Cristiano v Sacca
2022 NY Slip Op 33517(U)
September 28, 2022
Supreme Court, New York County
Docket Number: Index No. 805333/2016
Judge: John J. Kelley

SUPREME COURT OF THE STATE OF NEW YORK
NEW YORK COUNTY

PRESENT: **HON. JOHN J. KELLEY** **PART** **56M**

Justice

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JOSEPH CRISTIANO, by the Administrator of his Estate, MARIANNA CRISTIANO and MARIANNA CRISTIANO, Individually,

Plaintiff,

- v -

MICHAEL SACCA, M.D., GARRI PASKLINSKY, M.D., PAVAN J. DALAL, M.D., ANNIKA MARGUERITE MEYER, M.D., SUNG Y. KIM, M.D., GOOD SAMARITAN HOSPITAL, and THE MOUNT SINAI HOSPITAL,

Defendant.

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INDEX NO. 805333/2016

MOTION DATE 06/27/2022

MOTION SEQ. NO. 003

DECISION + ORDER ON MOTION

The following e-filed documents, listed by NYSCEF document number (Motion 003) 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 141, 143, 145, 146, 147, 148

were read on this motion to/for JUDGMENT - SUMMARY.

I. INTRODUCTION

In this action to recover damages for medical malpractice based on departures from good and accepted practice, lack of informed consent, and wrongful death, the defendants Sung Y. Kim, M.D., and The Mount Sinai Hospital (MSH) together move pursuant to CPLR 3212 for summary judgment dismissing the complaint insofar as asserted against them. The plaintiff opposes the motion. The motion is granted only to the extent that Kim and MSH (together the movants) are awarded summary judgment dismissing the lack of informed consent cause of action insofar as asserted against them, and the motion is otherwise denied.

II. FACTUAL BACKGROUND

The crux of the plaintiff's claims in this action is that, shortly before a June 2015 hospital admission at MSH, her decedent, Joseph Cristiano, had developed a pseudoaneurysm that

should have been diagnosed on computed tomography angiogram (CTA) imaging generated at that hospital, but that the pseudoaneurysm was not diagnosed, and thus remained untreated. She asserted that the defendants' failure timely to diagnose and treat the pseudoaneurysm permitted the adverse effects of that condition to deteriorate, causing her decedent to sustain an abdominal aortic aneurysm rupture in August 2015 that eventuated in his death.

As of December 2014, the decedent was 62 years old. Prior to that date, he had been diagnosed with hypertension. In 1990, the decedent underwent aorto-femoral bypass surgery, involving percutaneous placement of a covered stent in the left iliac artery. In 1994, he suffered from a myocardial infarction, underwent coronary artery bypass graft surgery with the placement of stents, and was diagnosed with coronary artery disease. In 2003, the stent that had been placed in 1990 failed due to rupture, and a pseudoaneurysm developed. He thus underwent axillo-bifemoral bypass surgery at that time, which was complicated by an avulsion of the axillary anastomosis one month later. Occlusion of this graft, however, was treated successfully with lytic therapy. In 2003, the decedent also suffered from a stroke. In 2006, he was diagnosed with heart arrhythmia, underwent the placement of an implantable cardioverter-defibrillator (ICD), and was placed on anticoagulation therapy. That same year, he was also diagnosed with end stage renal disease, and began hemodialysis. In 2007, the decedent was diagnosed with bladder cancer. Prior to 2014, the decedent also was diagnosed with type II diabetes, anemia, hyperlipidemia, sleep apnea, acute-on-chronic congestive heart failure, and peripheral vascular disease.

On December 12, 2014, the decedent was admitted to the defendant Good Samaritan Hospital (GSH) in West Islip, New York, after a syncopal episode, during which his ICD malfunctioned, a situation referred to as "firing." He also complained of increasing lower back pain, which was attributed to multilevel degenerative changes in the lumbar/sacral regions of his spine. In light of the decedent's history of peripheral vascular disease with decreased lower extremity pulses, the defendant Michael Sacca, M.D., was called in for a consultation on

December 16, 2014. According to the movants, a CTA scan taken at that time revealed a complete occlusion of the infrarenal aorta, with absence of flow into the right axillary and bifemoral bypass grafts, upon which Sacca recommended revascularization.

On December 24, 2014, Sacca, assisted by the defendant Garri Pasklinski, M.D., removed the prior aorto-femoral bypass graft, and replaced it with a cadaver graft. On December 25, 2014, the decedent evinced lower extremity pulses that were reflected on a Doppler ultrasound imaging test. Although he displayed warm legs and feet, he was completely unable to move his legs. Thus, on December 27, 2014, Physician's Assistant Marie Spano reported in the GSH chart that the decedent "now c[omplains]/o[f] new b[i]/l[ateral] lower extremity weakness and inability to ambulate at all." A December 28, 2014 CT scan of the decedent's lumbar spine revealed "calcification displaced inward from the aortic wall, consistent with calcific thrombus or chronic aortic dissection," as well as a "heterogeneous collection" measuring three centimeters (cm) by four cm at the proximal superior mesenteric artery, with a soft tissue density at the level of the left external iliac vessels. The radiologist who read the scan believed the "heterogeneous collection" to be a hematoma. According to the movants, there was no definite identification of the etiology of the decedent's lower extremity weakness and no improvement prior to the decedent's discharge from GSH on January 8, 2015.

On April 22, 2015, the decedent fell. On May 2, 2015, he was re-admitted to GSH through the emergency room because he manifested increased confusion and speech changes in the weeks since his fall. Examination revealed that the decedent had a non-healing ulcer in the left groin, with "drainage expressed." A culture of the wound area was positive for e. coli bacteria, proteus mirabilis bacteria, and coagulase-negative staphylococci bacteria. While the decedent remained at GSH, CT and CTA scans depicted a collection of fluid adjacent to the superior portions of the stent graft, measuring approximately five cm in diameter. The lesion did not enhance, and while the abdominal aorta was occluded, the stent graft and common iliac artery grafts were patent, that is, open and unobstructed. At GSH, Sacca assumed primary

responsibility for the decedent's care. A scan employing radioactive indium reflected the presence of a collection of radionuclides within the femoral bypass, extending to the inguinal region, that Sacca concluded was evidence of an infection of the non-functioning disconnected R-L femoral graft.

Sacca removed the fluid collection uneventfully on May 12, 2015, and testified at his deposition that he not believe that the infection extended beyond that graft because the indium scan only reacted at the groin area and not anywhere else, and also because the femoral-femoral graft was located in the subcutaneous space near the groin and nowhere near the retroperitoneal space. Sacca noted in his May 12, 2015 operative report that no evidence existed suggesting that the infection extended down to the biologic aorto-bifemoral bypass. The decedent remained stable from that date until his May 28, 2015 discharge to a sub-acute rehabilitation facility.

On June 3, 2015, the decedent's family brought him to MSH to address his complaints of shortness of breath and altered mental status. His initial physical examination, however, did not document a groin wound or scarring in the area in connection with his May 2015 treatment at GSH. Chest x-rays revealed a consolidation of the lower lobe of the decedent's right lung that was consistent with pneumonia. Shortly thereafter, Kim, a vascular surgeon, undertook to provide medical care to the decedent.

On June 4, 2015, Kim ordered a CTA, with radioactive iodine contrast, of the decedent's abdomen and pelvis, along with a portion of the decedent's legs. That CTA imaging was read by MSH radiologist Aaron Fischman, M.D., who, according to the movants, did so "without the benefit of comparison to prior films." Dr. Fischman's findings were of

> "an infrarenal aortofemoral bypass graft in place. There is low density outpouching at the takeoff site of the aortobilliac graft measuring up to 5.2 cm in diameter *consistent with an aneurysm in this location*, *representing postoperative perigraft fluid collection*. The left iliac portion of this graft appears narrowed distally. The anastomoses of the external iliac portions of the graft with the proximal femoral arteries bilaterally appear patent."

(emphasis added). The plaintiff contended, however, that there is nothing in the medical or hospital records to suggest that the CTA was read without the benefit of comparison to prior films. Dr. Fischman's recorded impression of this CTA scan was

> "Marked atherosclerotic disease throughout the visualized arteries.
>
> "Status post aortofemoral bypass placement with *aneurysmal dilatation* measuring up to 5.2cm at the takeoff site compatible with postoperative perigraft fluid collection *possibly* representing a seroma.
>
> "Occluded right axillary/femoral graft
>
> "Two-vessel runoff to the bilateral lower extremities.
>
> "Large right and moderate left pleural effusions with adjacent atelectasis comprising much of the lower lobes bilaterally."

(emphasis added).

At his deposition, Kim testified that he recalled the finding on the CTA scan indicating the presence of a fluid collection in the area of the prior surgery, more specifically, in the retroperitoneal space in the area of the perirenal aorta. Kim recalled discussing the feature appearing on the imaging with his senior vascular surgery partner, Raj Malik, M.D., and also with Robert Lookstein, M.D., MSH's chief of interventional radiology, both of whom, according to Kim, confirmed that it was indeed a innocuous fluid collection, and that treatment was not indicated. The plaintiff contested the reliability of Kim's recollection in this regard, asserting that neither Dr. Malik's nor Dr. Lookstein's opinions in this regard were included in the hospital's records and, thus, were inadmissible hearsay.

Kim further testified that, upon imaging, there was no iodine contrast observable within the fluid collection and, hence, the feature on the scan that he described as a fluid collection was not an aneurysm or pseudoaneurysm. He explained that, if the feature on the scan were in fact a pseudoaneurysm, one would observe contrast leaking into it. The plaintiff objected that, although the statement concerning the presence or absence of contrast within the fluid collection may or may not have been true, the remainder of this testimony constituted a

contested opinion rather than a fact. Kim also opined that fluid collections around surgical sites are common and that post-surgical fluid collections are usually encapsulated by the surrounding tissue. The plaintiffs contested the validity of those opinions.

Kim averred at his deposition that the June 4, 2015 CTA study showed that the major aorto-bifemoral bypass had been successful, as there was blood flow through the bypass, and that he did not see any aneurysmal-type defect. The plaintiff contested these statements as statements of opinion, and not fact. Kim concluded hypothetically that, even if it were a true aneurysm, surgery would not be indicated to treat a 5.2 cm-aneurysm, as the standard of care is to forego surgery in connection win any aneurysm less than 5.5 cm in diameter.

Kim testified that, subsequent to the angiogram, he had a discussion with the plaintiff, during which he told her that her decedent had no major circulation problems, specifically, that the decedent's weakness and a left toe ulceration were not due to any major circulation problems. Kim assured her that he did not see anything wrong with the prior surgeries. Although the plaintiff did not contest the allegations that Kim made these statements to her, she nonetheless asserted that the content of those statements constituted opinion, and contested the validity of those opinions.

Infectious disease specialist Eric Neibart, M.D., consulted with the decedent on June 5, 2015, and noted that the decedent was afebrile and without leukocytosis, and that a chest x-ray was positive for effusions, but not pneumonia. Dr. Neibart concluded that antibiotics were not needed. The decedent remained afebrile with a normal white blood cell count for the remainder of the admission.

On June 7, 2015, the decedent underwent a CT of his lumbar spine. The findings of that imaging included severe atherosclerotic disease. The records memorialized that the decedent was

> "Status post aorto-bifemoral bypass graft. Previous identified collection adjacent to the graft takeoff *possibly representing a seroma* is incompletely imaged, better

> appreciated on recent CT angiogram 6/4/2015. Moderate bilateral pleural effusions.
>
> "Moderate to severe left-sided hydroureteronephrosis. Multiple bilateral renal cysts some of which are hyperdense. incompletely characterized on this study.
>
> "*Consider ultrasound or MRI for further characterization*."

(emphasis added).

On June 12, 2015, Kim obtained pre-operative clearance, and thereupon performed a left-leg angiogram upon the decedent to ascertain the source of the decedent's severe left foot symptoms, including a non-healing ulcer on the fifth toe of his left foot. Kim asserted that the angiogram was necessary because CT angiography could not confirm the patency of the relevant vessel due to calcifications, but that the angiogram that he did perform revealed results that were within normal limits. Kim did not perform any further angiography or diagnostic testing on the fluid collection in the retroperitoneal space near the perirenal aorta. On June 17, 2015, the decedent was discharged from MSH.

On August 20, 2015 at 2:50 p.m., the decedent presented via ambulance to the emergency room of Plainview Hospital in Plainview, New York, at which time he was unresponsive. According to the plaintiff, the decedent had gone to his rehabilitation appointment earlier that day and had become unresponsive. At Plainview Hospital, the decedent was emergently intubated and admitted to the intensive care unit. The decedent's hemoglobin level was 6.7 grams per deciliter of blood and his hematocrit level, measuring the percentage of red cells in his blood, was 20.7%, both of which levels are considered low. Two units of packed red bloods cell and one unit of fresh frozen plasma were transfused into the decedent's bloodstream via rapid infusion. Although a CT scan of the decedent's head was normal, a CT scan of his abdomen showed a large hematoma, measuring 8.2 cm by 7.7 cm by 13.1 cm, that was adjacent to the abdominal aorta, along with a moderate hemoperitoneum, or presence of blood in the peritoneal cavity due to leakage, that his physicians strongly suspected was caused by an aortic injury or rupture.

Cardiologist Neeral Patel, M.D., consulted with the team that was treating the decedent, and recommended an immediate CT scan with contrast, both to find the extravasation, or leakage, site, and to provide a better "road map" for anticipated vascular surgery. A CTA scan of the decedent's abdomen and pelvis revealed a large hematoma, measuring 7.8 cm by 7.8 cm by 11.3 cm, that was abutting the anterior wall of the abdominal aorta. The scan further revealed the presence of an irregular, lobulated outpouching, arising from the anterior wall of the graft, located approximately 4 cm distal to the graft anastomosis, with disruption of the anterior wall of the aorta at that site and focal outpouching of the proximal limbs of the graft. The scan also revealed the native aorta measured 1.1 cm by 1.6 cm at the point of the graft bifurcation. The decedent's team concluded that these findings were consistent with a pseudoaneurysm.

Late in the evening of August 20, 2015, the decedent was transferred from Plainview Hospital to North Shore University Hospital (NSUH) in Manhasset, New York, and he was received at NSUH very shortly after midnight on August 21, 2015. At NSUH, vascular surgeon Yana Etkin, M.D., reviewed the CTA from Plainview Hospital, and developed a working hypothesis that the leak was coming from the distal anastomosis, and that it would be impossible to perform an open heart surgery, based upon her concerns that the affected area might be an infected field and that placing another graft was not ideal. Upon concluding that an attempted surgery nonetheless was necessary to save the decedent's life, Dr. Etkin explained to the decedent's family that the mortality rate was approximately 90% and the morbidity rate was 100%. As set forth in Dr. Etkin's notes, she successfully sealed the leak with an endovascular abdominal aortic aneurysm repair (EVAR) device. She also performed a left-to-right femoral-to-femoral bypass. Immediately subsequent to the surgery, the decedent evinced pulses bilaterally that were observable via Doppler ultrasound monitoring. The decedent was transferred to NSHU's surgical intensive care unit, and then to the regular intensive care unit,

where he was monitored and followed by Dr. Etkin, as well as NSUH's renal care, infectious disease, and electrophysiology departments, but he remained in critical condition.

On August 25, 2015, the decedent developed sepsis from e. coli bacteremia and was given a very poor prognosis. On August 26, 2015, the medical staff at NSUH designated him as a "do not resuscitate" patient. The decedent died on August 26, 2015 at 12:30 p.m. According to the plaintiff, the official cause of her decedent's death was "cardiopulmonary arrest due to septic shock, which was caused or contributed to by a ruptured aortic aneurysm." NSUH's chart noted that the family declined an autopsy.

III. THE PLAINTIFF'S ALLEGATIONS

In her complaint, the plaintiff alleged that the movants, among others, were negligent in their provision of medical care to her decedent, that they departed from accepted standards of care, and that these departures caused or contributed to her decedent's injuries, including his death. She also alleged that the movants failed to obtain her decedent's fully informed consent to the procedures that they performed, and that their failure in this regard caused or contributed to the decedent's injuries and death. The plaintiff also alleged that MSH should be held vicariously liable for the medical malpractice committed by its employees, including physicians, physicians' assistants, and nurses. In addition, the plaintiff alleged that the movants negligently caused her decedent's death and that the decedent's death caused pecuniary loss to his estate. Finally, she alleged that she was entitled to recover for the loss of her decedent's consortium from the date that the movants committed malpractice to the time of her decedent's death.

In her bill of particulars addressed to Kim, the plaintiff asserted that Kim deviated from accepted standards of medical practice in failing properly to diagnose the decedent's condition, including the presence of an aneurysm, read diagnostic testing results, appreciate the decedent's history of aneurysm, order appropriate diagnostic testing, and perform, read, and interpret CT angiography. The plaintiff further asserted that Kim failed to treat her decedent's

condition with the appropriate urgency and was negligent in discharging him from MSH on June 17, 2015. The plaintiff also alleged that Kim failed properly to treat her decedent's aneurysm by, among other things, declining to perform emergency surgery, and in allowing the aneurysm to rupture. In addition, she alleged that Kim failed to diagnose her decedent with an abdominal aortic aneurysm and in failing to appreciate the presence of, or advise the decedent of, this life-threatening condition. The plaintiff additionally alleged that Kim was negligent in

> "failing to promptly, properly, timely and adequately order, direct, recommend, advise, refer, provide, perform and/or ensure the performance of such medical procedures as were urgently required to prevent the worsening of Plaintiff's decedent's conditions; in failing to promptly, properly, timely and adequately detect, discover, diagnose, consider, evaluate, investigate, treat and manage the said conditions at such time as it was more easily treatable, operable, manageable and/or curable; in causing, allowing and permitting Plaintiff's decedent's conditions to increase, worsen and progress; [and] in failing to promptly, properly, timely and adequately order, direct, recommend, advise, refer, provide, perform and/or ensure compliance with orders, directions, instructions and policies relative to the testing, care, treatment and management of Plaintiff's decedent."

The plaintiff also faulted Kim for in failing to call in other qualified medical personnel, or refer the decedent to specialists, including, but not limited to, other vascular surgeons, in failing to memorialize and employ the decedent's medical history, and in failing to memorialize accurate entries in the relevant medical and hospital records and charts. In addition, she averred that Kim failed to perform necessary and required tests, examinations, and evaluations to determine the extent and nature of her decedent's condition, both pre-operatively, operatively, and post-operatively.

The plaintiff alleged that, as a consequence of these departures from good and accepted practice, her decedent sustained a ruptured abdominal aortic aneurysm, a ruptured pseudoaneurysm, septic shock, and cardiac/cardiopulmonary arrest, all of which caused significant conscious pain and suffering, significant emotional and mental pain and suffering, fear of impending death, and death itself.

In addition, the plaintiff alleged that Kim failed fully to inform her decedent of the

> "nature, purposes, known perils, recognized hazards, risks, or possible complications of the examinations, evaluations, diagnoses, consultations, care, treatments, procedures, tests, studies, services, or advice ordered for, requested for, recommended for, advised for, performed upon, rendered to, or provided to Plaintiff's decedent."

She also asserted that Kim failed to inform her decedent of any alternative methods of treatment, and that had the decedent been fully informed as to hazards and dangers of the procedure that Kim ultimately performed, he would have refused Kim's "examinations, evaluations, diagnoses, consultations, care, treatments, procedures, tests, studies, services, or advice, or would have sought and/or obtained alternative examinations, evaluations, diagnoses, consultations, care, treatments, procedures, tests, studies, services, and/or advice."

A review of the docket entries in this action does not reveal whether MSH ever served a demand for a bill of particulars as to its own malpractice, and the papers submitted by the movants here do not include either such a demand or a bill of particulars addressed to MSH.

IV. THE SUMMARY JUDGMENT MOTION

In support of their motion, the movants submitted the pleadings, the bills of particulars addressed to Kim and his codefendants other than MSH, the parties' deposition transcripts, the note of issue, and relevant medical and hospital records, as well as the expert affirmation of Todd Berland, M.D., a physician who is board-certified in general surgery and vascular surgery.

Upon reviewing the December 28, 2014 post-operative CTA imaging of the decedent's abdomen and pelvis from GSH, Dr. Berland concluded that the imaging revealed a patent aortoiliac bifemoral graft, as well as "some free fluid 2 cm proximal to the graft." He opined that the free fluid was not a pseudoaneurysm, and asserted that he observed no active bleeding, "as there is no extravasation of contrast from the patent graft into the area of free fluid, confirming that there is no communication of blood from the graft to this fluid." Dr. Berland stated that this condition was "simply a normal post-operative finding." With respect to the May 6, 2015 abdominal CTA performed at GSH, Dr. Berland concluded that "the free fluid was in the same

area proximal to the graft as seen on the previous 12/28/14 CTA, but was now encapsulated." He similarly opined that the image did not represent a pseudoaneurysm, as "again no extravasation of contrast is seen from the patent graft into the area of encapsulated free fluid, confirming that there is no communication of blood from the graft to this fluid." Dr. Berland asserted that, instead, the imaging depicted a seroma, which he defined as "a harmless collection, resulting from sterile lymphatic fluid caused by disruption of lymphatic vessels during surgery." He characterized the presence of a seroma as a normal post-operative finding that required no surgical intervention, and noted that "the area of the bifurcation, distal to the graft, showed no abnormal findings."

In connection with the June 4, 2015 CTA of the decedent's abdomen, pelvis, and lower extremities performed at MSH, which is the primary subject matter of this motion, Dr. Berland asserted that "[t]he seroma was unchanged from the prior 5/6/15 study. The seroma above the graft was the same size and again showed no contrast within it." He continued that,

> "[l]ikewise, distal to the graft, at the point of bifurcation, there was no abnormal finding. It is my opinion within a reasonable degree of medical certainty that this seroma did not require further investigation or treatment on 6/4/2015. It is my opinion that Dr. Kim appropriately concluded that no vascular surgical intervention was required during the June 2015 admission to Mt. Sinai Hospital for either the bypass graft or the seroma."

Dr. Berland further opined that, had vascular surgical intervention been required, the most appropriate course of action for Kim to have taken would have been to transfer the decedent back to vascular surgeon Sacca at GSH for management. As Dr. Berland explained it, the decedent had three major grafting procedures and, by the time of Kim's intervention, he had a number of non-functioning grafts, with the most recent axillary-femoral-femoral bypass still in place, so that Sacca would have been the most familiar with the decedent's anatomy and the most appropriate physician to treat any vascular problems. In any event, Dr. Berland reiterated that, as of the decedent's June 17, 2015 discharge from MSH, there was no finding on any imaging that warranted further investigation or surgical intervention by either Kim or Sacca.

Dr. Berland averred that the CTA of the decedent's abdomen and pelvis performed on August 20, 2015 at Plainview Hospital showed a disruption at the anterior aspect of the bifurcation, "where previously there were no abnormal findings." As he described it, the rupture was distal both to the graft and to the site where "the stable, encapsulated fluid collections were seen on the prior studies." Dr. Berland did not, however, describe how far the rupture was from the location of the collection of fluid. Although Dr. Berland concluded that these images did indeed confirm that a rupture at the bifurcation caused a bleed *into the area* where the seroma was located, he reasoned that they did not constitute an indication that the source of the bleeding was the seroma itself or the portion of the graft adjacent to it. He thus opined that the "stable, encapsulated fluid collections seen on the previous CTA studies were not aneurysms or pseudoaneurysms," that, "prior to August 20, 2015, none of the imaging studies performed on this decedent showed evidence of an aneurysm or pseudoaneurysm," and that "there was no sign of abnormality at the bifurcation on the prior imaging that would have raised any concern that vascular surgical intervention was warranted at any time up to 6/17/2015."

Dr. Berland ultimately concluded that there was "no physical or vascular relationship between the stable fluid collection seen on the studies from December 2014 through June 2015 and the rupture at the bifurcation, located distal to the graft, seen in August 2015," and that, as such, neither Kim nor MSH departed from the standards of accepted medical practice in reaching the same conclusions with respect to the December 2014, May 2015, and June 2015 CTA imaging. He further asserted that the care rendered by the movants did not cause or exacerbate the decedent's injuries.

In opposition to the motion, the plaintiff relied on the documents submitted by the movants, and also submitted the expert affirmation of David Mayer, M.D., a physician board certified in general surgery, who averred that he had extensive training in all aspects of vascular surgery, having performed more than 10,000 major open vascular and endovascular surgery operations. Dr. Mayer asserted that he had countless patients who presented with vascular

issues, including pseudoaneurysms, that he was familiar with the signs, symptoms, and presentation of pseudoaneurysms, and that he was familiar with the standards of care applicable to the diagnosis and treatment of that condition, as well as the exigency of treatment and the risks associated with delayed treatment. Dr. Mayer opined that the movants departed from accepted standards of care by ignoring the decedent's pseudoaneurysm at a time when treatment was still possible, by failing to provide proper and timely treatment, including surgical intervention, by failing to warn the decedent that he was suffering from a pseudoaneurysm that they did not treat, and by failing to warn the decedent of the risks associated with that condition. He further opined that the movants' failure timely to diagnose the pseudoaneurysm caused the decedent's condition to deteriorate, caused the decedent to lose an opportunity for a cure, and ultimately led to the rupture of the aortic aneurysm that caused the decedent's death.

Dr. Mayer asserted that Dr. Fischman's radiological findings in connection with the June 4, 2015 CTA scan were "highly suspicious for anatomic disruption and pseudoaneurysm formation." He further noted that the June 7, 2015 lumbar spine CT still identified a seroma only as a *possible* explanation for the feature depicted in the imaging, and that there was a clear directive to Kim in that radiology report that he should "[c]onsider ultrasound or MRI for further characterization" of that image. Dr. Mayer pointed out that, notwithstanding this note, Kim never ordered an ultrasound or MRI, nor did he provide any explanation as to why he did not consider Dr. Fischman's recommendations in this regard. Dr. Mayer asserted that "[t]hese imaging studies, if done, would have properly identified the pseudoaneurysm and would have ruled out the false diagnosis of seroma." He further noted that a mention of seromas and aneurysms appeared only in MSH's radiology reports, while appearing nowhere in the remaining medical records, and he thus opined that Kim's testimony concerning the hearsay statements of Drs. Malik and Lookstein purportedly confirming the presence only of an innocuous fluid collection did not represent an accurate medical history.

Dr. Mayer expressly refuted Kim's testimony to the effect that the subject imaging did not depict an aneurysm, which Kim based on the success of the major aorto-bifemoral bypass that permitted blood flow through the vessel, and the absence of observable iodine contrast within the image of the fluid collection. In this regard, he explicitly disagreed with Kim's conclusion that, if the feature seen on the imaging were indeed a pseudoaneurysm, one would observe contrast leaking into it. As Dr. Mayer asserted,

> "[t]his is not accurate, contradicts the actual findings demonstrated on the June 4, 2015 CTA, is not included in the medical record, and does not explain why further studies were never ordered."

Dr. Mayer further averred that the movants departed from accepted practice because the decedent was never warned about his pseudoaneurysm or even a seroma, nor was he instructed to undergo further scans or treatment of either of those conditions. Rather, Dr. Mayer asserted that the decedent was allowed to be discharged, and was not advised that, without treatment, a pseudoaneurysm could rupture, resulting in a major medical emergency. He stated that, in fact, this is precisely what occurred, inasmuch as the untreated pseudoaneurysm deteriorated, causing the decedent's August 2015 hospitalization and the rupture leading to the decedent's death.

As Dr. Mayer explained,

> "[p]seudoaneurysms are false aneurysms that occur at the site of arterial injury. They are unlike true aneurysms as a layer of the arterial wall does not contain them. Prompt recognition and treatment are required. Differential diagnosis of a femoral pseudoaneurysm includes: Hematoma, Seroma, and Infection/abscess.
>
> "The risk of rupture is higher than that of a true aneurysm of comparable size due to poor support of the aneurysm wall and thus false aneurysms generally require treatment. When left untreated, pseudoaneurysms can rupture into the retroperitoneal space, causing significant bleeding that may not be immediately obvious. Furthermore, bleeding which may be initially contained in the retroperitoneal space can, if untreated, eventually rupture into the free peritoneal cavity causing uncontrollable fatal hemorrhage once the tamponade is lost, which occurred here."

He continued that, even if the decedent had been suffering from a seroma, also known as a perigraft fluid collection, rather than a pseudoaneurysm, the fact that it went ignored and

untreated is still a departure from good and accepted medical practice. In this respect, Dr. Mayer opined that,

> "[t]his is so because a perigraft fluid collection *must be considered a pseudoaneurysm until proven otherwise, or risk rupture and fatal exsanguination, as occurred here*. It should be noted that Mr. Cristiano's June 4, 2015 CTA scan showed much more than an innocuous fluid collection or seroma. In fact, it showed an aneurysmal dilatation measuring 5.2 cm at the takeoff (aortic anastomosis) of the aortofemoral graft with a perigraft fluid collection which represented contained retroperitoneal blood. This was an ominous finding highly suspicious for a contained leak at the proximal graft-aorticanastomosis which was a ticking time bomb highly likely to progress to a free rupture leading to the death of the patient from massive hemorrhage, as occurred here. This red flag was completely ignored by the herein defendants."

(emphasis added).

Dr. Mayer asserted that it was necessary to rule out or rule in a pseudoaneurysm, and, if ruled in, thereafter to treat it. He stated that, based upon the findings of the June 4, 2015 CTA scan, the decedent should have been taken promptly to the interventional suite for an arteriogram, and once the pseudoaneurysm was identified, an endovascular stent should have been deployed across the area, effectively sealing the disrupted, leaking proximal aortic anastomosis. According to Dr. Mayer, this approach would have prevented the contained leak from progressing to the fatal free intraperitoneal rupture and hemorrhage that the decedent sustained in August 2015.

Dr. Mayer opined that the movants' departures from good practice, as he described them above, allowed the decedent's pseudoaneurysm go unappreciated and untreated, leading to its rupture, and the decedent to suffer a massive hemorrhage, cardiopulmonary arrest, and death. As he explained it, had the decedent received timely and appropriate treatment, including "straightforward endovascular stent placement," the pseudoaneurysm would have been sealed off, as the physicians at NSUH unsuccessfully attempted to do in August 2015 when the decedent's condition had deteriorated beyond the point where such treatment would have been effective. He stated that, had the decedent timely received appropriate intervention,

he would not have experienced a rupture in late August 2015, thereby avoiding death from uncontrollable bleeding.

Dr. Mayer expressly disagreed with Dr. Berland's opinion that the defendants did not depart from accepted standards of care in interpreting and acting on the imaging that appeared on the June 4, 2015 CTA, concluding that the imaging, as he read it, displayed a life-threatening pseudoaneurysm. As he reiterated, although Dr. Berland incorrectly suggested that the imaging depicted an innocuous seroma, such a diagnosis nonetheless was insufficient to explain the lack of follow-up and the lack of treatment, as Kim made no actual assessments regarding the purported seroma. Dr. Mayer gave no credence to Dr. Berland's opinions in this regard, insisting that the standard of care for distinguishing a seroma from a pseudoaneurysm requires ruling out a pseudoaneurysm though further studies, and that the most appropriate study would have been an arteriogram, which would have been both diagnostic and therapeutic, enabling endovascular stent intervention that would have prevented his fatal hemorrhage.

In reply, the movants submitted an attorneys' affirmation, in which counsel, relying on an expert affirmation submitted by a codefendant in connection with another motion sequence in this action, primarily contended that the fatal rupture occurred at a location four centimeters away from the area where the suspicious fluid collection was observed in the June 4, 2015 CTA imaging. Hence, the movants argue that, even if they improperly diagnosed a pseudoaneurysm as a seroma, any such failure did not proximately cause the decedent's fatal injuries. The movants also refer to their codefendants' expert affirmations to corroborate their contention that no pseudoaneurysm was seen on any CTA imaging performed in December 2014, May 2015, or June 2015, suggesting, but not expressly stating, that the rupture that caused the decedent's death arose from a completely new aneurysm or pseudoaneurysm that developed in a different location after the decedent was discharged from MSH on June 17, 2015.

A. SUMMARY JUDGMENT STANDARDS

It is well settled that the movant on a summary judgment motion "must make a prima facie showing of entitlement to judgment as a matter of law, tendering sufficient evidence to eliminate any material issues of fact from the case" (*Winegrad v New York Univ. Med. Ctr.*, 64 NY2d 851, 853 [1985] [citations omitted]). The motion must be supported by evidence in admissible form (*see Zuckerman v City of New York*, 49 NY2d 557, 562 [1980]), as well as the pleadings and other proof such as affidavits, depositions, and written admissions (*see* CPLR 3212). The facts must be viewed in the light most favorable to the non-moving party (*see Vega v Restani Constr. Corp.*, 18 NY3d 499, 503 [2012]). In other words, "[i]n determining whether summary judgment is appropriate, the motion court should draw all reasonable inferences in favor of the nonmoving party and should not pass on issues of credibility" (*Garcia v J.C. Duggan, Inc.*, 180 AD2d 579, 580 [1st Dept 1992]). Once the movant meets its burden, it is incumbent upon the non-moving party to establish the existence of material issues of fact (*see Vega v Restani Constr. Corp.*, 18 NY3d at 503). A movant's failure to make a prima facie showing requires denial of the motion, regardless of the sufficiency of the opposing papers (s*ee id.*; *Medina v Fischer Mills Condo Assn.,* 181 AD3d 448, 449 [1st Dept 2020]).

"The drastic remedy of summary judgment, which deprives a party of his [or her] day in court, should not be granted where there is any doubt as to the existence of triable issues or the issue is even 'arguable'" (*De Paris v Women's Natl. Republican Club, Inc.*, 148 AD3d 401, 403-404 [1st Dept 2017]; *see Bronx-Lebanon Hosp. Ctr. v Mount Eden Ctr.*, 161 AD2d 480, 480 [1st Dept 1990]). Thus, a moving defendant does not meet its burden of affirmatively establishing entitlement to judgment as a matter of law merely by pointing to gaps in the plaintiff's case. It must affirmatively demonstrate the merit of its defense (s*ee Koulermos v A.O. Smith Water Prods.*, 137 AD3d 575, 576 [1st Dept 2016]; *Katz v United Synagogue of Conservative Judaism,* 135 AD3d 458, 462 [1st Dept 2016]).

B. MEDICAL MALPRACTICE BASED ON DEPARTURE FROM ACCEPTED PRACTICE

"To sustain a cause of action for medical malpractice, a plaintiff must prove two essential elements: (1) a deviation or departure from accepted practice, and (2) evidence that such departure was a proximate cause of plaintiff's injury" (*Frye v Montefiore Med. Ctr.*, 70 AD3d 15, 24 [1st Dept 2009]; *see Roques v Noble*, 73 AD3d 204, 206 [1st Dept 2010]; *Elias v Bash*, 54 AD3d 354, 357 [2d Dept 2008]; *DeFilippo v New York Downtown Hosp.*, 10 AD3d 521, 522 [1st Dept 2004]).

Where a physician fails properly to diagnose a patient's condition, thus providing less than optimal treatment or delaying appropriate treatment, and the insufficiency of or delay in treatment proximately causes injury, he or she will be deemed to have departed from good and accepted medical practice (*see Zabary v North Shore Hosp. in Plainview,* 190 AD3d 790, 795 [2d Dept 2021]; *Lewis v Rutkovsky*, 153 AD3d 450, 451 [1st Dept 2017]; *Monzon v Chiaramonte*, 140 AD3d 1126, 1128 [2d Dept 2016] ["(c)ases . . . which allege medical malpractice for failure to diagnose a condition . . . pertain to the level or standard of care expected of a physician in the community"]; *O'Sullivan v Presbyterian Hosp. at Columbia Presbyterian Medical Ctr.*, 217 AD2d 98, 101 [1st Dept 1995]).

A defendant physician moving for summary judgment must make a prima facie showing of entitlement to judgment as a matter of law by establishing the absence of a triable issue of fact as to his or her alleged departure from accepted standards of medical practice (*Alvarez v Prospect Hosp.,* 68 NY2d 320, 324 [1986]; *Frye v Montefiore Med. Ctr.*, 70 AD3d at 24) or by establishing that the plaintiff was not injured by such treatment (*see McGuigan v Centereach Mgt. Group, Inc.*, 94 AD3d 955 [2d Dept 2012]; *Sharp v Weber*, 77 AD3d 812 [2d Dept 2010]; *see generally Stukas v Streiter*, 83 AD3d 18 [2d Dept 2011]).

To satisfy the burden, a defendant must present expert opinion testimony that is supported by the facts in the record, addresses the essential allegations in the complaint or the

bill of particulars, and is detailed, specific, and factual in nature (*see Roques v Noble*, 73 AD3d at 206; *Joyner-Pack v. Sykes*, 54 AD3d 727, 729 [2d Dept 2008]; *Koi Hou Chan v Yeung*, 66 AD3d 642 [2d Dept 2009]; *Jones v Ricciardelli*, 40 AD3d 935 [2d Dept 2007]). If the expert's opinion is not based on facts in the record, the facts must be personally known to the expert and, in any event, the opinion of a defendant's expert should specify "in what way" the patient's treatment was proper and "elucidate the standard of care" (*Ocasio-Gary v Lawrence Hospital*, 69 AD3d 403, 404 [1st Dept 2010]). Stated another way, the defendant's expert's opinion must "explain 'what defendant did and why'" (*id*., quoting *Wasserman v Carella*, 307 AD2d 225, 226, [1st Dept 2003]). Furthermore, to satisfy his or her burden on a motion for summary judgment, a defendant must address and rebut specific allegations of malpractice set forth in the plaintiff's bill of particulars (*see Wall v Flushing Hosp. Med. Ctr*., 78 AD3d 1043 [2d Dept 2010]; *Grant v Hudson Val. Hosp. Ctr*., 55 AD3d 874 [2d Dept 2008]; *Terranova v Finklea*, 45 AD3d 572 [2d Dept 2007]).

Once satisfied by the defendant, the burden shifts to the plaintiff to demonstrate the existence of a triable issue of fact by submitting an expert's affidavit or affirmation attesting to a departure from accepted medical practice and opining that the defendant's acts or omissions were a competent producing cause of the plaintiff's injuries (*see Roques v Noble*, 73 AD3d at 207; *Landry v Jakubowitz*, 68 AD3d 728 [2d Dept 2009]; *Luu v Paskowski*, 57 AD3d 856 [2d Dept 2008]). Thus, to defeat a defendant's prima facie showing of entitlement to judgment as a matter of law, a plaintiff must produce expert testimony regarding specific acts of malpractice, and not just testimony that contains "[g]eneral allegations of medical malpractice, merely conclusory and unsupported by competent evidence tending to establish the essential elements of medical malpractice" (*Alvarez v Prospect Hosp*., 68 NY2d at 325; *see Frye v Montefiore Med. Ctr*., 70 AD3d at 24). In most instances, the opinion of a qualified expert that the plaintiff's injuries resulted from a deviation from relevant industry or medical standards is sufficient to preclude an award of summary judgment in a defendant's favor (*see Murphy v Conner*, 84

NY2d 969, 972 [1994]; *Frye v Montefiore Med. Ctr.*, 70 AD3d at 24). Where the expert's "ultimate assertions are speculative or unsupported by any evidentiary foundation, however, the opinion should be given no probative force and is insufficient to withstand summary judgment" (*Diaz v New York Downtown Hosp.*, 99 NY2d 542, 544 [2002]; *see Frye v Montefiore Med. Ctr.*, 70 AD3d at 24).

1. Claims Against Kim

Contrary to the plaintiff's contention, the movants did, in fact, establish their prima facie entitlement to judgment as a matter of law in connection with the medical malpractice cause of action. Dr. Berland's expert affirmation was not conclusory, in that he personally read the various CTA scans, and opined that the feature seen on the relevant imaging from December 2014, May 2015, and June 2015 was not an aneurysm or pseudoaneurysm. He explicitly concluded that it was a seroma, that is, an innocuous collection of fluids, that did not warrant additional testing or procedures to rule out an aneurysm or pseudoaneurysm. Dr. Berland explicitly opined that Kim's determination to forego any further testing or procedures was within the standard of care, and concluded that the August 2015 aortic rupture that led to the decedent's death occurred in an unrelated aneurysm or pseudoaneurysm that was distal both to the graft and to the site where the fluid buildup was located.

The plaintiff, however, raised a triable issue of fact with her expert's affirmation as to whether Kim properly read the June 4, 2015 CTA imaging, properly diagnosed a seroma based upon the radiologist's suggestion, and failed to develop a proper differential diagnosis in order to rule out an aneurysm or pseudoaneurysm. Dr. Mayer unambiguously read the scan as depicting a pseudoaneurysm, after concluding that other factors militated in favor of that diagnosis. He also explicitly opined that, under the circumstances presented by the decedent's case, further testing was required by the standard of care even if Kim could properly have made an initial diagnosis of seroma, as the standard of care required him to rule out aneurysm or pseudoaneurysm. Dr. Mayer also unambiguously opined that the failure to diagnose and treat

the pseudoaneurysm in June 2015 led directly to the August 2015 rupture that killed the decedent.

The parties' experts thus presented starkly different opinions concerning whether Kim departed from accepted care in his diagnosis, in limiting any differential diagnosis so as to omit consideration of a pseudoaneurysm, in failing immediately to order additional tests in light of the decedent's history, and in failing immediately to treat the 5.2-cm feature with surgery, instead discharging the decedent to his home on June 17, 2015.

It is immaterial as to whether the proper course of care upon suspicion of a pseudoaneurysm would have been to refer the decedent back to his previous vascular surgeon, or to refer him to someone else who could undertake an arteriogram and perform surgery to rectify any problems arising from a pseudoaneurysm. As it turned out, Kim did neither. Moreover, the court rejects the movants' argument with respect to proximate cause. Although Dr. Berland opined that the rupture was distal to the fluid collection, thus suggesting that the area of rupture and the fluid collection concerned two distinct anatomical features, he did not quantify the distance between the two, which, according to the expert affirmations cited in the movants' reply papers, was only 4 cm. Dr. Berland thus could not render an opinion as to whether that distance did indeed reflect the presence of two distinct features, or whether their proximity suggested that they were one and the same feature, or at least physically intertwined. In any event, the movants raised the issue of distance for the first time in reply, and did not, in any event, make a prima facie showing that the area of rupture and the area of fluid collection were indeed completely distinct.

Hence, the court must deny that branch of the motion seeking summary judgment dismissing the medical malpractice cause of action insofar as asserted against Kim.

2. Claims Against MSH

A hospital or other medical facility is liable for the negligence or malpractice of its employees (*see Hill v St. Clare's Hospital,* 67 NY2d 72, 79 [1986]; *Bing v Thunig*, 2 NY2d 656,

667 [1957]; *Singh v Sukhu,* 180 AD3d 837, 839 [2d Dept 2020]; *Pollicina v Misericordia Hosp. Medical Ctr*., 158 AD2d 194. 199 [1st Dept 1990]). Although Kim denied in his answer that he was an employee of MSH, he testified at his deposition that he was, in fact, a full-time employee of MSH. The movants do not claim otherwise in their motion papers. Because the court declines to award Kim summary judgment dismissing the medical malpractice cause of action insofar as asserted against him, the court must also deny that branch of the motion seeking summary judgment dismissing the vicarious liability cause of action insofar as asserted against MSH, to the extent that it is premised upon the medical practice claims against Kim.

C. LACK OF INFORMED CONSENT

The elements of a cause of action for lack of informed consent are

> "(1) that the person providing the professional treatment failed to disclose alternatives thereto and failed to inform the patient of reasonably foreseeable risks associated with the treatment, and the alternatives, that a reasonable medical practitioner would have disclosed in the same circumstances, (2) that a reasonably prudent patient in the same position would not have undergone the treatment if he or she had been fully informed, and (3) that the lack of informed consent is a proximate cause of the injury"

(*Spano v Bertocci*, 299 AD2d 335, 337-338 [2d Dept 2002]; *see Zapata v Buitriago*, 107 AD3d 977, 979 [2d Dept. 2013]). For a statutory claim of lack of informed consent to be actionable, a defendant must have engaged in a "non-emergency treatment, procedure or surgery" or "a diagnostic procedure which involved invasion or disruption of the integrity of the body" (Public Health Law § 2805-d[2]). "'The mere fact that the plaintiff signed a consent form does not establish the defendants' prima facie entitlement to judgment as a matter of law'" (*Huichun Feng v. Accord Physicians*, 194 AD3d 795, 797 [2d Dept 2021], quoting *Schussheim v Barazani*, 136 AD3d 787, 789 [2d Dept 2016]). Nonetheless. a defendant may satisfy his or her burden of demonstrating a prima facie entitlement to judgment as a matter of law in connection with such a cause of action where a patient signs a detailed consent form, and there is also evidence that the necessity of the procedure, along with known risks and dangers, was discussed prior to the surgery (*see Bamberg-Taylor v Strauch*, 192 AD3d 401, 401-402 [1st Dept 2021]).

"A failure to diagnose cannot be the basis of a cause of action for lack of informed consent unless associated with a diagnostic procedure that 'involve[s] invasion or disruption of the integrity of the body'" (*Janeczko v Russell*, 46 AD3d 324, 325 [1st Dept 2007], quoting Public Health Law § 2805-d[2][b]; *see Lewis v Rutkovsky*, 153 AD3d at 456), and that invasion or disruption is claimed to have caused the injury. Moreover, a claim to recover for lack of informed consent cannot be maintained where the alleged injuries resulted either from the failure to undertake a procedure or the postponement of that procedure (*see Ellis v Eng*, 70 AD3d 887, 892 [2d Dept 2010]; *Jaycox v Reid*, 5 AD3d 994, 995 [4th Dept 1994]). Here the alleged failure to diagnose a pseudoaneurysm did not lead to unnecessary surgery or an unnecessary procedure, and did not lead to an invasion of bodily integrity that caused the decedent's injuries. Rather, this matter presents the more common situation in which the failure to diagnose allegedly led to the delay in performing an invasive procedure that, had it been performed in timely manner, purportedly would have avoided the decedent's injuries.

Hence, in opposition to the movants' prima facie showing of entitlement to judgment as a matter of law in connection with the lack of informed consent cause of action, the plaintiff failed to raise a triable issue of fact. Consequently, that branch of the motion seeking summary judgment dismissing that cause of action insofar as asserted against the movants must be granted.

V. CONCLUSION

In light of the foregoing, it is

ORDERED that the motion of the defendants Sung Y. Kim, M.D., and The Mount Sinai Hospital for summary judgment dismissing the complaint insofar as asserted against them is granted only to the extent that they are awarded summary judgment dismissing the lack of informed consent cause of action insofar as asserted against them, and the motion is otherwise denied.

This constitutes the Decision and Order of the court.

9/28/2022
DATE

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...LEY, J.S.C

CHECK ONE:		CASE DISPOSED			X	NON-FINAL DISPOSITION	
		GRANTED		DENIED	X	GRANTED IN PART	OTHER
APPLICATION:		SETTLE ORDER				SUBMIT ORDER	
CHECK IF APPROPRIATE:		INCLUDES TRANSFER/REASSIGN				FIDUCIARY APPOINTMENT	REFERENCE