At an IAS Term, Part 15 of the Supreme Court of the State of New York, held in and for the County of Kings, at the Courthouse thereof at 360 Adams St., Brooklyn, New York on the 23rd day of May 2022.

P R E S E N T:
HON. PAMELA L. FISHER,
J.S.C.

----------X

YELENA RIKELMAN, as an Administrator of the Estate of RITA RIKELMAN, deceased, and YELENA RIKELMAN, individually,

Plaintiff,

- against -

MICHAEL BORGER, M.D., ROBERT C. NEELY, M.D., COLUMBIA UNIVERSITY COLLEGE OF PHYSICIANS AND SURGEONS and NEW YORK PRESBYTERIAN-COLUMBIA UNIVERSITY MEDICAL CENTER,

Defendants.

----------X

DECISION/ORDER

Index No: 516919/2017

Recitation, as required by CPLR §2219(a), of the papers considered in the review of this motion:

	Papers Numbered
Notice of Motion/Cross Motion/Order to Show Cause and Affidavits (Affirmations) Annexed	1, 2, 3
Opposing Affidavits (Affirmations)	4, 5, 6
Reply Affidavits (Affirmations)	7, 8

Upon the foregoing papers in this medical malpractice action, defendants, The New York and Presbyterian Hospital s/h/a New York Presbyterian-Columbia University Medical Center and The Trustees of Columbia University in the City of New York s/h/a Columbia University College of Physicians and Surgeons, move, pursuant to CPLR § 3212, for summary judgment, dismissing plaintiff's complaint against them, and directing the Clerk of the Court to enter judgment in their favor. Defendants also move to dismiss plaintiff's first and second causes of action, and any allegations of direct negligence against the individual defendant physicians, Michael Borger, M.D. and Robert C.

Neely, M.D., on the grounds that they were never served, and to amend the caption to reflect their dismissal from the action.

Plaintiff commenced this action by filing a summons and complaint on or about August 20, 2017 (Defendants' Affirmation in Support ¶ 21; Summons & Complaint, annexed as Exhibit D to defendants' motion papers). Defendants, Dr. Michael Borger, M.D. and Robert C. Neely, M.D. were "never served with the [s]ummons and [c]omplaint, and neither has appeared in this action" (Defendants' Affirmation in Support ¶ 21). Issue was joined by defendants, The New York and Presbyterian Hospital (NYPH) and The Trustees of Columbia University in the City of New York (Columbia University) on October 20, 2017, and plaintiff served bills of particulars upon defendants, NYPH and Columbia University on or about August 7, 2018 (*Id.* at ¶¶ 21-22; Answers annexed as Exhibit E to defendants' motion papers; Verified Bills of Particulars annexed as Exhibit F to defendants' motion papers). Plaintiff served a supplemental bill of particulars upon defendants, NYPH and Columbia University on or about March 19, 2019 (Defendants' Affirmation in Support ¶ 22; Supplemental Verified Bill of Particulars, annexed as Exhibit G to defendants' motion papers). In her complaint and bills of particulars, plaintiff alleges that defendants departed from good and acceptable medical practice in their treatment of the decedent between December 9, 2015 and January 12, 2016 by "delaying appropriate and necessary treatment," neglecting to "administer supplemental oxygen," "fail[ing] to adequately monitor plaintiff decedent's oxygen saturation," "permitt[ing] plaintiff decedent to develop heparin induced thrombocytopenia" and "toxic metabolic encephalopathy," "negligently permitting plaintiff decedent to develop volume overload," "negligently failing to monitor plaintiff decedent's tidal volume," "fail[ing] to treat plaintiff decedent's pneumonia" and "pulmonary embolism," failing to obtain decedent's informed consent for the aortic valve replacement surgery, and neglecting to "timely turn and position plaintiff decedent" (Complaint ¶¶ 6, 16, 26-27, 37-38, 44, 53; Verified Bill of Particulars as to NYPH ¶¶ 2-7, 11, 14; Verified Bill of Particulars as to Columbia

University ¶¶ 2-7, 11, 14). As a result of defendants' alleged malpractice, plaintiff is claiming that decedent sustained the following injuries: hypoxemic respiratory failure, tachycardia, severe respiratory distress, chest pain, shortness of breath, dyspnea, desaturation, basal pneumonia, atelectasis, candida urinary tract infection, sepsis, septic shock, renal failure, pulmonary congestion and hypostasis, leukocytosis, pulmonary edema, hypophosphatemia, fever, bacteremia, agitated delirium, toxic-metabolic encephalopathy, metabolic acidosis, cardiac congestion, somnolence, heparin induced thrombocytopenia, ulcers, anemia, prolonged hospital stay, and death (Verified Bill of Particulars as to NYPH ¶ 17; Verified Bill of Particulars as to Columbia University ¶ 17).

The following facts are not in dispute. Ms. Rikelman, who was 69 years old in December 2015, "had an extensive cardiac and medical history dating back many years" (Plaintiff's Statement of Facts ¶ 2; Statement of Uncontested Facts ¶ 2, annexed as Exhibit A to defendants' motion papers). She had been diagnosed with "hypertension, aortic insufficiency, aortic stenosis and right coronary artery stenosis," and she was 5'2 inches in height and weighed 230 pounds (Plaintiff's Statement of Facts ¶ 2; Statement of Uncontested Facts ¶ 2). In August 2004, she "underwent a right heart catheterization" (*Id.*; Plaintiff's Statement of Facts ¶ 2). Decedent "was prescribed and took various medications to control her hypertension," including Losartan and Metoprolol (*Id.* at ¶ 3). From 2004 to 2014, decedent "underwent multiple catheterizations and stent placement procedure[s] due to her coronary artery disease" (*Id.*).

On April 4, 2015, decedent "underwent a nuclear stress test that demonstrated a perfusion abnormality involving the septal wall encompassing approximately 12% of the LV (left ventricular) myocardium with only 4% reversibility" (Statement of Uncontested Facts ¶ 4). Ms. Rikelman was "diagnosed" "with severe aortic valve stenosis," and she was "scheduled for non-emergent/elective heart surgery on December 9, 2015" at NYPH (*Id.* at ¶ 4; Plaintiff's Statement of Facts ¶ 4). On December 8, 2015, decedent went to NYPH for a "pre-operative chest x-ray, which was ordered by Dr.

Borger, the cardiothoracic surgeon" (*Id.* at ¶ 5). Both Dr. Borger and Dr. Neely, "a cardiothoracic fellow [who would be] assist[ing] in the surgery" the following day, "reviewed" the "chest imaging study," which "revealed low lung volumes, increased broncho vascular markings, pulmonary vascular congestion and pulmonary edema" (*Id.*).

On December 9, 2015, decedent "was admitted to [NYPH]," and "Dr. Michael Borger was the admitting Attending cardiothoracic surgeon" (Statement of Uncontested Facts ¶ 5). Dr. Borger "performed an aortic valve replacement and" "a patch enlargement of the aortic annulus with autologous pericardium" (*Id.*). Dr. Borger "also performed a single bypass of the RIMA (right internal mammary artery) to the RCA for what was described as residual right coronary artery stenosis" (*Id.*). Dr. Borger performed these procedures with the assistance of Dr. Neely (*Id.*). After the surgery, the decedent "was transferred to the CTICU (cardiothoracic intensive care unit)," and "[s]he was kept intubated" "due to a large A-a gradient" (*Id.* at ¶ 6; Plaintiff's Statement of Facts ¶ 8). A post-operative transesophageal echocardiogram (TEE) was performed, which revealed "3+ MR (mitral regurgitation) and trace TR (tricuspid regurgitation)" (Statement of Uncontested Facts ¶ 6). On December 10, 2015, decedent "was noted to have hypoxemia (low oxygenation)/large A-a gradient that required mechanical ventilation" due to "possible volume overload/pulmonary edema" (Plaintiff's Statement of Facts ¶ 9). On December 11, 2015, decedent "underwent a trial of extubation," but "had an episode of supraventricular tachycardia" (Statement of Uncontested Facts ¶ 7). Ms. Rikelman "underwent a direct current cardioversion, which returned her to a normal sinus rhythm" (*Id.*). She also "experienced a drop in her oxygen saturation down to 81%, which necessitated reintubation" (Plaintiff's Statement of Facts ¶ 10). Decedent was "diagnosed with hypoxemia secondary to likely volume overload," and she was given "Furosemide IV bolus" (*Id.*).

On December 12, 2015, Ms. Rikelman "had a CT angiogram which showed no evidence of a pulmonary embolus, but there were patchy opacities in the right lung and bibasilar atelectasis"

(Statement of Uncontested Facts ¶ 8). A head CT scan was performed, which was negative (*Id.*). On December 13, 2015, decedent "was started on Vancomycin and Zosyn for a presumed pneumonia," and "[c]ultures were drawn," but "there was no growth on the cultures" "[a]s of December 14th" (*Id.*). A transthoracic echocardiogram (TTE) was performed, "yield[ing] an ejection fraction of 55 to 60% (normal) with RV (right ventricular) function and size normal, no aortic insufficiency and only trace tricuspid regurgitation" (*Id.* at ¶ 9). On December 15, 2015, decedent "underwent a repeat chest x-ray which revealed bilateral small pleural effusions which [were] suggestive of developing pneumonia," and she was "still on Lasix" (*Id.*; Plaintiff's Statement of Facts ¶ 11). On December 16, 2015, decedent "was examined by a thoracic surgeon for consideration of a tracheostomy due to hypoxemic respiratory failure which was attributed to volume overload and underlying pneumonia" (*Id.* at ¶ 12). On December 17, 2015, the decedent's "bilateral pleural chest tubes were removed, and she remained intubated" (*Id.* at ¶ 13). On December 18, 2015, "Ms. Rikelman underwent a tracheostomy" (*Id.*).

On December 20, 2015, a chest x-ray was performed, which "showed increased consolidation," and a chest CT revealed "persistent extensive dependent atelectasis and a small pleural effusion" (*Id.* at ¶ 14; Statement of Uncontested Facts ¶ 10). A head CT was also performed, which showed "no evidence of significant pathology including stroke" (*Id.*). On December 21, 2015, "x-rays demonstrated a new mosaic ground glass appearance in the upper lobes with possible edema," and decedent "was continued on antibiotics (Vancomycin and Zosyn)" (*Id.* at ¶ 11). The record indicates that decedent did not have a fever, but she "had an increased white count," and "had developed acute kidney insufficiency" (*Id.*). A note from a consult with pulmonary attending, Dr. Keith Brenner states that decedent "had a hospital acquired pneumonia," and attempts to "[wean] her off the ventilator" had been unsuccessful (*Id.*). On December 29, 2015, the chart documents that decedent had a "stage I sacral pressure ulcer" (Plaintiff's Statement of Facts ¶ 16). On December 30, 2015, the chart states that decedent had "unstageable ulcers at the anus/buttocks" (*Id.*). On January 1, 2016, decedent's

"respiratory culture was positive for Candida, a fungal infection," and her "platelet count was 52,000" (*Id.* at ¶ 17; Statement of Uncontested Facts ¶ 12). On January 4, 2016, "a HIT antibody assay test was drawn and sent," which was "positive leading to the patient being started on Argatroban for potential HIT syndrome," "while the SRA testing results were pending" (*Id.*). As of January 9, 2016, "Ms. Rikelman's platelet count had increased to 79,000, and by January 10[th], it was 100,000" (*Id.*).

On January 11, 2016, a chest x-ray was performed, "reveal[ing] the existence of pulmonary edema" (*Id.* at ¶ 13). Ms. Rikelman's white blood cell count continued to rise, and it was 20,000 at 2:56 PM, and 33,400 at 9 PM (*Id.*). CT scans were performed, indicating the "absence of suspicious intra-abdominal pathology" (*Id.*). On January 12, 2016, "a palliative care meeting was held with members of [decedent's] family, who executed a DNR (do not resuscitate order)" (Plaintiff's Statement of Facts ¶ 19). Ms. Rikelman died later that day (*Id.*).

In support of their motion for summary judgment, defendants submit an expert affidavit from W. Clark Hargrove, M.D., a physician board certified in surgery and thoracic surgery, and an expert affirmation from Michael Khilkin, D.O, a physician board certified in internal medicine, critical care medicine, pulmonary disease, and hospice and palliative medicine (Hargrove Expert Affidavit ¶ 1, annexed as Exhibit B to defendants' motion papers; Khilkin Expert Affirmation ¶ 1, annexed as Exhibit C to defendants' motion papers). They contend that defendants did not deviate from acceptable medical practice during their treatment of the decedent, and that they did not proximately cause her injuries (Hargrove Expert Affidavit ¶ 5; Khilkin Expert Affirmation ¶ 5). Their opinions are based on review of the bills of particulars, medical records, deposition transcripts, and statement of uncontested facts, as well as their education, training, and experience (Hargrove Expert Affidavit ¶ 6; Khilkin Expert Affirmation ¶ 6). Dr. Hargrove opines that decedent "was an appropriate candidate for both an aortic valve replacement and for the CABG (coronary artery bypass graft) involving the RCA (right coronary artery)" since "[h]er aortic valve was severely calcified," "she was symptomatic for years,"

and "the RCA continued to be stenotic, despite multiple cardiac catheterizations with balloon angioplasty and placement of stents" (Hargrove Expert Affidavit ¶ 21). He maintains that the decedent "was at high risk for a significant cardiac event including myocardial infarction or death without surgery" (*Id.*). Dr. Hargrove contends that the surgery was not "contraindicate[ed]," even though decedent had "a degree of pulmonary congestion," "shortness of breath," "marked obesity, sleep apnea and diabetes," which increased her risk for "some of the known potential" "complications" of the surgery, as these risks were "outweighed by" the risks of "not undergoing the surgery" (*Id.* at ¶ 22). Dr. Hargrove affirms that Dr. Borger properly obtained decedent's informed consent for the aortic valve replacement and CABG, as Dr. Borger advised her "of the reasons for the procedure she was to undergo, the benefits of the procedure, the alternatives and the attendant potential risks associated with the procedure," and she signed a consent form certifying that she was advised of the risks, benefits, and alternatives of the procedures (*Id.* at ¶¶ 23-25). Further, he opines that a reasonable patient with Ms. Rikelman's medical history who had been "fully informed of the risks" "would not have foregone the procedure" (*Id.* at ¶ 25).

Dr. Hargrove alleges that decedent's post-operative complications were not caused by any deviations from the standard of care (*Id.* at ¶¶ 33, 36, 46). He claims that the fact that the patient may have had "reduced right ventricular function" after surgery was "not related to the technical aspects of the surgery," and that this condition is "not uncommon, and is generally related to lung function" (*Id.* at ¶ 36). Dr. Hargrove disagrees with plaintiff's contention that the "patient was improperly permitted to become volume overloaded" (*Id.* at ¶¶ 38-40). He states that the anesthesiology record from the surgery documents that the "overall net input of fluid was less than 1 liter, which does not even account for pre-surgical dehydration," and that "[i]t is common for cardiothoracic surgical patients to have intra-operative and immediate net fluid inputs in this order or larger" (*Id.* at ¶ 39). Dr. Hargrove suggests that defendants did not deviate from the standard of care in "manag[ing]" decedent's fluid

input, as "patients who undergo aortic valve replacement surgery need additional volume to pump blood adequately, i.e., to provide the necessary force to push blood across the valve" (*Id.* at ¶¶ 38, 39). Further, he contends that decedent "was appropriately being treated with Lasix and other diuretics throughout the admission to counteract any excess fluids to the patient's heart and body" (*Id.* at ¶ 40). Dr. Hargrove argues that the fact that the decedent developed a large A-a gradient following the operation, "does not mean the surgery was not indicated or should have been avoided" (*Id.* at ¶ 41). He explains that the large A-a gradient in this case "may be related to an underlying chronic lung disease in the form of pulmonary congestion," and that it is not "uncommon" for patients to develop this complication post-operatively, especially "patients with marked obesity" (*Id.*). Given that the decedent had a "high risk of a cardiac event associated with her significant stenoses," Dr. Hargrove maintains that the "risk of not doing the surgery was far greater" than the risk of her developing a large A-a gradient post-operatively (*Id.*). Dr. Hargrove opines that "converting [the decedent] to a tracheostomy," was appropriate, given the "difficulty [in] weaning Ms. Rikelman off" "the ventilator," and that this procedure "did not cause any injury to her" (*Id.* at ¶¶ 43-44). He concludes that decedent's injuries and death were not caused by "any improper cardiothoracic surgical care," and that there was no "cardiothoracic surgical intervention that would have in any way changed [decedent's] post-operative course or affected her ultimate outcome" (*Id.* at ¶¶ 45, 46).

Dr. Khilkin concurs with Dr. Hargrove's opinion that the development of a large A-a gradient following surgery is "not uncommon," "particularly in patients with marked or morbid obesity" (Khilkin Expert Affirmation ¶ 16). He maintains that the large A-a gradient was "recognized immediately after surgery," and appropriately "treated in the form of oxygenation via the ventilator and changes to the ventilator's settings as needed" (*Id.* at ¶ 17). Further, the decedent was also "placed on Dobutamine, which helps the heart squeeze," and "aids in oxygenation" (*Id.*). Dr. Khilkin alleges that the decedent's oxygen levels were properly monitored during her hospital stay, as the chart

confirms that whenever "there was evidence of a drop in her oxygenation, appropriate changes were made to the ventilator settings accordingly, which resulted in better oxygenation levels" (*Id.* at ¶ 18). Therefore, Dr. Khilkin affirms that "all of plaintiff's claims concerning ventilation, oxygenation and/or tidal volume have no merit" (*Id.*). Further, he concludes that "none of the temporary episodes of decreased oxygenation ever led to an injury to the patient, and did not cause her eventual death" (*Id.*). Dr. Khilkin agrees with Dr. Hargrove's opinion that decedent was not "improperly permitted to become volume overloaded" based on the anesthesiology records confirming that the "overall net input of fluid was less than 1 liter" (*Id.* at ¶¶ 30-31). He claims that this amount of fluid input was "well within the standard of care," and he has "seen and treated thousands of patients who arrive in the ICU, and it is common to receive such patients with post-operative net fluid inputs in this order or larger" (*Id.* at ¶ 31). Further, he states that the decedent was "appropriately being treated with Lasix and other diuretics throughout the admission to counteract any excess fluids to the patient's heart and body," and that "fluid excess" "did not cause any injury to the patient or her death" (*Id.* at ¶ 32).

Dr. Khilkin contends that decedent's post-operative complications were not proximately caused by defendants' treatment, and that these complications were appropriately treated once they developed (*Id.* at ¶¶ 34, 35-36, 50). He alleges that the decedent's difficulty in being weaned off the ventilator contributed to her decline, and her development of "[v]entilator-associated pneumonia (VAP)" (*Id.* at ¶¶ 34-35). He explains that when a patient "cannot tolerate coming off the ventilator," "the patient can develop pneumonia, urinary tract infections, or other forms of infections," and this is more common in "morbidly obese patients" (*Id.* at ¶ 34). Further, he states that VAP is a "common postoperative complication for patients who are on a ventilator in the ICU," and "accounts for up to 50% of pneumonias in the ICU" (*Id.* at ¶ 35). Dr. Khilkin maintains that the decedent's VAP was not caused by any "departure from accepted medical standards and practices," and "was appropriately treated with antibiotics," including "Vancomycin and Zosyn," and "continued proper oxygenation" (*Id.* at ¶¶ 35-

36). He concludes that decedent's pneumonia improved during decedent's hospital stay based on her chest x-rays (*Id.* at ¶ 36). Dr. Khilkin suggests that defendants did not deviate from the standard of care by failing to treat an infection (*Id.* at ¶¶ 36-37). He confirms that when "blood cultures were positive for coagulase negative staph infection" in "early January 2016," "Infectious Disease made appropriate changes to the antibiotic regimen to treat that infection" by discontinuing the Vancomycin, and substituting Daptomycin (*Id.* at ¶ 37).

Dr. Khilkin asserts that defendants did not depart from acceptable medical practice by "fail[ing] to prevent toxic-metabolic encephalopathy (TME)" (*Id.* at ¶¶ 39-40). He points out that "[i]t was never confirmed that the patient in fact had TME," and that it is a "catch-all diagnosis encompassing delirium and other altered states of confusion (or altered mental status), as a result of cerebral dysfunction in the absence of a structural brain cause" (*Id.*). He suggests that whether the patient did or did not have TME is not material, as she "was being treated for any underlying causes [of] TME," and "her mental status changes did not lead to any injury, or cause her eventual death" (*Id.* at ¶ 40). Dr. Khilkin maintains that defendants properly treated decedent for heparin-induced thrombocytopenia (HIT) syndrome when decedent's platelet count dropped to 29,000 by performing a HIT assay analysis on the decedent on January 4, 2016 (*Id.* at ¶¶ 44-45). He states that there are two tests in the HIT assay analysis: a HIT antibody assay and an SRA (serotonin release assay) (*Id.* at ¶ 43). Dr. Khilkin explains that if the first "test is negative, [then] there is no need to perform the second stage of the analysis" (*Id.*). The decedent's HIT antibody assay was "positive on January 6, 2016," and "an SRA assay was immediately performed, and subsequently was positive, confirming the diagnosis" (*Id.* at ¶ 44). Dr. Khilkin contends that defendants appropriately treated decedent for HIT syndrome by discontinuing Heparin and putting the plaintiff on Argatroban once the HIT antibody assay came back positive, while the SRA assay results were still pending (*Id.* at ¶ 45). He alleges that no injury occurred due to decedent's temporary drop in platelets, as "[t]here were no clinical findings suspicious for DVT (deep

vein thrombosis)" (*Id.*). Dr. Khilkin disputes plaintiff's claim that defendants deviated from acceptable medical practice by "fail[ing] to timely diagnose and treat a pulmonary embolism," as "there is no evidence that the patient in fact developed a pulmonary embolism" based on the chest CT from January 12, 2016 (*Id.* at ¶ 47). In any event, Dr. Khilkin confirms that decedent was appropriately treated for this complication with Argatroban, and "anticoagulants throughout her admission to try to prevent clotting, including clots in the form of DVT, pulmonary embolism, and embolic stroke" (*Id.* at ¶¶ 47-48). He alleges that decedent's white blood cell count "rose precipitously" on January 11, 2016, due to "patient's pneumonia and resultant sepsis," but there was nothing more the hospital staff could do, as she "was already on multiple antibiotics" (*Id.* at ¶ 49). He concludes that decedent's complications and death were not proximately caused by any departure from the standard of care, but ultimately resulted from her being unable to be weaned off the ventilator, "despite [the] excellent care" she received (*Id.* at ¶¶ 50-51).

In opposition to defendants' motion for summary judgment, plaintiff submits redacted expert affirmations from a physician board certified in internal medicine with a sub-certification in pulmonary disease, and a physician board certified in anesthesiology (Pulmonary Expert Affirmation at 1, annexed as Exhibit A to plaintiff's opposition papers; Anesthesiology Expert Affirmation at 1, annexed as Exhibit B to plaintiff's opposition papers). They conclude that defendants departed from acceptable medical practice during their treatment of the decedent, and that these departures proximately caused her injuries (Pulmonary Expert Affirmation at 2; Anesthesiology Expert Affirmation at 2). Plaintiff's expert opinions are based on review of the medical records, deposition transcripts, and "defendants' contentions outlined in their motion to dismiss together with the annexed exhibits," as well as their own education, training, and experience (Plaintiff's Pulmonary Expert Affirmation at 1-2; Plaintiff's Anesthesiology Expert Affirmation at 2). Both of plaintiff's experts maintain that defendants deviated from the standard of care by failing to "[optimize decedent] for the surgery in view of her significant

pulmonary disease (fluid overload) seen on the pre-operative chest x-ray" (Plaintiff's Pulmonary Expert Affirmation at 2; Plaintiff's Anesthesiology Expert Affirmation at 2). They contend that this departure resulted in decedent's "oxygenation" "issues," her being unable to be "weaned off a ventilator following surgery," and her death (Plaintiff's Pulmonary Expert Affirmation at 2; Plaintiff's Anesthesiology Expert Affirmation at 2). Plaintiff's experts explain that the "chest x-ray findings demonstrated pre-operative fluid overload, a condition that had to be addressed with administration of diuretics before proceeding with the elective/non-emergency cardiac surgery" (Plaintiff's Pulmonary Expert Affirmation at 3; Plaintiff's Anesthesiology Expert Affirmation at 3). Plaintiff's experts state that defendants' failure to address decedent's fluid overload prior to surgery constitutes a departure from the standard of care, as "there would be additional fluids used during surgery, which would add further strain on an already fluid overloaded pulmonary system," and "the patient's body positioning during surgery coupled with her body habitus would prevent the lungs [from] fully expand[ing]," "thereby contributing to hypoxemia" (Plaintiff's Pulmonary Expert Affirmation at 4; Plaintiff's Anesthesiology Expert Affirmation at 3-4). They opine that the "appropriate course of action was to sufficiently diurese the patient and repeat the chest x-ray to ensure that [decedent] was not fluid overloaded prior to surgery" (Plaintiff's Pulmonary Expert Affirmation at 4; Plaintiff's Anesthesiology Expert Affirmation at 4). Plaintiff's pulmonary expert also alleges that defendants deviated from the standard of care by failing to properly turn and position her during her hospital stay, resulting in the development of pressure ulcers (Plaintiff's Pulmonary Expert Affirmation at 6-7). He/she states that the hospital records do not "specify into which position the decedent was [turned] and repositioned," or confirm that the decedent was "turned and repositioned at all" (*Id.* at 6). Plaintiff's pulmonary expert contends that the standard of care required that the decedent be turned and repositioned "more frequently than every two hours" as she was "suffering from hypoxemia" and was obese, indicating that she was at a high risk for "skin breakdown" (*Id.* at 6-7). Further, the defendants were required to

document the turning and positioning in decedent's chart, and he/she claims that these failures proximately caused the "development and deterioration of [decedent's] pressure ulcers" (*Id.* at 6, 8).

In reply, defendants reiterate that Dr. Borger and Dr. Neely must be dismissed from the action, as they were never served with process, and therefore, the Court does not have personal jurisdiction over them (Attorney Reply Affirmation ¶ 3). Defendants maintain that the expert opinions they have submitted demonstrate that they did not deviate from the standard of care during their treatment of decedent, and that they did not proximately cause her injuries and death (*Id.*). Defendants allege that plaintiff's expert opinions are insufficient to defeat summary judgment, as they fail to "rebut any of the opinions of [defendants'] experts, and instead raised two wholly new theories of departure," which were not in the bills of particulars (*Id.* at ¶ 5).

To prevail on a cause of action for medical malpractice, the plaintiff must prove that defendant "deviated or departed from accepted community standards of practice, and that such departure was a proximate cause of the plaintiff's injuries" (*Stukas v. Streiter*, 83 AD3d 18, 23 [2d. Dept. 2011]). On a motion for summary judgment, defendant must "make a prima facie showing that there was no departure from good and accepted medical practice or that the plaintiff was not injured thereby" (*Iulo v. Staten Is. Univ. Hosp.*, 106 AD3d 696, 697 [2d. Dept. 2013]). To "sustain this burden, the defendant must address and rebut any specific allegations of malpractice set forth in the plaintiff's bill of particulars" (*Anonymous v. Gleason*, 175 AD3d 614, 617 [2d. Dept. 2019]; *Bendel v. Rajpal*, 101 AD3d 662, 663 [2d. Dept. 2012]). Once the defendant meets its burden, the burden then shifts to the plaintiff to "raise a triable issue of fact with respect to the element of the cause of action or theory of nonliability that is the subject of the moving party's prima facie showing" (*Stukas*, 83 AD3d at 24). If the defendant "makes only a prima facie showing that he or she did not deviate or depart from accepted medical practice, the plaintiff, in order to defeat summary judgment, need only raise a triable issue of fact as to the alleged deviation or departure, and need not address the issue of proximate cause"

(*Hayden v. Gordon*, 91 AD3d 819, 821 [2d. Dept. 2012]). Conclusory allegations that are "unsupported by competent evidence tending to establish the essential elements of medical malpractice are insufficient to defeat defendant physician's summary judgment motion" (*Deutsch v. Chaglassian*, 71 AD3d 718, 719 [2d. Dept. 2010]). Further, a plaintiff cannot defeat a motion for summary judgment by "rais[ing] a new or materially different theory of" "liability" "for the first time in opposition to a motion for summary judgment" that was not "pleaded in the complaint or bills of particulars" (*Gleason*, 175 AD3d at 617; *Cox v. Herzog*, 192 AD3d 757, 759 [2d. Dept. 2021]; *Abalola v. Flower Hosp.*, 44 AD3d 522, 522 [1st Dept. 2007]). Where the parties have submitted conflicting expert reports, summary judgment should not be granted; "[s]uch credibility issues can only be resolved by a jury" (*Deutsch*, 71 AD3d at 719).

Defendants' motion to dismiss the first and second causes of action, and all allegations of negligence against Dr. Borger and Dr. Neely, is granted, as plaintiff never served these defendants, and the deadline to serve them has passed (CPLR § 306-b). Therefore, the Court does not have personal jurisdiction over them, and they must be dismissed from the action (*See* CPLR § 3211(a)(8); *Colin v. New York Community Hosp. of Brooklyn, Inc.*, 39 Misc.3d 1222(A), at *1 [Sup Ct, Kings County 2013]). The Court also grants defendants' motion to remove Dr. Borger and Dr. Neely from the caption, and all future papers filed with the Court shall bear the amended caption.

Defendants' motion for summary judgment, pursuant to CPLR § 3212, is granted in part and denied in part. Defendants met their prima facie burden on all the allegations in the bills of particulars, except for the claim that defendants failed to "timely turn and position" decedent (Verified Bill of Particulars as to NYPH ¶ 2-7; Verified Bill of Particulars as to Columbia University ¶ 2-7). Defendants' experts, Dr. Hargrove and Dr. Khilkin, affirmed that the practice and procedures by Dr. Borger, Dr. Neely and the staff at NYPH were within acceptable standards of medical practice, and that no act or omission of theirs proximately caused any injury to the decedent. Dr. Hargrove opined

that decedent was a candidate for the procedures performed by Dr. Borger and Dr. Neely, that Dr. Borger properly obtained her informed consent, and that decedent's fluid levels were appropriately monitored during her hospital stay. Dr. Khilkin concurred with Dr. Hargrove's opinion, and concluded that decedent was properly treated for HIT syndrome and TME, and that her postoperative complications were the result of her being unable to be weaned off the ventilator, and not due to any treatment she received at NYPH. Their opinions constitute competent evidence, in that they are based on the bills of particulars, medical records, deposition transcripts, and statement of uncontested facts.

In opposition, plaintiff produced two affidavits of merit from a board-certified internal medicine physician with a sub-certification in pulmonary disease, and a board-certified anesthesiologist, attesting to departures from accepted standards of medical practice, and that these departures were a competent producing cause of the decedent's injuries. Plaintiff's expert opinions fail to raise a triable issue of fact regarding any of the claims in the bills of particulars that were addressed by defendants' experts, and instead, raise a new claim that the defendants failed to treat decedent's fluid overload before the surgery. Although the plaintiff in the bills of particulars alleged that defendants "negligently permitt[ed] plaintiff decedent to develop volume overload," this claim is different than the one addressed by plaintiff's experts, as it implies that the decedent was not volume overloaded before the surgery (Verified Bill of Particulars as to NYPH ¶ 2-7; Verified Bill of Particulars as to Columbia University ¶ 2-7). As the claim raised by plaintiff's experts was not included in the complaint or bills of particulars, defendants' experts "were not required" to address it in their opinions, and this "new theory of liability" is insufficient to defeat defendants' motion for summary judgment on all the claims in the bills of particulars, except for the claim regarding the failure to turn and position decedent (*Stein v. Kendall at Ithaca*, 129 AD3d 1366, 1367 [3d. Dept. 2015]; *Abalola*, 44 AD3d at 522; *Gleason*, 175 AD3d at 617; *Dolan v. Halpern*, 73 AD3d 1117, 1119 [2d. Dept. 2010]). As defendants' experts never addressed the allegation that defendants did not timely

turn and position decedent, they failed to meet their prima facie burden on this claim, and the Court is required to deny summary judgment on this claim, "regardless of the sufficiency of the opposing papers" (*Bendel*, 101 AD3d at 663; *Huichun Feng v. Accord Physicians*, 194 AD3d 795, 796 [2d. Dept. 2021]). Accordingly, defendants' motion for summary judgment is granted on all claims in the bills of particulars, except for the failure to adequately turn and position decedent.

Defendants' motion to dismiss the first and second causes of action in the complaint, and all allegations of negligence against Dr. Borger and Dr. Neely is granted, and the caption is amended to reflect their dismissal. All future papers filed with the Court shall bear the amended caption. Defendants' motion for summary judgment is granted in part and denied in part. All claims in the bills of particulars, except for the failure to timely turn and position decedent, are hereby dismissed. The fifth cause of action for lack of informed consent is dismissed.

This constitutes the decision and order of the Court.

ENTER:

Hon. Pamela L. Fisher
J.S.C.

HON. PAMELA L. FISHER