considering the conflicting positions taken by plaintiff's own experts, she failed to raise a triable issue of fact as to the *causation* element of her medical malpractice and wrongful death claims as against Dr. D'Souza. See *Hilt v. Carpentieri*, 198 AD3d 625, 155 N.Y.S.3d 411 (2d Dept., 2021); *Javich v. Sullivan*, 192 A.D.3d 871,

¹¹ Nor did plaintiff's GE expert opine on the technical aspects of Dr. D'Souza's performance of the initial and repeat endoscopies. Compare Dr. D'Souza's exclusive reliance on cautery to control the patient's bleeding in the initial endoscopy *with* his subsequent use of endoclips, among other modalities, to control the patient's bleeding in the repeat endoscopy.

144 N.Y.S.3d 719 (2d Dept., 2021); *see also Attia v. Klebanov*, 192 A.D.3d 650, 143 N.Y.S.3d 408 (2d Dept., 2021).

Surgical Practice Defendants' Motion

As stated, the surgical practice defendants consist of: (1) Dr. Docimo, who was the on-call attending surgeon in the 12-hour period between 18:00 hours on August 21st and 6:00 hours on August 22nd; (2) Dr. Sasson, who was the subsequent on-call attending surgeon until he went off service at approximately 16:00 hours on August 23rd; and (3) the surgical practice which, at the time, employed both Drs. Docimo and Sasson.

The surgical practice defendants, by way of the expert affirmation of their board-certified surgeon, Jerald D. Wishner, M.D. ("Dr. Wishner"), made a prima facie showing that neither Dr. Docimo nor Dr. Sasson (and vicariously the Surgical Associates) deviated from the applicable standard of care, and that none of their alleged acts and omissions proximately caused the patient's injuries and death. *See* Dr. Wishner's Affirmation, ¶¶ 38-40 (opinions as to Dr. Docimo), ¶¶ 43-46 (opinions as to Dr. Sasson) (NYSCEF Doc No. 106).

In opposition, the affirmation of plaintiff's expert surgeon failed to raise a triable issue of fact as to both the departure and causation elements of the medical malpractice and wrongful death claims as against each of the surgical practice defendants. The opinions of plaintiff's expert surgeon contradict the record on two key points. First, although physicians owe a general duty of care to their patients, that duty may be limited to those medical functions that are undertaken by the physician and which are relied on by the patient. *See Kleinert v. Begum*, 144 A.D.2d 645, 535 N.Y.S.2d 43 (2d Dept.,

1988). As stated, Dr. Docimo's involvement with the patient consisted of a single telephone consultation with his surgical resident Dr. Hirai between 2:00 and 3:00 hours on August 22nd, *after* the intensivists had already scheduled the patient for the IR embolization to be performed a few hours thence, and, more fundamentally, *after* the patient had undergone two endoscopies. Given Dr. Docimo's limited and, more importantly, his belated involvement in the patient's care as the result of the intensivists' unilateral decision, it was appropriate for him, at the time when he was consulted, to rely on the interventional radiology to stop the bleeding, and, in fact, the patient's bleeding ceased upon the IR embolization. It would be pure speculation to presume (and this Court declines to do so) that Dr. Docimo, who was at home at the time of his resident's call to him between 2:00 and 3:00 hours on August 22nd, had sufficient time after he was notified of the patient's condition by his resident, to adequately prepare for, and perform, intestinal surgery on the patient in lieu of the upcoming IR embolization that was performed (and, without dispute, was performed adequately) at approximately 4:15 hours the same morning. *Accord Longhi v. Lewit*, 187 A.D.3d 873, 133 N.Y.S.3d 623 (2d Dept., 2020), *lv denied* 36 N.Y.3d 906, 140 N.Y.S.3d 192 (2021).

Second and related to the foregoing is the undisputed fact that the intensivists were managing the patient's care. On admission to Stony Brook at 1:27 hours on August 20th, the intensivists were facing a *medical* emergency in the form of the patient's upper GI bleeding. Although, without the experts' aid, this Court is unable to ascertain when the patient's medical emergency transformed into a *surgical* emergency, the record makes it clear that the intensivists called the surgical service in the early morning of August 22nd –

after the patient had bled for the third consecutive night following two failed endoscopic attempts to stop the bleeding.

Conclusion

Accordingly, it is

ORDERED that Dr. D’Souza’s motion in Seq. No. 1 for summary judgment dismissing the complaint as against him is *granted*, and the complaint is dismissed in its entirety as against Dr. D’Souza without costs and disbursements; and it is further

ORDERED that the joint motion of Dr. Docimo, Dr. Sasson, Dr. Perwaiz, and Surgical Associates in Seq. No. 2 is *granted*, and the complaint is dismissed in its entirety as against each such defendant without costs and disbursements; and it is further

ORDERED that to reflect the dismissal of the foregoing defendants, as well as the prior stipulated dismissal of defendants Dr. Clores and Dr. Liu-Burdowski (NYSCEF Doc No. 71), this action is severed and continued as against the remaining defendants, Stony Brook University Hospital Gastroenterology and Hepatology, and Bariatric and Metabolic Weight Loss Center, with the caption so amended to read as follows:

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LINNETT GORDON, as Administrator of
the Estate of JERRY W. GORDON, Deceased,

Plaintiff,

-against-

Index No. 525849/18

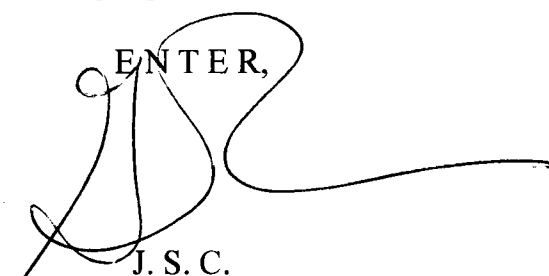
STONY BROOK UNIVERSITY HOSPITAL
GASTROENTEROLOGY AND HEPATOLOGY, and
BARIATRIC AND METABOLIC WEIGHT LOSS CENTER,

Defendants.
-----X

; and it is further

ORDERED that Dr. D'Souza's counsel is directed to electronically serve a copy of this decision, order, judgment with notice of entry on the other parties' respective counsel, and to electronically file an affidavit of service thereof with the Kings County Clerk.

This constitutes the decision, order, and judgment of this Court.

ENTER,

J. S. C.
HON. GENINE D. EDWARDS