Miller v Wun
2023 NY Slip Op 30237(U)
January 24, 2023
Supreme Court, Kings County
Docket Number: Index No. 524330/19
Judge: Genine D. Edwards
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At an IAS Term. Part 80 of the Supreme Court of the State of New York, held in and for the County of Kings, at the Courthouse, at 360 Adams Street, Brooklyn, New York, on the 24th day of January 2023.

PRESENT:

HON. GENINE D. EDWARDS,
Justice.

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ESTELLE MILLER,
Plaintiff,

-against-

HERRICK WUN, M.D.,
THE NEW YORK AND PRESBYTERIAN HOSPITAL,
JOHN BABER, M.D.,
BHAVAH SHAH, M.D.,
SIYAO LIU, M.D.,
CAITLIN MORAN, R.N.,
DOE CHERRY, M.D.,
DRAKE LEBRUN, M.D.,
SANTOSH MURTHY, M.D.,
and JARED KNOPMAN, M.D.,
Defendants.

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DECISION AND ORDER
Index No. 524330/19
Mot. Seq. No. 4

The following e-filed papers read herein: NYSCEF Doc. Nos.:

Notice of Motion, Affirmations (Affidavits), and Exhibits Annexed.....81-110
Affirmations (Affidavits) in Opposition and Exhibits Annexed.....122-138
Reply Affirmation and Exhibits Annexed.....144-148

In this action to recover damages for medical malpractice arising out of a hemorrhagic stroke, summary judgment dismissing all claims is jointly sought by the following three groups of individual defendants, as well as by their employer, The New York and Presbyterian Hospital ("NYPH"):[2]

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[1] The caption reflects the prior dismissal of defendants Lori Rubin, M.D. ("Dr. Rubin"), and Lama Obeid, M.D., by stipulations, each dated May 25, 2022, with the caption being amended accordingly by the so-ordered stipulation, dated May 26, 2022 (NYSCEF Doc. Nos. 139-140, 142).

[2] The Court rearranged the order in which defendants are listed in their joint motion.

(1) the vascular surgery team of defendants, attending Herrick Wun, M.D. ("Dr. Wun"), fellow John Baber, M.D. ("Dr. Baber"), and resident Drake LeBrun, M.D. ("Dr. LeBrun", collectively with Dr. Wun and Dr. Baber, the "vascular surgery defendants"), on the basis of, among other submissions, the expert physician affirmation by Larry Scher, M.D., dated March 4, 2022 (the "defense expert vascular surgeon") (NYSCEF Doc. No. 84);

(2) the PACU team of defendants, PACU attending Liang Shen, M.D. ("Dr. Shen"), PACU resident Siyao Liu, M.D. (sued in her own name as well as "Doe Cherry, M.D.") ("Dr. Liu"), and PACU nurse Caitlin Moran, R.N. ("Nurse Moran", collectively with Dr. Shen and Dr. Liu, the "PACU defendants"), on the basis of, among other submissions, the expert physician affirmation by Marc S. Kanchuger, M.D., dated March 10, 2022 (the "defense expert anesthesiologist") (NYSCEF Doc. No. 85); and

(3) the neurology/neurosurgery team of defendants, stroke-team attending Jared Knopman, M.D. ("Dr. Knopman"), stroke-team attending Santosh Murthy, M.D. (also known as Santosh Bhaskar Murthy, M.D.) ("Dr. Murthy"), and stroke-team resident Bhavan Shah, M.D. ("Dr. Shah", collectively with Drs. Knopman and Murthy, the "stroke-team defendants"), on the basis of, among other submissions, the expert physician affirmation by Stanley Tuhrim, M.D., dated March 9, 2022 (the "defense expert neurologist", collectively with the defense expert vascular surgeon and defense expert anesthesiologist, the "defense experts") (NYSCEF Doc. No. 86).[3]

[3] The stroke-team defendants, together with the vascular surgery and PACU defendants are collectively referred to as the "individual defendants," whereas the individual defendants, together with NYPH, are collectively referred to as "defendants."

Plaintiff Estelle Miller (the "patient") objects to defendants' motion by way of, among other submissions: (1) the plaintiff's expert surgeon and vascular surgeon affirmation, dated May 17, 2022 (the "patient's expert vascular surgeon"); (2) the plaintiff's expert anesthesiology affirmation, dated May 23, 2022 (the "patient's expert anesthesiologist"); and (3) the plaintiff's expert neurosurgery affirmation, dated May 25, 2022 (the "patient's expert neurosurgeon", collectively with the patient's expert vascular surgeon and expert anesthesiologist, the "patient's experts") (NYSCEF Doc. Nos. 126, 127, and 125, respectively).

Summary[4]

In the afternoon of September 15, 2018,[5] the patient, then 71 years of age, presented as a walk-in to (and was admitted in the early hours of the following morning to the vascular surgery service of) NYPH with the principal complaints of a sudden color change to blue/gray in her left foot's fifth toe (the "pinky toe").[6] Pre-admission, she experienced pain in her pinky toe for the preceding two weeks, despite her then-ongoing treatment of the pinky toe by her primary care physician for suspected cellulitis and, prior to the cellulitis diagnosis, for suspected fungal infection. The patient's admitting diagnosis at NYPH was "cellulitis of left toe." On admission to NYPH, the patient was neurologically intact, with no history of

[4] The record on this motion is voluminous (in excess of 5,000 pages excluding duplicate submissions). In the interest of brevity, this opinion recounts only the portions of the record necessary to the decision.

[5] All references are to calendar year 2018, unless otherwise indicated. All references to September 18 are to the date of September 18, 2018.

[6] All citations to the patient's NYPH medical chart are to its bates-numbered version as was e-filed by her counsel under NYSCEF Doc. No. 128.

any stroke or stroke-like events.[7] Nonetheless, the patient's medical history was significant for several stroke-predisposing factors: (1) peripheral vascular disease; (2) hyperlipidemia; (3) persistent life-long smoking; and (4) long-standing hypertension that was not adequately controlled pre-admission -- her blood pressure upon presentation to the emergency room ("ER") was substantially elevated at 186/101.

In the post-admission period to NYPH's vascular surgery service between September 15 and September 18 (the "preoperative period"), the patient's left lower extremity (inclusive of her pinky toe) was radiographically determined to suffer from a "left lower extremity fifth toe cyanosis." One available treatment modality (and the one to which the patient consented) was an elective (meaning, non-emergent) left lower extremity endoscopic angiogram, angioplasty, and stenting (the "endovascular procedure"). In preparation for the endovascular procedure, the patient received subcutaneous Heparin every eight hours during the preoperative period, including on the morning of her procedure on September 18.

In the early afternoon of September 18, the patient underwent (under monitored anesthesia care) the endovascular procedure, performed by vascular attending surgeon Dr. Wun, who was assisted in the procedure by vascular surgery fellow Dr. Baber. At (or shortly after) the beginning of the endovascular procedure, the patient received an intraoperative bolus of intravenous Heparin to prevent intravascular thrombosis caused by stasis occurring from the interruption of blood flow during the performance of the procedure.

[7] The patient was overweight with BMI of 28, based on her weight of 81.4 kg (179.5 pounds), and her height of 170.2 cm (5 feet, 7 inches).

The anesthesia for the endovascular procedure started at 12:15 hours and ended at 14:20 hours on September 18, with the procedure itself lasting from 12:47 hours to 14:05 hours on that day. The patient, though persistently hypertensive in the course of the endovascular procedure, received no antihypertensives at any time during the procedure.[8] The endovascular procedure ended without incident. The pre- and post-procedure diagnosis remained the same: namely, "[l]eft lower extremity atherosclerosis with gangrene and rest pain [*i.e.*, pain at rest]."

Post-operatively (*i.e.*, at, or shortly after, the conclusion of the anesthesia at approximately 14:20 hours), Dr. Rubin transferred the patient for recovery to the post-anesthesia care unit known as "PACU North" ("PACU"), which was "primarily [for] patients who [were] less acutely ill and [who] under[went] ambulatory-type procedures."[9] At approximately 14:18 hours and again at 14:26 hours, the patient was assessed as neurologically intact, achieving, in each instance, the maximum score of 15 on the Glasgow Coma Scale.[10] At 15:02 hours, PACU resident Dr. Liu assessed the patient's mental status as "[l]ightly asleep, eyes open immediately."[11] Dr. Liu further indicated in her post-anesthesia

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[8] The operating anesthesiologist Dr. Rubin's 23 separate blood pressure measurements performed during the endovascular procedure, when viewed in their totality, demonstrated that the patient was persistently hypertensive throughout the procedure. Dr. Rubin's EBT tr at page 52, lines 7-14; at page 31, line 23 to page 35, line 9. Dr. Rubin was not involved with the patient in the PACU. Dr. Rubin's EBT tr at page 38, lines 22-24. By stipulation, Dr. Rubin was subsequently dismissed from this action.

[9] Dr. Shen's EBT tr at page 14, lines 17-20 (NYSCEF Doc. No. 99); Nurse Moran's EBT tr at page 12, lines 8-10 (NYSCEF Doc. No. 100).

[10] Glasgow Coma Scale rated the patient in three categories: (1) eye opening; (2) best verbal response; and (3) best motor response. PACU Admission Note, timed at 14:18 hours and e-signed by PACU Nurse Moran at 14:50 hours.

[11] "Anesthesia Post Anesthesia Evaluation," timed at 15:02 hours and e-signed by Dr. Liu.

assessment note that the patient was hypertensive at 169/75. The patient's post-operative hypertension preceded the onset of her neurological symptoms.

At approximately 15:00 hours (or within one hour after the end of the endovascular procedure), the patient received (with water) a 200 mg "loading dose"[12] of an oral antiplatelet agent named Plavix.[13] Shortly after the Plavix administration, the patient suffered the hemorrhagic stroke,[14] which first became manifest to Nurse Moran (by way of the patient's neurological signs, symptoms, and responses) sometime between approximately 15:02 hours and approximately 15:18 hours (the "stroke onset").[15] At 15:18 hours, Nurse Moran telephoned her findings to PACU resident Dr. Liu.[16] At 15:21 hours, Nurse Moran

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[12] Defense expert neurologist's affirmation, ¶ 23. The loading dose consisted of four tablets, 75 mg each, totaling 300 mg of Plavix, taken orally.

[13] Dr. Baber's EBT tr at page 24, lines 7-13 (NYSCEF Doc. No. 131).

[14] A spontaneous, non-traumatic hemorrhagic stroke (or "brain bleed") – essentially a rupture of one or more of the cerebral vessels – is classified into two predominant types: (1) the intracerebral hemorrhage occurring within the brain parenchyma (which was the type of the hemorrhagic stroke the patient suffered); and (2) the subarachnoid hemorrhage occurring within the subarachnoid space surrounding the brain (typically, a burst aneurysm), which was not the case here.

[15] A sudden change in the patient's speech at approximately 15:10 hours prompted Nurse Moran to initiate "a comprehensive neurological assessment" to determine if "there was any type of neurological deficits." Nurse Moran's EBT tr at page 36, lines 17-23. Both Nurse Moran and the patient's daughter at bedside had previously dismissed as non sequitur the patient's nearly contemporaneous verbal complaints of inability to talk (expressed by the patient at approximately 15:02 hours to Nurse Moran, and at approximately 15:10 hours to the patient's daughter at bedside). Nurse Moran's EBT at page 28, lines 2-20; page 34, lines 17-21. Nurse Moran's neurological assessment, which she performed between approximately 15:10 hours and approximately 15:18 hours, was positive for "slurred speech, asymmetrical smile, . . . facial droop, and right[-]side deviation of the tongue." Nurse Moran's EBT tr at page 39, line 3 to page 40, line 9.

[16] Nurse Moran, not being a physician, was not permitted to diagnose a stroke and call a stroke code. Dr. Shen's EBT tr at page 23, lines 3-5. The stroke diagnosis, which is a medical decision-making by one or more physicians, must be distinguished from the *code activation*, which is its clerical implementation, meaning that Nurse Moran, *any* vascular surgery defendant, *any* PACU defendant, or practically "[a]nyone" could telephone the unit clerk with instructions "to call a [particular] phone number to *activate* it." Dr. Wun's EBT tr at page 31, line 16 to page 32, line 6 (emphasis added).

additionally paged the PACU defendants.[17] At approximately 15:23 hours, Dr. Liu (on return to the patient's bedside and after performing her own neurological check, which she completed at approximately 15:25 hours) confirmed Nurse Moran's findings and, at approximately 15:27 hours, paged her superior – PACU attending Dr. Shen. At 15:32 hours, Dr. Shen arrived at the patient's bedside in response to Dr. Liu's page.[18] Dr. Shen's visit, according to his progress note (timed at 16:34 hours and e-signed at 16:45 hours), lasted for a total of 50 minutes from approximately 15:32 hours to 16:22 hours ("Dr. Shen's progress note").[19] Dr. Shen, in his initial evaluation of the patient, considered the residual effects of the patient's operative anesthesia and her pre-existing neurological deficits as a *more likely cause* of her signs/symptoms than those of a stroke.[20] To Dr. Shen, the patient's difficulty in finding words during his cranial nerve examination (as documented in his progress note) did not signify a stroke potential.[21] In the course of his examination, Dr. Shen *did* observe the patient's right-sided weakness.[22]

Separately from contacting the PACU physician team at 15:18 hours and again at 15:21 hours, Nurse Moran notified the vascular surgery team of the worsening of the patient's

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[17] PACU Continuation Note, timed and e-signed by Nurse Moran at 15:21 hours, stated in full:

> "Paged anesthesia to come assess patient. Patient complaining[,] she can[']t talk. *Speech is* understandable but *a little slurred.* No deficit noted in any extremity. *Smile [is] not symmetrical and tongue [is] deviating to the right at this time.*" (emphasis added).

[18] Anesthesia Attending Note, timed at 16:34 hours.

[19] According to his progress note, Dr. Shen devoted "*[c]ritical care time [of] 50 min* for acute CVA [cardiovascular accident] at high risk of life-threatening neurologic deterioration" (emphasis added).

[20] Dr. Shen's EBT tr at page 46, line 16 to page 47, line 14.

[21] Dr. Shen's EBT tr at page 62, line 10 to page 63, line 3.

[22] Dr. Shen's EBT tr at page 66, lines 12-18; page 67, line 12 to page 68, line 6.

condition.[23] At 15:20 hours, Nurse Moran text-paged her findings to the vascular surgery team. At 15:25 hours, Nurse Moran additionally phone-paged the vascular surgery team. At 15:30 hours, vascular surgery resident Dr. LeBrun returned Nurse Moran's phone-page and, at approximately 15:39 hours, he joined Nurse Moran, Dr. Shen, and Dr. Liu at the patient's bedside.[24] After speaking with the PACU team at bedside, Dr. LeBrun went off to find his superior – vascular surgery fellow Dr. Baber (who, as noted, assisted Dr. Wun with the patient's endovascular procedure). By the time Dr. LeBrun returned with Dr. Baber to the patient's bedside, however, the decision to call the stroke code had already been made, as more fully set forth in the margin.[25] Meanwhile, the head of the vascular surgery team – vascular attending surgeon Dr. Wun – remained off-premises. After performing the endovascular procedure on the patient, Dr. Wun went to another hospital, leaving Drs. Baber and LeBrun to cover for him.[26]

Viewing the evidence in a light most favorable to the patient as the non-movant, it appeared that Drs. Shen and Liu jointly decided to call (or announce as a medical decision)

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[23] Dr. Shen's EBT tr at page 22, line 24 to page 23, line 3.

[24] PACU Continuation Note, timed and e-signed by PACU Nurse Moran at 15:39 hours, stated:

> "[Dr.] Drake [LeBrun] from vascular [surgery] came to assess patient. Anesthesia attending Dr. Shen at bedside to assess patient. Drake from vascular went to speak with fellows [*i.e.*, Dr. Baber] regarding patient's condition."

[25] Dr. Baber's EBT tr at page 28, lines 11-14 ("By the time that I had arrived, the stroke team was already present[,] and they were making the decisions regarding management at that point."); at page 28, lines 3-6 ("I was there [at the patient's bedside in the PACU] for a few minutes. . . . I was there with her until I transported her to the CT scanner.").

[26] Dr. Wun's EBT tr at page 66, line 14 to page 67, line 12.

the stroke code at approximately 15:42 hours.[27] With such decision having been made. PACU Nurse Moran, in turn, caused the stroke code to be activated, likewise at approximately 15:42 hours, to summon the stroke team.[28]

Stroke-team resident Dr. Shah, however, presented a different (and a more accelerated) chronology of relevant events. According to Dr. Shah's "Neurology Consult Note," timed at 17:17 hours: (1) the stroke onset took place at exactly 15:00 hours (rather than between approximately 15:02 hours and approximately 15:18 hours as reflected in the PACU notes); (2) the patient's "last known normal" was likewise at precisely 15:00 hours (rather than at 15:02 hours as documented in the PACU notes); (3) the stroke team was paged at 15:28 hours (rather than at 15:42 hours when the decision to call the stroke code was made, according to the PACU notes); and (4) Dr. Shah arrived at the patient's bedside at 15:30 hours (rather than at or after 15:42 hours, according to the PACU notes).[29]

Putting the distinction in timing aside, the substance of Dr. Shah's Neurology Consult Note was disturbing. According to his Neurology Consult Note, "[b]ased on [the] initial evaluation and history[,] stroke or underlying ICH [intracerebral hemorrhage] was suspected post [H]eparin and [P]lavix load." As calculated by Dr. Shah at 15:45 hours, the patient's

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[27] Dr. Shen's progress note stated that he first saw the patient at 15:32 hours, and that "[a]pproximately within 10 min, [the patient was] noted to be moving RUE [right upper extremity] less," together with the additional findings he was then documenting in his progress note; namely, that the patient, though still following his commands, was "somewhat more somnolent." Using 15:32 hours as Dr. Shen's starting time of his bedside examination of the patient and advancing it by "10 min" to account for its duration, it is reasonable to conclude that the decision to call the stroke code was made at approximately 15:42 hours by Drs. Shen and Liu.

[28] As noted, whereas only physicians could determine whether to *call* (or initiate) the stroke code, Nurse Moran or anyone else could *activate* the stroke code (once the decision was made) by telephoning the unit clerk. Dr. Shen's EBT tr at page 31, line 16 to page 32, line 6.

[29] Dr. Shah was not deposed in this action.

National Institute of Health Stroke Scale – a measure of stroke severity on the scoring range of 0 to 42 – yielded a moderate-to-severe stroke score of 18. Concurrently, Dr. Shah calculated the patient's score on the Glasgow Coma Scale – a bedside assessment of her level of consciousness – at 12, which score was consistent with a moderate brain injury.[30] Further, Dr. Shah estimated the patient's hematoma volume (abbreviated as "ICH" in his Neurology Consult Note) at, or greater than, 30 cc, which was indicative of a moderate hematoma volume.

At approximately 15:45 hours, stroke-team resident Dr. Shah (with vascular surgery fellow Dr. Baber pushing the patient's gurney[31]) transported the patient to the radiology suite for an urgent brain CT scan. At approximately 15:45 hours, the patient's brain CT scan was performed, with its findings being reviewed/interpreted by stroke-team resident Dr. Shah before the official findings became available. As part of his Neurology Consult Note, Dr. Shah documented his own preliminary findings of a 4 x 6 cm acute left frontal temporal bleed with fluid level and mass effect. The subsequently released official interpretation of the patient's brain CT scan confirmed Dr. Shah's preliminary findings. Specifically, the official interpretation of the patient's brain CT scan found: (1) a 6.7 x 4.6 cm mixed-density hyperacute/acute hematoma centered within the posterior left frontal operculum, inferior left parietal lobe, left parietal operculum; and (2) a focal area of active contrast extravasation (*i.e.*, ongoing bleeding) measuring 4.5 mm along the course of a proximal posterior M4 left middle cerebral artery branch at the hematoma's left dorsal lateral aspect.

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[30] As noted, the patient's *pre*-stroke onset score on the Glasgow Coma Scale had been at the maximum of 15.

[31] Dr. Baber's EBT tr page 28, lines 3-6.

Immediately following his preliminary interpretation of the CT scan films, Dr. Shah (with Dr. Baber again lending assistance with the transport[32]) had the patient transferred to the neuro ICU. At 16:00 hours, Nurse Moran "handed off" the patient to the neuro ICU,[33] although the patient's official admission time to the neuro ICU was timed at 17:14 hours. With the stroke code having been called at 15:42 hours and the patient's de facto admission to the neuro ICU at 16:00 hours, the vascular surgery defendants' involvement with the patient ceased. Likewise, stroke-team resident Dr. Shah's involvement with the patient ended upon her admission to the neuro ICU. Starting at, or shortly after, 16:00 hours, the remaining stroke-team defendants (*i.e.*, neuro ICU attending Dr. Murthy and neurosurgeon attending Dr. Knopman; collectively, the "stroke-team attendings") took over the patient's medico-surgical care, subject to PACU attending Dr. Shen completing, at 16:22 hours, his previously commenced 50-minute "critical care" visit with the patient (as reflected in Dr. Shen's progress note).

For the ensuing few hours in the neuro ICU, the patient was medically managed by stroke-team attendings Drs. Murthy and Knopman. The patient's blood pressure, as was measured at 16:30 hours in the neuro ICU, was hypertensive at 189/84. At 16:32 hours, stroke-team attending Dr. Knopman directed that: (1) the patient's systolic blood pressure be maintained below the level of 140 (the "normotensive level"); (2) her INR (level of anticoagulation) be reduced to 1.4 or below to reverse the Heparin-induced anticoagulation and to increase her coagulation; and (3) her platelet count be increased to 100,000+ to reverse

[32] Dr. Baber's EBT at page 28, lines 20-23.

[33] "Transfer Sending Note – Nursing," timed at 16:45 hours.

her Plavix-induced platelet reduction.[34] At 16:47 hours, antihypertensive Cardene was started with the goal of reaching the normotensive level. At 16:50 hours, the patient received Protamine with the goal of increasing her coagulation. Between 17:00 hours to 17:45 hours, the patient was infused with one unit of platelets with the goal of increasing her platelet count.

Next, between 18:03 hours and 18:10 hours, PACU attending Dr. Shen (together with his PACU resident Dr. Liu) was summoned to the neuro ICU to perform a rapid-sequence intubation on the patient. The necessity of the rapid-sequence intubation reflected the interim deterioration of the patient's cognitive status because, as Dr. Shen confirmed in his deposition testimony, no intubation was necessary when he initially examined the patient approximately two hours prior.[35] In fact, the patient's score on the Glasgow Coma Scale, by the time of her intubation, had fallen to 8, which score suggested a severe brain injury.[36] Drs. Shen and Liu's intubation of the patient concluded their further involvement with the patient.

Despite the ongoing medical stabilization of the then-intubated patient in the neuro ICU, she continued to exhibit progressive somnolence or lethargy (as well as an altered mental status), requiring an emergent neurosurgery to evacuate the hematoma and relieve the hematoma-induced intracranial pressure. At 18:37 hours, the anesthesia for the patient's neurosurgery was started. The first incision was made at 19:09 hours, neurosurgery was

[34] Neurosurgery resident's consult note, timed at 16:32 hours on September 18 and cosigned by stroke-team attending Dr. Knopman at 07:49 hours on September 19.

[35] Dr. Shen's EBT tr at page 83, lines 5-13; page 83, lines 23 to page 84, line 15.

[36] Dr. Murthy's Neuro ICU Attending Follow-Up Note, timed at 17:25 hours and signed by him at 23:32 hours.

concluded at 20:30 hours, and the patient was moved out of the operating room at 20:47 hours.[37] Intraoperatively, a procoagulant was topically administered to staunch brain bleeding. As part of neurosurgery, stroke-team attending Dr. Knopman performed a left-sided decompressive hemicraniectomy (removal of the bone plate), with hematoma evacuation and intracranial pressure relief.[38] The hemicraniectomy, though a life-saving measure, could not "reverse [the patient's already sustained] severe [neurologic] deficits."[39]

On a macro level, the six-hour period between 12:37 hours and 18:37 hours on September 18 turned out to be a particularly trying time for the patient. Her elective endovascular procedure for her gangrenous left toe that was started (via first incision) uneventfully at 12:37 hours on September 18 eventually led to her undergoing an emergency, lifesaving hemicraniectomy six hours later on the same day.

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[37] The patient received preoperative antibiotics within one hour prior to the skin incision for the neurosurgery.

[38] The operative report vividly reflected the seriousness of the patient's neurosurgery:

> "The brain [once reached by Dr. Knopman] was noted to be markedly swollen secondary to intracranial hypertension and intraparenchymal hemorrhage. . . . [T]he intraparenchymal hematoma as well as [the] contused parietal lobe [were] removed. *After removal of the intraparenchymal hematoma, the brain was noted to markedly soften*. . . . The dura was flapped on top of the brain but was not reapproximated so as to allow for potential postoperative swelling. A large [4 cm x 5 cm] Duraform [Dural Graft Implant] was placed in the epidural space. A . . . flat JP [surgical drain] was tunneled out a separate stab incision in the skin and sutured to the skin. . . . [T]he temporalis muscle as well as the galea [*i.e.*, the connective tissue layer continuous with the occipitofrontalis muscle] were reapproximated utilizing . . . sutures. The skin was reapproximated utilizing staples."

Dr. Knopman's Operative Report; Operating Room Record. pages 2 and 4 of 7 (emphasis added).

[39] Dr. Knopman's EBT tr at page 23, line 7 to page 24, line 6; at page 24, lines 13-18 (explaining that "*If a patient is decompensating, you want to take that patient to the operating room urgently*. If a patient is not decompensating from the standpoint of raised intracranial pressure, there is no indication for surgery.") (NYSCEF Doc. No. 101) (emphasis added).

On October 9, the patient was discharged from NYPH to an outside rehabilitation facility. On December 26, she was returned to NYPH for a left cranioplasty to replace the portion of the skull that was temporarily removed during the initial hemicraniectomy. Following several courses of rehabilitation, the patient was returned to her house in Brooklyn where she continued to reside at the time of her deposition.

Although a survivor, the patient became severely disabled by the stroke. Despite her extensive post-discharge rehabilitation, she remained a right-sided hemiplegic who, at the time of her daughters' depositions held in January 2021, was wheelchair-dependent, requiring one-on-one, around-the-clock personal care in all activities of her daily living. The cognitive impact of her stroke – the patient's severe memory impairment – was reflected by her answers during her deposition conducted in February 2021, as more fully set forth in the margin.[40] In contrast to her currently debilitated state, the patient, before her stroke, was a successful businessperson running her own beauty salons, with branches in Brooklyn, New York and Deal, New Jersey. Additional facts are stated when relevant to the discussion below.

Litigation

On November 6, 2019, the patient commenced this action seeking damages for injuries that she allegedly sustained as a result of the individual defendants' alleged negligence in

[40] At her deposition, the patient could not recall, among other matters, the following: (1) her home address; (2) her birthday; (3) the first name of one of her daughters; (4) whether she ever had any problems with her toes; (5) the admission to NYPH at issue; (6) the post-stroke admission to the rehabilitation facility; and (7) the names of any of her four grandchildren, the name of either of her two home-health aides, or the name of the particular home-health aide who was sitting next to her at her deposition. *See* Patient's EBT tr at page 9, line 14 to page 20, line 25 (NYSCEF Doc. No. 94).

causing (or contributing to) – as well as in failing to diagnose and treat – the stroke that she suffered while she was under their care, and she further alleged that NYPH was vicariously liable for the aforementioned negligence. For purposes of the judicial analysis, the patient's medical malpractice claim could be separated into two conceptually and chronologically distinct categories, depending on whether the alleged medico-surgical departures either preceded or, alternatively, followed the stroke onset at approximately 15:00 hours (at the earliest) on September 18 (the "*pre*-stroke onset claim" and the "*post*-stroke onset claim," respectively). The *pre*-stroke onset aspects of the patient's medical malpractice claim were grounded on: (1) the allegedly improper performance of the endovascular procedure (which, among other things, failed to prevent the postoperative loss of her pinky toe[41]); (2) the alleged failure to treat her perioperative systolic hypertension; (3) the allegedly excessive pre- and intraoperative administration of Heparin to her; (4) the allegedly improper postoperative administration of Plavix to her; and (5) other allegedly negligent acts/omissions that "improperly caus[ed] [her] brain damage" and "hemorrhagic stroke."[42] The *post*-stroke onset aspects of the patient's medical malpractice claim (*i.e.*, those alleged acts/omissions which arose on and after 15:00 hours, at the earliest, on September 18) were predicated, for the most part, on the alleged departures on the part of each group of defendants (*i.e.*, vascular surgery, PACU, and stroke team), in failing to promptly undertake, *after the stroke onset*, one or more of the following measures: (1) to recognize the prodromal symptoms of the stroke; (2) to call

[41] At some point following the patient's discharge from NYPH, her pinky toe – the immediate cause of her admission to NYPH's vascular surgery service and which remained gangrenous throughout – fell off on its own without medical intervention.

[42] Amended Verified Bill of Particulars as to NYPH, dated January 4, 2022, ¶ 7 (NYSCEF Doc. No. 93).

the stroke code, and to perform a radiological study to confirm its presence (collectively, the "stroke-diagnosis delay"); (3) to lower the patient's elevated systolic blood pressure to the normotensive level; (4) to reverse the anticoagulant effect of Heparin; (5) to reverse the antiplatelet effect of Plavix; and (6) to perform emergency neurosurgery to evacuate the hematoma and reduce the intracranial pressure.

The patient's lack of informed consent claim was grounded on Dr. Wun's alleged failure, in connection with the endovascular procedure, "to warn [the patient and her family at bedside] of the risks of brain damage, stroke[,] or being wheelchair bound."[43] The patient's final claim asserted (for the most part) vicarious liability on the part of NYPH.[44]

On January 12, 2022, a note of issue was filed, thereby signifying that discovery was complete. On March 11, 2022, defendants timely served the instant motion. On July 15, 2022, the instant motion was fully submitted, with the Court reserving decision. Additional facts are stated when relevant to the discussion below.

Standard of Review

To succeed on a motion for summary judgment, the proponent is required to "make a prima facie showing of entitlement to judgment as a matter of law, tendering sufficient evidence to demonstrate the absence of any material issues of fact." *Alvarez v. Prospect Hosp.*, 68 N.Y.2d 320, 508 N.Y.S.2d 923 (1986). "Summary judgment is designed to

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[43] Amended Verified Bill of Particulars as to Dr. Wun, dated January 4, 2022, ¶ 7 (NYSCEF Doc. No. 93).

[44] By stipulation, dated March 3, 2022, the patient withdrew her claim of negligent hiring as against NYPH (NYSCEF Doc. No. 110).

expedite all civil cases by eliminating from the Trial Calendar claims which can properly be resolved as a matter of law." *Andre v. Pomeroy*, 35 N.Y.2d 361, 362 N.Y.S.2d 131 (1974). "Since [summary judgment] deprives the litigant of his [or her] day in court it is considered a drastic remedy which should only be employed when there is no doubt as to the absence of triable issues." *Id.* "[O]n such a motion, the court's role is limited to issue finding, not issue resolution." *Kriz v. Schum*, 75 N.Y.2d 25, 550 N.Y.S.2d 584 (1989). "Summary judgment disposition is inappropriate where varying inferences may be drawn, because in those cases it is for the factfinder to weigh the evidence and resolve any issues necessary to a final conclusion." *Dormitory Auth. v. Samson Constr. Co.*, 30 N.Y.3d 704, 70 N.Y.S.3d 893 (2018) (Rivera, J., dissenting) (citing *Kriz v. Schum*, 75 N.Y.2d 25, 550 N.Y.S.2d 584 [1989]). Further, "[t]he court may not weigh the credibility of the affiants on a motion for summary judgment unless it clearly appears that the issues are not genuine, but feigned." *Glick & Dolleck, Inc. v. Tri-Pac Export Corp.*, 22 N.Y.2d 439, 293 N.Y.S.2d 93 (1968). What's more, the "facts must be viewed in the light most favorable to the non-moving party." *Vega v. Restani Const. Corp.*, 18 N.Y.3d 499, 942 N.Y.S.2d 13 (2012) (internal quotation marks omitted). Thus, the drastic remedy of summary judgment may only be granted where, viewing the facts in the light most favorable to the non-movant, "the moving party . . . tender[ed] sufficient evidence to demonstrate the absence of any material issues of fact," and "the non-moving party . . . subsequently fail[ed] to establish the existence of material issues of fact which require a trial of the action." *Vega v Restani Const. Corp.*, 18 N.Y.3d 499, 942 N.Y.S.2d 13 (2012) (internal quotation marks and citations omitted).

"In moving for summary judgment dismissing a complaint alleging medical malpractice, a defendant must establish, prima facie, either that there was no departure or that any departure was not a proximate cause of the plaintiff's injuries." *Lesniak v. Stockholm Obstetrics & Gynecological Servs., P.C.*, 132 A.D.3d 959, 18 N.Y.S.3d 689 (2d Dept., 2015). "Establishing entitlement to summary judgment as a matter of law requires the defendant to rebut[ ] with factual proof plaintiff's claim of malpractice." *Pullman v. Silverman*, 28 N.Y.3d 1060, 43 N.Y.S.3d 793 (2016) (internal quotation marks omitted). "Once a defendant has made such a showing, the burden shifts to the plaintiff to submit evidentiary facts or materials to rebut the defendant's prima facie showing." *Pezulich v. Grecco*, 206 A.D.3d 827, 169 N.Y.S.3d 680 (2d Dept., 2022). Where the parties adduced conflicting medical expert opinions based on documentary, non-speculative evidence, summary judgment is inappropriate. *See Feinberg v. Feit*, 23 A.D.3d 517, 806 N.Y.S.2d 661 (2d Dept., 2005).

With respect to the cause of action premised on lack of informed consent, "a defendant can establish entitlement to summary judgment by demonstrating that the plaintiff signed a detailed consent form after being apprised of alternatives and foreseeable risks, by demonstrating that a reasonably prudent person in the plaintiff's position would not have declined to undergo the surgery, or by demonstrating that the actual procedure performed for which there was no informed consent was not a proximate cause of the injury." *Pirri-Logan v. Pearl*, 192 A.D.3d 1149, 145 N.Y.S.3d 545 (2d Dept., 2021). "The alleged qualitative insufficiency of the consent must be supported by expert medical testimony." *Johnson v. Jacobowitz*, 65 A.D.3d 610, 884 N.Y.S.2d 158 (2d Dept., 2009), *lv denied* 14 N.Y.3d 710, 903 N.Y.S.2d 768 (2010).

Discussion

Medical Malpractice Claim

Each group of defendants (by way of the respective affirmations of their defense experts) made a prima facie showing as to each of the *pre-* and *post-*stroke onset aspects of the patient's medical malpractice claim; in particular, that none of the individual defendants (and, vicariously, NYPH) deviated from the accepted standards of care, and that any alleged deviation was not a proximate cause of the patient's injuries.[45] *See Messeroux v. Maimonides Med. Ctr.*, 181 A.D.3d 583, 121 N.Y.S.3d 136 (2d Dept., 2020).

In opposition, none of the patient's experts addressed the specific opinions expressed by the defense experts as to the *pre-*stroke onset aspects of her medical malpractice claim. *See Townsend v. Vaisman*, 203 A.D.3d 1199, 166 N.Y.S.3d 221 (2d Dept., 2022). Thus, the *pre-*stroke onset aspects of the patient's medical malpractice claim as against the individual defendants (together with the corresponding portion of her vicarious liability claim as against NYPH) were subject to dismissal, as more fully set forth in the decretal paragraphs below. The remainder of this portion of the decision/order addresses the *post-*stroke onset aspects of plaintiff's medical malpractice claim as against each group of defendants.[46]

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[45] The Court, in reviewing the record, disregarded the supporting affirmations by defendant Dr. Wun and by the subsequently dismissed defendant Dr. Rubin (NYSCEF Doc. Nos. 88 and 89). Dr. Wun's and Dr. Rubin's respective affirmations were not in admissible form because, at the time of their execution, each affiant was a party defendant. *See* CPLR 2106 (a); *Household Fin. Realty Corp. of New York v. Della Cioppa*, 153 A.D.3d 908, 61 N.Y.S.3d 259 (2d Dept., 2017).

[46] The precise timing of the patient's stroke onset would be for the jury to determine because her pathophysiology – "[d]erangement of function seen in disease" – was changing moment by moment. *See* Stedman's Medical Dictionary, entry 662320 pathophysiology (online edition).

Vascular Surgery Defendants

The patient (by way of the affirmations of her experts) raised triable issues of fact on the departure and causation elements of the *post*-stroke onset aspects of her medical malpractice claim as against the vascular surgery defendants, insofar as such claim against those defendants was grounded on the alleged *stroke-diagnosis delay*. More particularly, it would be for the jury to determine whether each vascular surgery defendant allegedly failed to timely diagnose the patient's stroke in the 42-minute interval between its alleged onset at as early as 15:00 hours (if the chronology in Dr. Shah's note was credited) and the stroke-code call at as late as 15:42 hours (if the PACU's notes, rather than Dr. Shah's note, were credited in that regard). At the summary judgment stage of litigation, the Court was required to (and did) credit PACU attending Dr. Shen's deposition testimony that the vascular surgery defendants (together with the PACU defendants) remained responsible for the patient's well-being until stroke-team resident Dr. Shah's arrival at the patient's bedside.[47] Thus, during the 42-minute interval *from the stroke onset and until the stroke code was called and stroke-team resident Dr. Shah's arrival at the patient's bedside*, all vascular surgery defendants, including vascular surgery attending Dr. Wun,[48] remained responsible for the patient's post-operative condition. Viewing the evidence in a light most favorable to the patient as the non-movant, none of the vascular surgery defendants provided *any* medical care to the patient for the

[47] Dr. Shen's EBT tr at page 16, lines 5-12; page 19, lines 14-17; page 22, line 24 to page 23, line 2. *See also* Dr. Shen's EBT tr at page 64, line 6 to page 65, line 3; page 69, lines 15-23; page 91, lines 16-23; page 92, lines 8-17; page 93, lines 10-12; page 98, lines 3-9.

[48] Defense counsel's contention that Dr. Wun "did not undertake to monitor the patient in the PACU" was contradicted by Dr. Shen's deposition testimony that the vascular surgery defendants (including Dr. Wun) were responsible for the patient's well-being until the arrival of the stroke team.

entirety of the aforementioned 42-minute interval. More specifically: (1) vascular surgery attending Dr. Wun remained off-premises post-operatively, inclusive throughout the onset and subsequent diagnosis of his patient's stroke; (2) vascular surgery resident Dr. LeBrun (upon his arrival at the patient's bedside) left the PACU to search for (and to obtain advice from) his superior – vascular surgery fellow Dr. Baber; and (3) Dr. Baber (by his own admission) showed up at the patient's bedside only *after* one (or more) of the stroke-team defendants had already arrived (in response to the code call) at the patient's bedside. Dr. Baber's assistance with transporting the patient (initially to the radiology suite for a brain CT scan from the PACU, and subsequently to the neuro ICU) was not equivalent to the specialized medical care she required (but never received) from him as Dr. Wun's principal back-up during the latter's absence from NYPH. Dr. Wun's physical absence from NYPH could not excuse him, inasmuch as vascular surgery defendants Drs. LeBrun and Baber who, at his direction, were covering for him during his absence from NYPH rendered no post-operative follow-up to the patient.

On the other hand, the vascular surgery defendants established that, starting with stroke-team resident Dr. Shah's arrival at the patient's bedside in response to the code call, none of them owed the patient any duty (nor did they assume such duty) to treat her stroke by, among other modalities, normalizing her blood pressure, prescribing/administering procoagulants, or prescribing/administering platelets. "Although physicians owe a general duty of care to their patients, that duty may be limited to those medical functions undertaken by the physician and relied on by the patient." *Chulla v. DiStefano*, 242 A.D.2d 657, 662 N.Y.S.2d 570 (2d Dept., 1997), *lv. dismissed* 91 N.Y.2d 921, 669 N.Y.S.2d 263 (1998).

Further. "the question of whether a physician owes a duty to the plaintiff is a question for the court, and is not an appropriate subject for expert opinion." *Donnelly v. Parikh*, 150 A.D.3d 820, 55 N.Y.S.3d 274 (2d Dept., 2017) (brackets and internal quotation marks omitted).

Here, the vascular surgery defendants submitted evidence that they appropriately deferred to the stroke-team defendants for treatment of the patient's stroke upon stroke-team resident Dr. Shah's arrival at her bedside, and that they played no role in treating her stroke, which Dr. Baber knew was being treated by the stroke-team defendants.[49] In fact, it was stroke-team resident Dr. Shah who had the patient admitted to the neuro ICU; it was the team of stroke-team attendings Drs. Murthy, and Knopman who medically treated the patient for her stroke in the neuro ICU; and it was stroke-team attending Dr. Knopman who performed neurosurgery. In opposition, the patient submitted no evidence to demonstrate that the vascular surgery defendants had assumed the duty of care to *treat* her stroke following stroke-team resident Dr. Shah's arrival at her bedside in response to the stroke-code call. *See Boone v. North Shore Univ. Hosp.*, 12 A.D.3d 338, 784 N.Y.S.2d 151 (2d Dept., 2004); *Wasserman v. Staten Is. Radiological Assoc.*, 2 A.D.3d 713, 770 N.Y.S.2d 108 (2d Dept., 2003); *see also Reid v. Soults*, 138 A.D.3d 1087, 31 N.Y.S.3d 527 (2d Dept., 2016); *Rivera v. New York Presbyt. Hosp.*, 95 A.D.3d 861, 944 N.Y.S.2d 181 (2d Dept., 2012), *lv. denied* 19 N.Y.3d 816, 955 N.Y.S.2d 555 (2012). Further, it was improper for the patient's experts to lump the vascular surgery defendants with the stroke-team defendants (as well as with the PACU

[49] Treatment of a condition is not the same as its diagnosis and the ensuing code call for help. Whereas the vascular surgery defendants owed no duty to the patient to *treat* her stroke, they were required (but allegedly failed) to *diagnose* her stroke and to *call* the stroke code.

defendants) in an attempt to spread the blame to co-defendants for the latter's alleged delays in their post-stroke treatment of the patient.[50]

PACU Defendants

In addition, the patient (by way of the affirmations of her experts) raised triable issues of fact on the departure and causation elements of the *post*-stroke onset aspects of her medical malpractice claim as against PACU attending Dr. Shen (but not as against PACU resident Dr. Liu and PACU Nurse Moran), insofar as such claim against Dr. Shen was grounded on the alleged delays in his *stroke diagnosis, blood-pressure normalization, blood anticoagulation, and platelet aggregation*, for the period of 50 minutes counting from the time of his arrival at the patient's bedside in the PACU at 15:32 hours and until the end of his "critical care" for the patient at approximately 16:22 hours (according to his progress note).[51] For ease of analysis, Dr. Shen's 50-minute visit with the patient could be further separated into two intervals: (1) the initial ten-minute interval from 15:32 hours to 15:42 hours (the "*pre*-code call interval"); and (2) the immediately succeeding 40-minute interval from 15:42 hours to 16:22 hours (the "*post*-code call interval"). In the *pre*-code call interval, Dr. Shen allegedly delayed (by as long as ten minutes) whether to call the stroke code. It would be for the jury to determine (after considering the parties' competing expert testimony) whether Dr. Shen (in his capacity as the on-duty attending physician in charge of the patient

[50] *See* patient's expert vascular surgeon's affirmation, ¶¶ 20-21; patient's expert anesthesiologist's affirmation, ¶ 22; patient's expert neurosurgeon's affirmation, ¶¶ 20-21.

[51] Dr. Shen's EBT tr at page 68, line 19 to page 69, line 14.

in the PACU) negligently delayed (by as long as ten minutes) calling the stroke code and, if so, the adverse consequences (if any) of his alleged delay to the patient.

Equally important, Dr. Shen's decision to call the stroke code at 15:42 hours (according to the PACU notes) and stroke-team resident Dr. Shah's prompt arrival at the patient's bedside, did *not* relieve him (Dr. Shen) of responsibility of continuing to treat his critically ill patient for the next 40 minutes between 15:42 hours and 16:22 hours, irrespective of the patient's interim admission to the neuro ICU at 16:00 hours. As he conceded in his deposition testimony, Dr. Shen spent the entirety of the *post*-code call interval of between 15:42 hours to 16:22 hours to "basically hel[p] sort of monitor the patient's vital signs, making sure there [were] no changes there, making sure the neurologic exam was about the same"; and to "mak[e] sure that the teams were coming to take her to the [CT] scan," although, in the latter instance, he conceded that he did not order the CT scan for the patient, did not accompany her to the CT scan, and did not review her CT scan films.[52] As he further admitted in his deposition testimony, Dr. Shen, during the *post*-code call interval, was polishing the contents of his progress note. In his own words, "[Dr. Shen] was sort of reviewing the events as they occurred, documenting," and "just talking to the bedside nurse [*i.e.*, PACU Nurse Moran], making sure that what [he] recalled was what she recalled in the documenting."[53] Stated otherwise, Dr. Shen did nothing to help his critically ill patient at any time during the remaining 40 minutes of his visit following his initiation of the stroke code ten minutes after his bedside arrival. More specifically, Dr. Shen (while indicating in his

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[52] Dr. Shen's EBT tr at page 70, lines 16-25.

[53] Dr. Shen's EBT tr at page 71, lines 10-19.

progress note that the patient's systolic blood pressure was elevated in the 160s) failed to order an antihypertensive at any time during the *post*-code interval.[54] In fact, the patient's systolic blood pressure, as measured at 16:00 hours, remained severely hypertensive at 207/101.[55] Furthermore, Dr. Shen allegedly failed for the entire duration of the *post*-code call interval: (1) to check on the patient's anticoagulation (or INR) blood values by ordering a lab panel (in fact, his custom and practice under comparable circumstances was *not* to consider a patient's anticoagulation blood values);[56] and (2) to order Protamine and platelets to reverse the anticoagulation and antiplatelet effects of Heparin and Plavix, respectively.[57]

With respect to PACU resident Dr. Liu, it is well established that "[a] resident . . . who is supervised by a[n] [attending] doctor during a medical procedure [or, as is the case here, a patient examination], and who does not exercise any independent medical judgment, cannot be held liable for medical malpractice unless the resident . . . knows that the supervising doctor's orders are so clearly contraindicated by normal practice that ordinary prudence requires inquiry into the correctness of the orders, or the resident . . . commits an independent act that constitutes a departure from accepted medical practice." *Poter v. Adams*, 104 A.D.3d

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[54] Dr. Shen's EBT tr at page 93, line 3 to page 95, line 3.

[55] Dr. Shen, at his deposition, advanced two reasons – both unpersuasive in the patient's experts' opinions – why the patient's systolic blood pressure did not need to be lowered despite her ongoing hemorrhagic stroke. First, inasmuch as the patient's pre-stroke (or base) systolic blood pressure was "around 160 to 170," her systolic hypertension, being typical for her, required no treatment even during the ongoing stroke. Second, according to Dr. Shen, a reduction in the patient's systolic blood as a general matter (that is, without specifying the pace with which systolic blood pressure was lowered) could worsen her stroke, even though he conceded, likewise as a general matter, that "allowing the blood pressure to be extremely high can lead to deteriorating outcomes." Dr. Shen's EBT tr at page 89, line 4 to page 90, line 11.

[56] Dr. Shen's EBT tr at page 90, lines 12-25; page 96, lines 3-11.

[57] Dr. Shen's EBT tr at page 97, line 18 to page 98, line 9.

925, 961 N.Y.S.2d 556 (2d Dept., 2013). Here, the PACU defendants made a prima facie showing (as corroborated by Dr. Liu's affidavit[58]) that Dr. Liu was a resident under the supervision of PACU attending Dr. Shen at the relevant time, and that Dr. Shen did not so greatly deviate from normal practice that Dr. Liu should be liable for failing to intervene. *See Quille v. New York City Health & Hosp. Corp.*, 152 AD3d 808, 59 N.Y.S.3d 131 (2d Dept., 2017). In opposition, the patient failed to raise a triable issue of fact as to Dr. Liu.

Next, the PACU defendants sustained their burden of making a prima facie showing of PACU Nurse Moran's entitlement to judgment as a matter of law, by submitting her deposition testimony, NYPH's records, and the affirmation of the defense expert anesthesiologist, establishing that at all times PACU Nurse Moran acted under the direction and supervision of the PACU physicians, and that she lacked the authority to call the stroke code (as opposed to performing a ministerial function of telephoning the unit clerk to activate the previously called, or announced, stroke code). *See France v. Packy*, 121 A.D.3d 836, 994 N.Y.S.2d 364 (2d Dept., 2014). In opposition, the patient failed to raise a triable issue of fact as to PACU Nurse Moran. As the Court noted in the analogous context of the vascular surgery defendants, it was improper for the patient's experts to lump PACU Nurse Moran (as well as PACU resident Dr. Liu) with PACU attending Dr. Shen so as to spread the blame to

[58] *See* Dr. Liu's affidavit, sworn to on March 8, 2022 (NYSCEF Doc. No. 90). Dr. Liu was not deposed in this action.

PACU Nurse Moran (as well as to Dr. Liu) for his (Dr. Shen's) alleged delay in deciding whether to call the code.[59]

Stroke-Team Defendants

Finally, the patient (by way of the affirmations of her experts) raised triable issues of fact on the *departure* element of the *post*-stroke onset aspects of her medical malpractice claim as against stroke-team *attendings* Drs. Murthy and Knopman) (but not as against stroke-team *resident* Dr. Shah), insofar as such claim was asserted against:

(1) *stroke-team attendings Drs. Murthy and Knopman* but only to the extent that such claim was grounded on their alleged delays in *blood-pressure normalization, blood anticoagulation, and platelet aggregation*, for the period starting at approximately 16:00 hours when the patient was admitted to the neuro ICU and ending at 18:37 hours when the patient's neurosurgery (by way of anesthesia administration) was commenced (the "post-neuro ICU/pre-hemicraniectomy period"); and, separately and in addition:

(2) *stroke-team attending Dr. Knopman* but only to the extent that such claim against him was further grounded on his alleged delay in performing the patient's *neurosurgery* until after the conclusion of the post-neuro ICU/pre-hemicraniectomy period.

With respect to the *causation* element of the *post*-stroke onset aspects of the patient's medical malpractice claim as against stroke-team *attendings* Drs. Murthy and Knopman (but not as against stroke-team *resident* Dr. Shah), the competing expert affirmations raised triable

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[59] *See* patient's expert anesthesiologist's affirmation, ¶¶ 19-21; patient's expert vascular surgeon's affirmation, ¶ 19; patient's expert neurosurgeon's affirmation, ¶¶ 18-19.

issues of fact as to: (1) whether the patient suffered at least some injury during the post-neuro ICU/pre-hemicraniectomy period due to the delay in receiving the appropriate and timely medico-surgical treatment from the stroke-team attendings; and (2) whether the patient's stroke progressed and her condition worsened, in each instance, during the post-neuro ICU/pre-hemicraniectomy period, as the result. *See Wexelbaum v. Jean*, 80 A.D.3d 756, 915 N.Y.S.2d 161 (2d Dept., 2011); *Videnovic v. Goodman*, 54 A.D.3d 937, 864 N.Y.S.2d 496 (2d Dept., 2008); *see also Anthony v. Freedman*, 207 A.D.3d 509, 169 N.Y.S.3d 820 (2d Dept., 2022).[60]

On the other hand, the stroke-team defendants established prima facie that *stroke-team resident Dr. Shah* complied with the accepted standards of care and caused no injury to the patient. As stated, Dr. Shah, upon his prompt arrival to the PACU in response to the stroke code: (1) immediately had the patient undergo a brain CT scan; (2) immediately interpreted her CT scan films; and (3) promptly transferred her to the neuro ICU where stroke-team attendings Drs. Murthy and Knopman took over her care. In opposition, the patient failed to raise a triable issue of fact as to Dr. Shah.

Informed Consent Claim

In support of this branch of defendants' motion, Dr. Wun demonstrated, through the defense expert vascular surgeon's affirmation (in ¶¶ 15 and 26 thereof), that a reasonably prudent person in the patient's position would not have declined to undergo the endoscopic

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[60] *See also Leberman v. Glick*, 207 A.D.3d 1203, 171 N.Y.S.3d 677 (4th Dept., 2022); *Sisko v. New York Hosp.*, 231 AD2d 420, 647 N.Y.S.2d 191 (1st Dept., 1996), *lv dismissed* 89 N.Y.2d 982, 656 N.Y.S.2d 740 (1997).

procedure if made aware of "[s]troke/hemorrhage in the brain" which "are rare but known and recognized risks associated with this procedure," and that any lack of informed consent did not proximately cause any injury. *See Pirri-Logan*, 192 A.D.3d 1149, 145 N.Y.S.3d 545; *Johnson v Staten Is. Med. Group*, 82 AD3d 708, 918 N.Y.S.2d 132 (2d Dept., 2011).

In opposition to Dr. Wun's prima facie showing of entitlement to summary judgment on her informed consent claim, the patient failed to demonstrate (by way of expert opinion) that a reasonable person in her position would have opted against the endoscopic procedure had she been fully informed of the risks of bleeding and hemorrhagic stroke.[61] *See Tibodeau v. Keeley*, 208 A.D.2d 610, 617 N.Y.S.2d 183 (2d Dept., 1994), *lv denied* 85 N.Y.2d 802, 624 N.Y.S.2d 372 (1995).

Any arguments not specifically addressed herein were considered and were rejected as without merit, or as academic in light of the Court's determination.

Conclusion

Accordingly, it is

ORDERED that defendants' motion for summary judgment (motion sequence number 4) is *granted to the extent* that: (1) all *pre*-stroke onset aspects of the patient's medical malpractice claim are dismissed as against all defendants; (2) certain of the *post*-stroke onset aspects of her medical malpractice claim are dismissed against all defendants, *with the exceptions stated below*; and (3) the entirety of her informed consent claim is dismissed as

[61] The patient's expert vascular surgeon's attestations (in ¶ 23 of his/her affirmation) were insufficient to raise a triable issue of fact as to whether an informed, reasonably prudent person would not have consented to the endoscopic procedure, as was performed by Dr. Wun on the patient.

against all defendants; and the remainder of their motion, *insofar as limited by the exceptions stated below, is denied*; and it is further

ORDERED that, notwithstanding the preceding decretal paragraph, the following *post*-stroke onset aspects of the patient's medical malpractice claim shall survive and continue as against:

(1) each vascular surgery defendant (*i.e.*, Drs. Wun, LeBrun, and Baber) insofar as such claim is predicated on such defendant's alleged *stroke-diagnosis delay* as described in this decision/order;

(2) PACU attending Dr. Shen for: (a) his alleged *stroke-diagnosis delay* during the *pre*-code call interval on September 18, 2018, as described in this decision/order; and (b) his alleged *delays in the blood-pressure normalization, blood anticoagulation, and platelet aggregation*, in each instance, during the *post*-code call interval on September 18, 2018, as described in this decision/order;

(3) stroke-team attendings Drs. Murthy and Knopman for their respective alleged *delays in the blood-pressure normalization, blood anticoagulation, and platelet aggregation* during the post-neuro ICU/pre-hemicraniectomy period as described in this decision/order, and, separately, Dr. Knopman for his alleged *delay in the performance of the patient's neurosurgery* until after the conclusion of the post-neuro ICU/pre-hemicraniectomy period as described in this decision/order; and

(4) NYPH vicariously and to the extent of the surviving and continued *post*-stroke onset aspects of the patient's medical malpractice claim as listed in subparagraphs (1) through (3) above; and it is further

ORDERED that defendants Bhavah Shah, M.D., Siyao Liu, M.D. (sued in her own name as well as "Doe Cherry, M.D."), and Caitlin Moran, R.N., are each dismissed from this action, and the action is severed and continued against the remaining defendants, with the amended caption to read as follows:

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ESTELLE MILLER,
Plaintiff,

-against- Index No. 524330/19

HERRICK WUN, M.D.,
THE NEW YORK AND PRESBYTERIAN HOSPITAL,
JOHN BABER, M.D.,
LIANG SHEN, M.D.,
DRAKE LEBRUN, M.D.,
SANTOSH MURTHY, M.D.,
and JARED KNOPMAN, M.D.,
Defendants.
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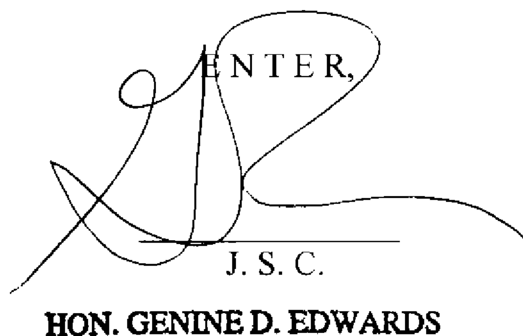
; and it is further

ORDERED that plaintiff's counsel is directed to electronically serve a copy of this decision/order with notice of entry on defense counsel and to electronically file an affidavit of service thereof with the Kings County Clerk; and it is further

ORDERED that the parties are reminded of their next appearance for an Alternate Dispute Resolution conference on April 5, 2023, at 11:30 a.m.

This constitutes the decision/order of this Court.

ENTER,



J. S. C.

HON. GENINE D. EDWARDS