

Sovocool v Cortland Regional Med. Ctr.

2022 NY Slip Op 34606(U)

April 12, 2022

Supreme Court, Cortland County

Docket Number: Index No. EF18-1207

Judge: Mark G. Masler

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At a Motion Term of the Supreme Court of the State of New York, held in and for the Sixth Judicial District, at the Cortland County Courthouse, in the City of Cortland, New York, on the 25th day of March 2022.

PRESENT: HON. MARK G. MASLER
Justice Presiding.

STATE OF NEW YORK
SUPREME COURT: COUNTY OF CORTLAND

ALYSSA SOVOCOOL and DIANNE SEAMAN,
Individually and as Executrixes of the Estate
of KAREN SOVOCOOL,
Plaintiffs,

v

CORTLAND REGIONAL MEDICAL CENTER;
MERVAT EID, M.D.; YOUNG LEE, M.D.;
HAMEED IQBAL, M.D.; and ESTATE OF
HASAN ZAKARIYYA,
Defendants.

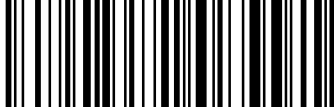
DECISION AND ORDER

Index No. EF18-1207
RJI No. 2019-0767-C

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	Pages 11
	DECISION + ORDER ON MOTION
	Elizabeth Larkin, County Clerk

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MARK G. MASLER, J. S. C.

Plaintiffs commenced this action for medical malpractice and wrongful death based on care and treatment provided to their decedent, Karen Sovocool, by defendants at Cortland Regional Medical Center (CRMC) in October of 2017. Each of the defendants now moves for summary judgment. Sovocool presented to the CRMC emergency department at approximately 6:30 p.m. on October 18, 2017, complaining of severe right upper quadrant epigastric pain radiating toward her back which had begun at approximately 3:00 a.m., accompanied by nausea. She acknowledged having had six similar episodes of pain over the preceding eight months. She was admitted to the hospital and, on October 19, 2017, was examined by a gastroenterologist, Dr. Young Lee, who diagnosed her as having gallstone pancreatitis and recommended that an endoscopic retrograde cholangiopancreatography (ERCP) be performed later that day. Sovocool was placed under general anesthesia under the supervision of anesthesiologist Dr. Mervat Eid, and Young successfully performed the ERCP without complications beginning shortly after 3:00 p.m.¹ Sovocool was transferred to the post-anesthesia care unit (PACU) at approximately 4:35 p.m. To this point, Sovocool's vital signs and oxygen saturation levels had been within normal limits.

The problems began upon Sovocool's transfer to the PACU, when she remained lethargic and somnolent, in other words, she did not rouse normally from the general anesthesia. Sovocool was placed on a non-rebreather oxygen mask and was provided with oxygen, after which her oxygen saturation levels remained in the 80s and 90s. Because Sovocool remained

¹ After the instant summary judgment motions were filed, the parties stipulated to the discontinuance of this action against Lee, with prejudice. The caption shall be amended accordingly.

nonresponsive, she was evaluated by Eid and hospitalist Dr. Hameed Iqbal. Eid saw Sovocool at 5:59 p.m., when she found Sovocool to be looking around and breathing comfortably, but nonresponsive verbally. Her oxygen saturation level was 92% on the non-rebreather mask, her pulse was low, and her blood pressure was elevated. Eid ordered administration of medications to lower her blood pressure and to help her better metabolize the anesthesia medications. Iqbal saw Sovocool at 6:44 p.m. He also noted oxygen saturation levels of 92%. He found that Sovocool responded to painful stimuli by withdrawing all four extremities and opening her eyes. He ordered basic blood tests, which were all, “for the most part,” within normal limits. He also ordered that blood be drawn to test Sovocool’s arterial blood gasses (ABGs), but the results were not available until 8:26 p.m. Iqbal’s assessment was that Sovocool was unable to metabolize the sedation administered to her for the ERCP due to her severe pancreatitis and acute liver injury, a conclusion which was consistent with Eid’s observations. Iqbal determined that intubation of Sovocool was not indicated because she was able to maintain oxygen saturation levels at 95% on the non-rebreather mask with supplemental oxygen and she responded to painful stimuli by opening her eyes.

At approximately 8:00 p.m., Sovocool was transferred to the intensive care unit (ICU), where she came under the care of Dr. Hasan Zakariyya. At 8:26 p.m., the results of the ABG tests that had been ordered by Iqbal were received. At 10:08 p.m., a rapid response was initiated because Sovocool’s oxygen saturation percentage had decreased into the 80s and she was “holding breath.” When Zakariyya arrived at Sovocool’s bedside, he found staff forcing air into her lungs with a bag valve mask. Zakariyya placed a non-rebreather mask and, with 15 liters of oxygen flowing, Sovocool’s oxygen saturation increased to 92%. Zakariyya was next called to

Sovocool's bedside for a second rapid response at 11:48 p.m. Her oxygen saturation had decreased to 75%, and he ordered that she be intubated. Beginning at 12:03 a.m. on October 20, 2017, Sovocool remained intubated and on a ventilator. At 12:43 a.m., Sovocool experienced ventricular tachycardia for one minute, for which Zakariyya ordered that she be administered the antiarrhythmic drug Amiodarone. At approximately 1:30 a.m., Sovocool underwent a CT scan which did not show any evidence of a brain injury. Sovocool resisted ventilation and her condition began to deteriorate. By 6:00 a.m. on October 20, 2017, she began to exhibit shock symptoms, including fever, increased white blood cell count, and hypotension. Due to Sovocool's condition, it was not possible to transport her to another hospital where a higher level of care could be provided until the afternoon of October 20, 2017.

At 3:30 p.m. on October 20, 2017, Sovocool was transported by helicopter to Crouse Hospital (Crouse) in Syracuse, where Dr. Russell Acevedo noted that Sovocool was experiencing acute respiratory failure secondary to septic shock and pancreatitis; that her oxygen saturation was 94% on admission to Crouse; and that she had "a very severe pancreatitis with SIRS [Systemic Inflammatory Response Syndrome]," with secondary myocardial depression (NY St Cts Elec Filing [NYSCEF] Doc No. 110 at 321, 323). Although Crouse was able to maintain or improve Sovocool's ventilation, her condition continued to deteriorate. On October 21, 2017, Sovocool had a grand mal seizure. A subsequent CT scan and an MRI both showed severe ischemic anoxic brain injuries, and an echocardiogram showed that she had a heart ejection fraction estimated to be only 20-25%. With her family's consent, Sovocool was extubated on October 21, 2017 and was provided with comfort care, until she died on October 23, 2017. The autopsy report notes, among other findings, that Sovocool had acute necrotizing pancreatitis; her

gallbladder exhibited necrosis and cholelithiasis; and she had septicemia.

The gravamen of plaintiffs' complaint against all three remaining individual defendants – Eid, Iqbal, and Zakariyya – is that the failure to protect Sovocool's airway by sooner intubating her constituted a breach of the standard of care applicable to each and directly caused the hypoxic and ischemic brain injuries that directly led to Sovocool's death.² “As the proponents of the respective motions for summary judgment, defendants bore the initial burden of establishing that they did not depart from acceptable standards of care or that any such departure did not cause the injury” (Longtemps v Oliva, 110 AD3d 1316, 1317 [2013] [citations omitted]). Defendants met this burden by submitting, among other things, affidavits from experts in their medical fields concluding that they did not depart from the acceptable standards of care and, further, that the instances of malpractice alleged by plaintiffs did not cause Sovocool's death.

In this regard, Eid's expert opined that Eid at all times met the accepted standards of care in administering anesthesia to Sovocool for the ERCP procedure and in her care of Sovocool in the PACU (NYSCEF Doc No. 73, Reagan aff, ¶¶ 20-22). Eid's expert specifically found that Eid's working diagnosis of Sovocool upon examination in the PACU – that Sovocool's failure to rouse from anesthesia resulted from an inability to metabolize the pain medications she had received– was appropriate, especially in light of Sovocool's morbid obesity and liver damage resulting from severe pancreatitis; and, further, that intubation of Sovocool while in the PACU was not indicated or appropriate (Reagan aff, ¶¶ 23-26). Significantly, Eid's expert specifically opined that Sovocool's death was caused by SIRS secondary to her pancreatitis, which the expert

² Plaintiffs do not assert a claim of negligence directly against CRMC; rather, they contend CRMC is vicariously liable for the alleged malpractice of the individual defendants.

noted were severe and irreversible conditions which caused multisystem organ failure and death and, further, that earlier intubation would not have prevented her death (Reagan aff, ¶ 30).

Iqbal's expert opined that Iqbal did not depart from the acceptable standard of care in his treatment of Sovocool, specifically finding that intubation of Sovocool while she was in the PACU was not indicated (NYSCEF Doc No. 72, Stallone aff, ¶¶ 20, 24). Iqbal's expert also found Iqbal's working diagnosis that Sovocool's inability to rouse from general anesthesia resulted from an inability to metabolize the pain medications she had received due to underlying severe pancreatitis and acute liver injury was appropriate, and that intubation while Sovocool was in the PACU was contraindicated (Stallone aff, ¶¶ 21-25). With respect to causation, Iqbal's expert noted that Sovocool suffered serious complications from her severe pancreatitis, and used a clinical tool known as the modified Rankin score to estimate that Sovocool had a substantial mortality risk of at least 15% solely from gallstone pancreatitis (Stallone aff, ¶ 29). Significantly, he specifically opined that Sovocool's SIRS, anoxic brain injury and ultimate death were caused solely by the natural progression of pancreatitis into irreversible multisystem organ failure that would have occurred even had she been intubated sooner (Stallone aff, ¶ 30).

Zakariyya's expert opined that Zakariyya's care and treatment of Sovocool met the accepted standard of care in all respects (NYSCEF Doc No. 101, Ingwer aff, ¶ 7). Zakariyya's expert opined that Zakariyya appropriately diagnosed Sovocool as having acute pancreatitis most likely secondary to gallstone with possible biliary obstruction by the gallstone, a diagnosis that was confirmed by the autopsy findings of acute necrotizing pancreatitis and gallbladder with necrosis and cholelithiasis (Ingwer aff, ¶ 10). The expert opined that irreversible multisystem organ failure was the cause of the decline in Sovocool's condition (Ingwer aff, ¶ 13). The

expert specifically found that Zakariyya's care of Sovocool at each of the rapid response events, his decision of when to intubate Sovocool, and his attempts to stabilize her following intubation were within the standard of care (Ingwer aff, ¶¶ 14-20, 22, 23). He noted that a CT scan taken after intubation showed no signs of intracranial abnormality (Ingwer aff, ¶ 15). Indeed, Zakariyya's expert concludes that Sovocool never had a moment of critical oxygen desaturation or cardiopulmonary arrest because of the care provided by Zakariyya, which also stabilized her and made possible her transfer to Crouse (Ingwer aff, ¶ 28). Notably, with respect to causation, Zakariyya's expert also found that Sovocool's death was caused solely by the progression of irreversible, acute necrotizing pancreatitis, which resulted in SIRS and multisystem organ failure that could not have been prevented by earlier intubation or even by treatment that "vastly exceeded the standard of care" (Ingwer aff, ¶¶ 24, 25).

Accordingly, the burden shifted to plaintiffs to present expert medical opinion evidence establishing that defendants deviated from the accepted standard of care and that such departures were a proximate cause of Sovocool's death (see Longtemps v Oliva, 110 AD3d at 1318). To this end, plaintiffs submitted redacted affidavits from an anesthesiologist and an internist who is also certified in pulmonary diseases and critical care medicine. Although they are not models of clarity, when viewed in light most favorable to plaintiffs, the affidavits of both experts meet the burden of establishing issues of fact with respect to whether the individual defendants deviated from the standard of care. The anesthesiologist opined that the standard of care required Eid to have intubated Sovocool when she was in the PACU due to the life-threatening nature of her pancreatitis and low oxygenation levels, specifically finding that the standard of care required the anesthesiologist to remove, or at least diminish, the impact of potential respiratory failure on

Sovocool's "overall precarious condition" (NYSCEF Doc No. 112, anesthesiologist aff, ¶¶ 23-26, 30, 31).³ The internist opined that Iqbal and Zakariyya both failed to meet the standard of care in several specific respects by failing to protect Sovocool's airway with an earlier intubation, stating, among other things, that Sovocool's failure to rouse from anesthesia and her state of septic shock were alone sufficient factors to require intubation (NYSCEF Doc No. 113, internist aff, ¶¶ 25-32).

However, the opinions of plaintiffs' experts on causation are conclusory and speculative because they did not address the specific assertions made by movants' experts regarding causation and failed to set forth an explanation of the opponent's reasoning based on specifically cited evidence in the record (see Tsitrin v New York Community Hosp., 154 AD3d 994, 996 [2017]). The anesthesiologist made no attempt to explain how defendants' alleged deviations from the standard of care caused Sovocool's death, stating only in conclusory fashion that the alleged deviations "were a substantial factor in causing harm and ultimately [her] death" (anesthesiologist aff, ¶¶ 22, 32). The internist likewise offered only speculative and conclusory opinions regarding causation (internist aff, ¶¶ 23-24, 33-39). This expert failed to (1) acknowledge or address the significant risk of death which Sovocool faced from pancreatitis and SIRS alone; (2) identify a specific course of treatment that could have been administered to Sovocool that would have successfully prevented progression of SIRS and multisystem organ failure which defendants' experts unanimously opined was irreversible; (3) explain how treatment for pancreatitis and SIRS could have been effective had she been intubated sooner,

³ As noted by defendants in reply, the results of the ABG tests were not obtained until after Eid and Iqbal had ceased their care of the patient; accordingly, no weight has been given to opinions regarding their care that are based on ABG levels (i.e. anesthesiologist aff, ¶¶ 27, 29).

with the earliest possible time for intubation being upon her transfer to the PACU approximately seven hours before she was ultimately intubated; or (4) address defendants' evidence showing that Sovocool did not suffer any brain injury prior to intubation. The speculative and conclusory nature of the internist's opinion regarding causation is apparent from his unsubstantiated claims that, had Sovocool been intubated at any time on October 17, 2017, between her transfer to the PACU at 4:35 p.m. and the second rapid response at 11:48 p.m., "more likely than not," she would be alive today or "would have had a 70% chance of survival" (internist aff, ¶¶ 37-38) (see Martingano v Hall, 188 AD3d 1638, 1640 [4th Dept 2020], lv denied 36 NY3d 912 [2021], citing Longtemps v Oliva, 110 AD3d at 1319; Tsitrin v New York Community Hosp., 154 AD3d at 996-997; Longtemps v Oliva, 110 AD3d at 1319). In short, although Sovocool's death is tragic and, being unexpected to her family, was undoubtedly especially traumatic to them, the court may not disregard the failure of plaintiffs' experts to establish the existence of an issue of fact regarding causation.

Based on the foregoing, defendants' motions for summary judgment must be, and hereby are, granted; the complaint is dismissed in its entirety, with prejudice.

This decision constitutes the order of the court. The filing of this decision and order, or transmittal of copies hereof, by the court shall not constitute notice of entry (see CPLR 5513).

Dated: April 12, 2022
Cortland, New York

ENTER

Digitally signed by Hon. Mark G. Masler, DN: cn=US, ou=Cortland County Supreme Court, o=Sixth Judicial District, cn=Hon. Mark G. Masler, e=cmrmasler_chambers@nycourts.gov

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HON. MARK G. MASLER
Supreme Court Justice

The following documents were filed with the Clerk of the County of Cortland:

- Notice of motion by Cortland Regional Medical Center defendants dated October 27, 2021.
- Affirmation of Justin L. Salkin dated October 27, 2021, with Exhibits A-U.
- Affirmation of Robert N. Kornfield, M.D., dated August 20, 2021.
- Affirmation of Martin Stallone, M.D., dated September 14, 2021.
- Affirmation of Joseph Reagan, M.D., dated August 4, 2021.
- Statement of material facts dated October 27, 2021.
- Notice of motion by Estate of Zakariyya dated November 24, 2021.
- Affidavit of John M. Coniglio, Esq., sworn to November 24, 2021, with Exhibits A-S.
- Statement of undisputed material facts dated November 23, 2021.
- Affidavit of Charles L. Falgiatano, Esq., sworn to March 11, 2022, with Exhibit A.
- Plaintiff's anesthesiology expert affidavit, sworn to February 8, 2022.
- Plaintiff's internal medicine, pulmonary disease, and critical care expert affidavit, sworn to January 31, 2022.
- Response to statement of material facts of Estate of Zakariyya dated March 11, 2022.
- Response to statement of material facts of Cortland Regional Medical Center defendants dated March 11, 2022.
- Affirmation of Justin L. Salkin dated March 23, 2022, with Exhibit V.
- Decision and Order dated April 12, 2022.