At an IAS Term, Part 63 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 24th day of May, 2022.

PRESENT:

HON. ELLEN M. SPODEK,
Justice.

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HELEN JONES, Administrator of the Estate of FIDEL MENDEZ, Deceased, and HELEN JONES, Individually,

Plaintiffs,

-against-

SAQUIB ZIA, M.D., ALEX GLATMAN, M.D., FARAJ M. FAOUR, M.D., BRIAN MCHUGH, M.D., SEAVIEW ANESTHESIA GROUP, LEONARD LEFKOVIC, M.D., and STATEN ISLAND UNIVERSITY HOSPITAL,

Defendants.

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DECISION, ORDER, AND JUDGMENT

Index No. 507836/18

Mot. Seq. No. 4

The following e-filed papers read herein:	NYSCEF Doc. No.:
Notice of Motion, Affirmations, and Exhibits Annexed	84-132
Affirmations in Opposition and Exhibits Annexed	138-141
Reply Affirmation	142

Upon the foregoing papers in this action to recover damages for medical malpractice, wrongful death, and lack of informed consent, defendants Saqib Zia, M.D. (incorrectly sued herein as Saquib Zia, M.D.) ("Dr. Zia"), Alex Glatman, M.D. ("Dr. Glatman"), Faraj M. Faour, M.D. ("Dr. Faour"), Brian McHugh, M.D. ("Dr. McHugh"), and Staten Island University Hospital ("SIUH" and collectively with Drs. Zia, Glatman, Faour, and McHugh, the "defendants") jointly move (in Seq. No. 4) for

summary judgment.[1] Plaintiffs Helen Jones, individually and as the administrator of the estate of Fidel Mendel, deceased (collectively, the "plaintiff"), object insofar as the defendants seek dismissal of the medical malpractice, wrongful death, and lack of informed consent claims premised on their *post-operative* care (or lack thereof) of her deceased son, Fidel Mendel (the "patient"), from November 25, 2016 through November 26, 2016.

Background

In the morning of Friday, November 25, 2016,[2] the patient, a 35-year-old man who was suffering from multiple, long-term health problems – including (1) insulin-dependent diabetes; (2) severe congestive heart failure ("CHF") with a reduced ejection fraction at 10-15%; (3) an AICD (defibrillator) placement for paroxysmal atrial fibrillation; (4) coronary artery disease; (5) stage 3 non-dialysis chronic kidney disease; (6) super-obesity with the body-mass index of 59.2; and (7) obstructive sleep apnea – underwent, without an issue, a below-the-knee amputation of his right leg under general anesthesia ("surgery").[3] For several hours post-surgery, the patient was recovering in the post-anesthesia care unit ("PACU"). At approximately 1 p.m., he was transferred from PACU

[1] The remaining defendants, Seaview Anesthesia Group and Leonard Lefkovic, M.D., either had defaulted in the case of Seaview or were dismissed without opposition in the case of Dr. Lefkovic (*see* Order Granting Default Judgment as against Seaview Anesthesia Group, dated September 18, 2018 [Spodek, J.] [NYSCEF Doc No. 44]; *see also* WebCivil Supreme – Motion Detail reflecting that Dr. Lefkovic's motion for summary judgment *[in Seq. No. 3] was granted on December 13*, 2021).

[2] Unless otherwise indicated, all subsequent references are to year 2016.

[3] Except where otherwise indicated, all references are to the patient's chart for his admission to SIUH from August 23, 2016 through November 26, 2016. The patient's chart is Bate-stamped 000001-005392 (NYSCEF Doc No. 109-130) ("SIUH's Records"). *See* SIUH's Records at 000004 and 000022; 001316 (Operative Anesthesia Record). *See also* SIUH's Records of prior treatment (in particular, the patient's internal medicine examination note, dated May 11, 2016, by Olga Yevsikova, M.D., stating that the patient *"had a history of sleep apnea since 2011"*) (NYSCEF Doc No. 108).

to the medico-surgical floor (the "general care floor"). The patient, while staying in a private room on the general care floor,[4] was monitored by attending hospitalist Dr. Faour, several resident-level hospitalists, and the nursing staff, both in the afternoon and in the evening of November 25th, as well as overnight from November 25th to November 26th. The patient was, at all pertinent times, in stable condition without any "red flags." Indeed, when the patient's defibrillator was checked at approximately 6 p.m. on November 25th, it revealed no "recent [arrhythmic] events" (SIUH's Records at 001336, *see also* SIUH's Records at 001338-001368). However, at 4:21 a.m. the next day (Saturday, November 26th), a resident, then visiting the patient in preparation for the morning rounds, found him unresponsive. Extensive resuscitation efforts were undertaken but to no avail. The patient was declared dead at 5 a.m. *The preliminary cause of his death was a cardiopulmonary* arrest (SIUH's Records at 005385). The patient's mother (plaintiff herein) requested an autopsy. The post-mortem findings and conclusions are as follows:

> "[Findings] At autopsy, the significant findings are cardiomegaly with biventricular dilatation, consistent with congestive heart failure, severe ischemic heart disease and disease of coronary arteries, with acute myocardial ischemia identified in bilateral atriums, bilateral ventricles, and septum. The lungs reveal bilateral pulmonary congestion, pulmonary edema, and 'heart failure cells.' The liver reveals centrilobular necrosis. The kidneys reveal acute tubular necrosis, and diabetic glomerulosclerosis.
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> [Conclusions] . . . [T]he underlying causes of death in this patient [are] consistent with his underlying disease of congestive heart failure, associated with acute myocardial ischemia/ischemic heart disease, secondary to his coronary artery disease" (SIUH's Records at 000977).

[4] The patient was isolated in a private room on the general care floor on account of his MRSA history (*SIUH's Records at 000853*).

On April 18, 2018, plaintiff commenced this action to recover damages for medical malpractice, wrongful death, and lack of informed consent against (among others): (1) SIUH where surgery was performed; (2) Dr. Zia, the operating vascular surgeon; (3) Dr. Glatman, one of the hospitalists who had followed the patient on the general care floor *before* surgery; (4) Dr. Faour, a hospitalist who followed on the patient the general care floor *after* surgery; and (5) Dr. McHugh, the surgical anesthesiologist who followed the patient during his stay in the PACU.

Standard of Review

As noted, plaintiff has asserted three claims against defendants: medical malpractice, wrongful death, and lack of informed consent. In the context of a medical malpractice claim, "[a] defendant moving for summary judgment . . . must demonstrate the absence of any material issues of fact with respect to at least one of the elements of a cause of action alleging medical malpractice: (1) whether the physician deviated or departed from accepted community standards of practice, or (2) that such a departure was a *proximate cause* of the plaintiff's injuries" and, where wrongful death is alleged, of wrongful death as well (*see Rosenthal v Alexander*, 180 AD34 826, 827 [2d Dept 2020] [internal citation omitted; emphasis added]; *Mandel v New York County Pub. Adm'r*, 29 AD3d 869, 871 [2d Dept 2006]). "When a defendant in a medical malpractice action demonstrates the absence of any material issues of fact with respect to at least one of those elements, summary judgment dismissing the action should eventuate unless the plaintiff raises a triable issue of fact in opposition" (*Schwartz v Partridge*, 179 AD3d 963, 964 [2d Dept 2020] [internal citations omitted]). Further, "to establish proximate causation, a plaintiff must present sufficient medical evidence from which a reasonable person might

conclude that it was more probable than not that the defendant's departure was a substantial factor in causing the plaintiff's injury" (*Bacchus-Sirju v Hollis Women's Ctr.*, 196 AD3d 670, 672 [2d Dept 2021]). "[E]xpert opinions that are conclusory, speculative, or unsupported by the record are insufficient to raise triable issues of fact" (*Lowe v Japal*, 170 AD3d 701, 702 [2019]).

Next, "[t]he elements of a cause of action to recover damages for wrongful death are (1) the death of a human being, (2) the wrongful act, neglect or default of the defendant by which the decedent's death was caused, (3) the survival of distributees who suffered pecuniary loss by reason of the death of decedent, and (4) the appointment of a personal representative of the decedent" (*Chong v New York City Tr. Auth.*, 83 AD2d 546, 547 [2d Dept 1981]). Only the second element of the wrongful death claim – the alleged medical malpractice – is at issue at this stage of litigation.

Lastly, to establish a claim for lack of informed consent, "a plaintiff must prove (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 actual procedure performed for which there was no informed consent was the proximate cause of the injury" (*Palagye v Loulmet*, ___ AD3d ___, 2022 NY Slip Op 01302 [2d Dept 2022]; *see* Public Health Law § 2805-d).

Discussion

Medical Malpractice Claim

Plaintiff's theory of her medical malpractice claim, as refined by her expert in his/her affirmation in opposition, is that the defendants (either individually or collectively, and, in the case of SIUH, vicariously) departed from the accepted standard of care by failing to ensure that the patient, on discharge from the PACU, would remain on uninterrupted telemetry monitoring, by being admitted either to (1) the intensive care unit ("ICU"), or, in the alternative, (2) the telemetry unit which is a lower level of care than the ICU but one where the patient's internal functions and vital signs could still be constantly monitored (*see* Plaintiff's Expert Affirmation [name redacted], dated November 19, 2021 [NYSCEF Doc No. 140]). According to plaintiff's expert, the defendants' failure in that regard (and in that regard only) proximately caused the patient's death (Plaintiff's Expert Affirmation, ¶ 57).

The Court finds that each of the defendants has established his (or its) prima facie entitlement to judgment as a matter of law on the subject of *proximate cause* by submitting expert affirmations from (among others): (1) Edward Katz, M.D. ("Dr. Katz"), a New York State-licensed physician who is triple board-certified in internal medicine, cardiovascular diseases, and adult comprehensive echocardiography; and (2) Elias Sakalis, M.D. ("Dr. Sakalis"), also a New York State-licensed physician who is board-certified in internal medicine. Drs. Katz and Sakalis each opine, based on the patient's non-eventful post-operative recovery on the general care floor, that placing him in the ICU or in the

telemetry unit would not have been outcome-determinative in light of his life-threatening perioperative comorbidities:

> "[The patient's] cause of death was noted to be cardiomegaly (655 gm, normal range based on [the] patient's height and weight 266-346 gm), congestive heart failure and acute myocardial ischemia. Based on the records and testimony in this case and the fact that [the patient] did not experience an acute myocardial infarction, it is my opinion that there is no basis for the claim that placing [the patient] in the ICU or a telemetry unit would have altered the outcome."[5]

In opposition to the defendants' prima facie showing on the subject of proximate cause, plaintiff's expert has failed to raise a triable issue of fact on that subject. The length of plaintiff's expert's 57-paragraph affirmation cannot make up for its lack of substance on the subject of proximate cause. The fundamental problems with plaintiff's expert's opinion (as limited to proximate cause) are two-fold. First, plaintiff's expert is not qualified to render an opinion on the subject of proximate cause because: (1) his/her opinion on that subject is outside his/her area of specialization and training as a double board-certified surgeon and vascular surgeon; and (2) he/she has failed to lay a foundation tending to support the reliability of his/her opinion on proximate cause, as more fully set forth in the margin[6] (*see Samer v Desai*, 179 AD3d 860, 863 [2d Dept 2020]; *Keane v Dayani*, 178

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[5] *See* Dr. Katz's Affirmation in Support of Motion for Summary Judgment, dated May 24, 2021, ¶ 28 (NYSCEF Doc No. 91). Dr. Sakalis's opinion in ¶ 33 of his affirmation, dated May 20, 2021, reads substantially the same (NYSCEF Doc No. 88).

[6] The introductory paragraphs of plaintiff's expert's affirmation make it clear that (1) post-operative care of surgical patients is merely incidental to the principal (if not, exclusive) performance of his (or her) duties as a surgeon (*see* ¶ 1 as reproduced below); and (2) the bulk of his (or her) knowledge of post-operative care is derived (at least, in part) from his (or her) attendance at various medical conferences and seminars (*see* ¶ 2 as reproduced below). Paragraph 1 of plaintiff's expert's affirmation reads in full:

(footnote continued)

AD3d 797, 799 [2d Dept 2019]; *Simpson v Edghill*, 169 AD3d 737, 738-739 [2d Dept 2019]; *Galluccio v Grossman*, 161 AD3d 1049, 1052 [2d Dept 2018]).

Second and more significant is that plaintiff's expert, in opining on proximate cause, fails to examine and *separately* address the distinct (and analytically different) elements of telemetry monitoring. Telemetry monitoring consists of three basic elements: (1) the telemetry monitoring set-up (*i.e.*, the attachment of the EKG leads and the pulse oximeter to a patient's body, together with the calibration of alarm triggers) (the "equipment set-up"); (2) the speed with which the hospital staff responds to the alarm (the "alarm-response time"); and (3) the treatment modalities to be utilized by the responding team (the "response-treatment modalities"). Whereas the first element of telemetry monitoring (*i.e.*, the equipment set-up) is exclusively within the set-up operator's control, the second and third elements of telemetry monitoring (*i.e.*, the alarm-response time and the response-treatment modalities, respectively) are outside the set-up operator's control and are

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> "I am a physician licensed to practice medicine in the State of New York. I am Board Certified by the American Board of Surgery and by the American Board of Vascular Surgery. I obtained my medical degree from a Medical College in St. Louis, Missouri, and completed a residency in *general surgery*, as well as fellowships in *critical care surgery* and *vascular surgery* at a major metropolitan hospital center in New York, NY. As a physician and surgeon, I have had thousands of hours of experience in the *operating room* and have performed thousands of *operative procedures*; I have dictated thousands of *operative reports*; and I have obtained thousands of informed consents [to the operative procedures]" (emphasis added).

Paragraph 2 of plaintiff's expert affirmation states, in relevant part, that:

> "Based upon my training, experience, and knowledge in the field of medicine and surgery, and as evidenced and required by my Board Certifications, *regular attendance and participation at medical seminars* and conferences throughout the United States, I am fully aware, knowledgeable and familiar with major surgical procedures and proper post operative care, particularly in regard to patients with multiple and serious comorbidities such as the plaintiff-decedent herein" (emphasis added).

obviously affected by other variables. As noted, the fundamental inadequacy of plaintiff's expert's opinion on proximate cause lies in his/her failure to *specifically* address the *second and third elements* of telemetry monitoring.[7] When it comes to the alarm-response time and the response-treatment modalities, plaintiff's expert's "but for" opinion on proximate cause (*i.e.*, that the patient would not have died but for the absence of telemetry monitoring) is self-contradictory, speculative, and unsupported by the record.

To illustrate the self-contradictory nature of plaintiff's expert's affirmation regarding the alarm-response time, *compare* his/her initial opinion in ¶ 32 (and reiterated in ¶ 42) *with* his/her concluding opinion in ¶ 57. Plaintiff's expert *initially* opines that the patient (had he been telemetry monitored) would have needed "*prompt* intervention" *because, in his/her own words,* "[a] short period of hypoxia (low blood oxygen) . . . lasting *more than 3-4 minutes* can be deadly or cause irreversible injury" (¶¶ 32 and 42, respectively [emphasis added]). But when plaintiff's expert *concludes* his/her opinion on proximate cause, he/she insists that a mere "intervention" (*rather than a "prompt"* intervention) in response to an alarm would have been sufficient (¶ 57). This is not a mere quibble over words; to the contrary, whether an alarm response is "prompt" has substantial consequences for any patient, particularly for the severely ill patient herein.

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[7] Plaintiff's expert is clear in his/her pronouncement regarding the first element of the telemetry monitoring (*i.e.*, the initial equipment set-up) (*see* Plaintiff's Expert Affirmation, ¶ 30 ["There are many reasonable medical scenarios in which (the patient's) death could be explained by problems that would have been easily treated and reversed *if monitoring had been in place and an alarm had alerted staff* to decreased oxygen saturation, diminished respiratory effort or abnormal cardiac rhythms."]; ¶ 57 ["To within a reasonable degree of medical certainty I believe that *if properly indicated monitoring had been in place[,] the staff would have been alerted* to the initial life threatening events. . ."] [emphasis added in each instance]).

In any event, the *effectiveness* of a prompt alarm response by the staff necessarily depends on the amount of time it takes for a patient to adequately respond to the intervention. This is the area where plaintiff's expert, in formulating his/her opinion on proximate cause, ignores two key points in the record; first, the pretrial testimony of defendant anesthesiologist Dr. McHugh reflects that the patient (by virtue of the abnormalities of his face and neck anatomy, as well as his chronic obstructive sleep apnea) presented a difficult airway to ventilate, as well as to intubate;[8] and second, that, in fact, it took *nine minutes* for the responding staff to intubate the patient, as documented in the CPR (code) flow sheet.[9]

With regard to the third and final element of telemetry monitoring – the response-treatment modalities – the opinion of plaintiff's expert (who, once again, ventures into an area outside his/her specialty) is unsupported by the record. According to plaintiff's expert, the patient's life could have been easily saved with simple measures. Plaintiff's expert hypothesizes – without taking into account the patient's severely reduced perioperative cardiopulmonary function and reserve due to his multiple preexisting comorbidities – that "[t]here are many *possible* scenarios in which prompt intervention would *most likely* have saved [the patient's life] even with simple measures like securing the airway, placing him

[8] Dr. McHugh testified (at page 14, line 3 to page 15, line 20 of his pretrial deposition) that the patient was difficult to intubate because: (1) the patient's airway was in class 3 (the airways are classified between 1 and 4, with class 1 being the easiest to intubate); and (2) his "thyromental" distance (*i.e.*, the distance from the top notch of his thyroid to his chin) was shorter than three finger widths.

[9] The Cardiopulmonary Resuscitation Flow Sheet reflects that four minutes (between 4:21 a.m. and 4:25 a.m.) had elapsed before the staff was able to establish his airway and use an Ambubag to ventilate him, and that an additional five minutes had elapsed (between 4:25 a.m. and 4:30 a.m.) before the staff was able to intubate him; thus, adding up to a total of *nine minutes* to perform intubation (*see* SIUH's Records at 000895).

on positive pressure air flow, treating an arrhythmia, repositioning him so his airway was not obstructed, intubation and ventilation and just simple arousal" (¶ 32 [emphasis added]).[10] Further down in his (her) affirmation, plaintiff's expert hypothesizes – likewise without taking into account the patient's face/neck anatomical abnormalities (as testified to by Dr. McHugh) – that "[i]t is *probable*, even *likely*, that a simple intervention such as application of a CPAP [continuous positive airway pressure] mask would have saved his life" (¶ 51 [emphasis added]). The aforecited word pairs of "possible/most likely" and "probable/likely" further undermine plaintiff's expert's already speculative opinion that telemetry monitoring – in the absence of red flags in the course of the patient's approximately 17-hour stay on the general care floor before the tragedy struck and he was discovered dead – would have saved his life. In sum, plaintiff's expert's opinion on proximate cause amounts to "bare conjecture," "rank speculation," and "hindsight reasoning," which (individually and collectively) are insufficient to establish the existence of a material issue of fact and, thus, defeat a motion for summary judgment (*see Micciola v Sacchi*, 36 AD3d 869, 871 [2d Dept 2007]; *see also Kerrins v South Nassau Communities Hosp.*, 148 AD3d 795, 796 [2d Dept 2017]; *Shashi v South Nassau Communities Hosp.*, 104 AD3d 838, 839 (2d Dept 2013).

[10] Plaintiff's expert's reference in ¶ 32 of his/her affirmation to a potential arrythmia is gratuitous. Plaintiff's expert disregards the fact, as noted in the text above, that the patient's defibrillator, following a post-operative check by the electrophysiology team at approximately 6 p.m. on November 25th, revealed no "recent [arrhythmic] events" (*see SIUH's Records at 001336* [consultation note]; *see also* SIUH's Records at 001338-001368 [defibrillator-interrogation reports]).

Wrongful Death Claim

Because the wrongful death claim is premised on the defendants' alleged medical malpractice, the same conclusion applies to this claim (*see Berthen v Bania*, 121 AD3d 732, 733 [2d Dept 2014]).

Informed Consent Claim

Lastly, the informed consent claim fails, inasmuch as no procedure was performed on the patient requiring his consent during his post-operative stay on the general care floor (*see* Public Health Law § 2805-d).

Conclusion

Accordingly, it is

ORDERED that defendants' motion (in Seq. No. 4) is *granted*, and the complaint is dismissed as against defendants Saqib Zia, M.D. (incorrectly sued herein as Saquib Zia, M.D.), Alex Glatman, M.D., Faraj M. Faour, M.D., Brian McHugh, M.D., and Staten Island University Hospital, without costs and disbursements; and it is further

ORDERED that the action is severed and continued as against the remaining defendant, Seaview Anesthesia Group; and it is further

ORDERED that to reflect the dismissal of the moving defendants, as well as the prior unopposed dismissal of defendant Leonard Lefkovic, M.D. (in Seq. No. 3), the

caption of this action is amended to read in its entirety as follows:

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HELEN JONES, Administrator of the Estate of
FIDEL MENDEZ, Deceased, and
HELEN JONES, Individually,

Plaintiffs,

-against- Index No. *507836/18*

SEAVIEW ANESTHESIA GROUP,

Defendant.

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; and it is further

ORDERED that the defendants' counsel is directed to electronically serve a copy of this decision, order, and 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 the Court.

ENTER,

J. S. C.
HON. ELLEN M. SPODEK

2022 MAY 25 AM 9:57
KINGS COUNTY CLERK'S OFFICE
FILED