Alessi v Diuguid
2023 NY Slip Op 33211(U)
September 14, 2023
Supreme Court, New York County
Docket Number: Index No. 805196/2018
Judge: John J. Kelley
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SUPREME COURT OF THE STATE OF NEW YORK
NEW YORK COUNTY

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

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NICOLETTE ALESSI, as Administrator of the Estate of LIBORIO ALESSI, JR., deceased,

Plaintiff,

- v -

DAVID DIUGUID, M.D., ENRICA MARCHI, M.D., FARHANA LATIF, M.D., and NEW YORK PRESBYTERIAN HOSPITAL/ COLUMBIA UNIVERSITY MEDICAL CENTER,

Defendants.

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INDEX NO. 805196/2018

MOTION DATE 05/05/2023

MOTION SEQ. NO. 004

DECISION + ORDER ON MOTION

The following e-filed documents, listed by NYSCEF document number (Motion 004) 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121

were read on this motion to/for SUMMARY JUDGMENT (AFTER JOINDER).

I. INTRODUCTION

In this action to recover damages for medical malpractice based on alleged departures from good and accepted practice, and for negligent hiring and supervision, the defendants David Diuguid, M.D., Enrica Marchi, M.D, and New York Presbyterian Hospital/Columbia University Medical Center (NYPH) (collectively the NYPH defendants) move pursuant to CPLR 3212 for summary judgment dismissing the complaint insofar as asserted against them. The plaintiff opposes the motion. The motion is granted to the extent that the NYPH defendants are awarded summary judgment dismissing the complaint insofar as asserted against Marchi, dismissing the negligent hiring and supervision causes of action insofar as asserted against all of them, and dismissing so much of the medical malpractice cause of action insofar as asserted against Diuguid and NYPH as was premised upon allegations that they failed timely to diagnose or treat polycythemia, failed to perform necessary diagnostic testing, and failed to perform

phlebotomies. The motion is otherwise denied, however, since there are triable issues of fact as to whether the NYPH defendants departed from good and accepted practice

(a) by failing fully to appreciate the significance of splenic and renal infarcts depicted on diagnostic imaging scans taken of the plaintiff's decedent at another hospital two days prior to his admission to NYPH,

(b) by failing fully to account for the decedent's increased risk of further blood clotting in light of his diagnosed conditions of polycythemia and coronary artery disease,

(c) by failing to work up the decedent with respect to this risk,

(d) by failing to prescribe an anticoagulant drug to replace the maintenance dosage of the anti-platelet drug Plavix that the decedent was taking when he was admitted to NYPH, and

(e) by failing to prescribe a maintenance regimen of anticoagulants to the decedent upon his discharge from NYPH.

There also are triable issues of fact as to whether these alleged departures caused the decedent to suffer from a stroke slightly more than three weeks after he was discharged from NYPH.

II. FACTUAL BACKGROUND

The crux of the plaintiff's claim is that hematologists/oncologists Diuguid and Marchi, while working for NYPH, departed from good and accepted practice in evaluating her decedent, Liborio Alessi, Jr., in connection with his diagnosed conditions of polycythemia and coronary artery disease, as well as in evaluating the increased risk of blood clotting arising from those conditions, and that all of the NYPH defendants negligently discharged her decedent from NYPH without prescribing a course of anticoagulants, despite his recent history of renal and splenic infarcts.

In 1997, the decedent underwent a heart transplant and, in 2004, was hospitalized for rejection of the transplant, but was thereafter stabilized. On February 21, 2012, the decedent, who by then was 43 years old, presented to cardiologist Maryjane Farr, M.D., at Columbia University's Heart Transplant Program, with a history of obesity, insulin-dependent diabetes, hypertension, chronic kidney disease, chronic depression, and obstructive sleep apnea. Dr.

Farr advised the decedent to undergo full annual examinations, including angiograms. Between May 15, 2012 and May 31, 2016, the decedent's hematocrit levels remained elevated, with readings fluctuating between 47.1% and 58.4% above the applicable reference range, while, between August 12, 2014 and May 31, 2016, his hemoglobin levels also were elevated, with readings approximately 15% above the applicable reference range.

From July 29, 2016 through August 1, 2016, the decedent was hospitalized at John T. Mather Memorial Hospital in Port Jefferson, New York (Mather), after he complained of left mid-abdominal pain. A computed tomography (CT) scan taken at Mather revealed hypoattenuation at the spleen that was concerning for either a splenic laceration, splenic infarct, or splenic emboli. Blood testing revealed that the decedent's hematocrit and hemoglobin levels were elevated, and, after a hematology/oncology consultation, the decedent was assessed as having polycythemia, also known as erythrocytosis, a general term for all conditions that result in an increase in the absolute red blood cell mass in a patient's body. Mather's hematology/oncology staff initially could not determine whether the decedent's polycythemia was primary and, thus, a myeloprolifterative blood cancer disorder, or secondary and, thus, the result of the excess production of the hormone erythropoietin (EPO), which stimulates blood production.

A July 30, 2016 transthoracic echocardiogram performed at Mather did not reveal any signs of endocarditis. A July 31, 2016 EPO blood test revealed levels within the established reference range. An August 1, 2016 abdominal magnetic resonance imaging (MRI) scan, however, revealed evolving splenic lesions and chronic renal lesions that the hospital's staff concluded were suggestive of multifocal infarcts due to their shape and location, although no major vascular thrombosis or stenosis was identified. An August 5, 2016 laboratory test on blood drawn prior to the decedent's discharge from Mather revealed the absence of a JAK2 V617F genetic mutation, which correlates with the development of myeloproliferative cancer. During his admission to Mather, the decedent was given the empiric antibiotics Ceftriaxone and Vancomycin to treat any bacterial infections, although none was identified as being present.

On August 1, 2016 at 9:20 p.m., the decedent requested to be discharged from Mather against medical advice. Mather's staff concluded that he should remain in the hospital because, at that time, he was still being worked up to determine the source of his abdominal pain, while the MRI scan had reflected the likelihood of multiple blockages in his spleen and kidneys. He was informed that leaving the hospital came with a risk of developing a severe infection, thrombosis, organ failure, or death. Medical staff at Mather also advised the decedent that he required further evaluation at NYPH in light of his history as a transplant patient.

On August 2, 2016, at 8:55 p.m., the plaintiff's decedent did, in fact, present to NYPH, at which time he was afebrile, with a heart rate of 96 beats per minute, an oxygen saturation rate of 99%, a slightly elevated respiratory rate of 20 breaths per minute, and a blood pressure reading of 164/89. Osman Sayman, M.D., who was the attending physician at the NYPH emergency room, examined the decedent and took his medical history. At that point, the decedent asserted that his abdominal pain had resolved. On August 3, 2016, at 1:07 a.m., the decedent was admitted to NYPH for evaluation. A chest X-ray taken shortly thereafter revealed no changes from the results of a May 31, 2016 image, while both hematocrit, hemoglobin, potassium, and creatinine levels in the decedent's blood were elevated, the latter suggesting acute kidney injury. An electrocardiogram undertaken later that morning revealed a sinus rhythm and a heart rate of 88 beats per minute, albeit with a 1st-degree atrioventricular block, that is, an abnormally slow conduction through the atrioventricular node. During a cardiology consultation later that afternoon with Marlena Habal, M.D., the decedent informed her that he was then currently being treated for coronary artery disease with Plavix, a blood thinner, antithrombotic, and anti-platelet drug. Dr. Habal noted that the decedent was asymptomatic at the time of her examination, and formulated a plan to obtain the test results from Mather, perform a transesophageal echocardiogram to rule out infectious endocarditis, obtain blood cultures, and arrange for a hematology consultation to address what appeared to her to be a long-term condition of polycythemia. Dr Habal's plan also included the decedent's continuation

of his at-home regimen of immunosuppressant drug therapy, and to measure his blood levels of the immunosuppressant cyclosporine.

During the early evening of August 3, 2016, the defendant Marchi, an NYPH hematology/oncology fellow, first examined the decedent. She took the decedent’s history, which included the heart transplant, obesity, a March 2014 gastric sleeve procedure to address the obesity, hypertension, diabetes, sleep apnea, chronic kidney disease, and coronary artery/carotid artery disease, as well as his recent complaints of abdominal pain. She reviewed the results of the MRI taken at Mather, which reported the presence of multi-focal wedge-shaped and “geographical”-shaped lesions in the periphery of the spleen, likely reflecting “evolving” infarcts, with a high T-1 signal, reflecting bleeding. That MRI report also noted the presence multi-focal areas of cortical infarcts of the kidneys, suggesting chronic etiology, but no evidence of any large vascular abdominal infarct. Additional laboratory studies that Marchi ordered revealed a continued elevation of the decedent’s hematocrit and hemoglobin levels, but reflected a normal red blood cell morphology and a normal white blood cell and platelet count, as well as prothrombin, activated partial thromboplastin, and blood clotting times that were within applicable reference ranges. Her physical examination of the decedent indicated that he had no swelling of the liver or spleen. Marchi ordered a further hematology consultation and recommended further evaluation and management of polycythemia. Her plan included a workup to determine whether the decedent’s polycythemia was primary (cancer-related) or secondary (likely EPO-related), which included testing for EPO blood levels.

That same day, the defendant Diuguid, an NYPH hematologist/oncologist, also examined the decedent, and made findings that were virtually identical to those reported by Marchi. He reported his impression as erythrocitosis (polycythemia) of unclear etiology, but suspected that the decedent’s polycythemia was secondary, that is, related to EPO.

On August 4, 2016, NYPH cardiologist Jennifer Haythe, M.D., reported that cardiology testing revealed normal left ventricular function, and that the left atrial appendage was closed.

Her plan was for further hematology and infectious disease consultations, further blood and urine cultures, and possible discharge of the decedent from NYPH. Later that same day, NYPH infectious disease specialist Brian Scully, M.D., consulted with the decedent. Dr. Scully reported that the decedent did not complain of any continuing pain during his examination, and that, although the decedent had polycythemia, there was no evidence of endocarditis or septic emboli. Dr. Scully confirmed that the blood samples drawn at Mather were negative for infection. On August 5, 2016, Dr. Haythe confirmed Dr. Scully's impressions, and reported that the transesophageal electrocardiogram was negative, concluding that the discharge of the decedent likely was warranted. Later that day, Marchi authored a follow-up note that the decedent's EPO blood levels were at the very low end of the applicable reference range, that, accordingly, the result was "not compatible with a diagnosis of secondary polycythemia," and that the decedent could be discharged from a hematological perspective, with a follow-up appointment with Diuguid at the hematology outpatient clinic. A few hours later, Diuguid appended an addendum to the decedent's chart, in which he concurred with Marchi's assessments and recommendations. Additional blood samples were drawn from the decedent that day as well for the purpose of testing it for the presence of the JAK2 V617F genetic mutation that is correlated with myeloproliferative blood cancers, as well as other mutations that also are correlated with such cancers. NYPH discharged the decedent on the afternoon of August 5, 2016, with instructions to follow up with appointments with Diuguid, an NYPH cardiologist, and an NYPH endocrinologist.

Between August 14, 2016 and August 19, 2016, results from the blood samples drawn from the decedent were reported, revealing the absence of the myeloproliferative JAK2 V617F, calreticulin, and MPL Codon 515 mutations from the decedent's blood. On August 25, 2016, the decedent made an appointment for a follow-up visit with Diuguid for August 29, 2016.

On August 29, 2016, however, the decedent was found unresponsive at his home, and was taken to Peconic Bay Medical Center in Riverhead, New York, where an MRI of his brain

revealed an area of diffusion restriction in the basal ganglia consistent with an acute infarct, with no gross hemorrhaging. The decedent was transferred to Stony Brook University Hospital in Stony Brook New York (Stony Brook), where a CT scan confirmed the presence of a hemorrhagic infarct involving the left basal ganglia, with associated mass effect or midline shift. A CT angiogram of the decedent's head performed the same day revealed a perfusion deficit in the left anterior lateral infrafrontal lobe, involving the occluded left M2 segment branch, with decreased blood flow, and increased mean blood transit time, albeit with overall preservation of blood volume, and additional perfusion abnormality adjacent to the region of hemorrhage, with mass effect. An additional head CT scan was performed at Stony Brook on August 30, 2016 that revealed an interval increase in the hemorrhage associated with the left cerebral artery territory infarction, with dissection hemorrhage into the left lateral ventricle and third ventricle.

Later on August 30, 2016, Stony Brook hematologists were consulted to manage the decedent's polycythemia, and the results of blood tests from August 29, 2016 indicated that the decedent's hematocrit and hemoglobin levels remained elevated. They formulated a plan for additional testing of EPO and JAK2 V617F levels and for the administration of phlebotomies, that is, the withdrawal of blood, to control red blood cell counts. They first performed a phlebotomy on August 31, 2016 and, on September 2, 2016, the decedent's hematocrit and hemoglobin fell to within the applicable reference ranges. That same date, the decedent underwent a left decompressive hemicraniectomy to relieve the pressure from the hemorrhaging in his brain. On September 8, 2016, Stony Brook reported that the decedent's EPO levels were within the applicable reference range, and that the decedent was negative for JAK2 V617F. A Stony Brook hematology fellow reported that it was unlikely that the decedent had primary polycythemia, but noted that a minuscule percentage of patients can harbor myeloproliferative mutations that do not show up on testing. The fellow further noted that the decedent's high hemoglobin levels could have been due to secondary polycythemia caused by obstructive sleep apnea, but that his EPO levels were too low to support or confirm a diagnosis of secondary

polycythemia. An attending hematologist thereafter nonetheless reported that the decedent likely had secondary polycythemia due to obstructive sleep apnea, and that the administration of any further phlebotomy "is not indicated for hemoglobin of less than 60%," a classification applicable to the decedent.

On September 27, 2016, the decedent was discharged from Stony Brook to a rehabilitation program. On April 18, 2017, the Supreme Court, Suffolk County, appointed Diana Ruvolo as the guardian of the decedent's person and property. On June 15, 2018, Ruvolo commenced the instant action on the decedent's behalf. On April 17, 2020, the decedent died. In an order dated April 15, 2021 (MOT SEQ 002), this court substituted Nicolette Alessi, as the administrator of the decedent's estate, as the plaintiff in this action.

III. THE PLAINTIFF'S CONTENTIONS

The complaint alleged that, while the decedent was an inpatient at NYPH, the NYPH defendants were negligent in neglecting to use reasonable care in the services that they rendered to him. The complaint also alleged that the NYPH defendants departed from good and accepted practice in failing to heed the decedent's complaints, failing promptly and properly to diagnose his condition and symptoms, and failing properly to investigate the cause of his polycythemia. The complaint further asserted that the NYPH defendants were negligent in failing to perform a proper workup of the decedent's symptoms, failing properly to monitor his condition, and failing to appreciate the significance of his medical history. The complaint also faulted the NYPH defendants for failing to perform the proper tests and procedures, including appropriate blood work and radiologic studies. In addition, the complaint alleged that the NYPH defendants failed to administer anticoagulants prior to and upon the decedent's discharge from NYPH, and failed timely to administer other medications, thus exacerbating the decedent's condition. Moreover, the complaint asserted that the NYPH defendants negligently monitored the decedent subsequent to his spleen infarction. As set forth in the complaint, the NYPH defendants allegedly discharged the decedent from NYPH prior to stabilizing him, thus causing

him to sustain a stroke and seizures. The complaint further averred that the NYPH defendants negligently failed to recommend or perform a phlebotomy, and instead performed contraindicated procedures.

The complaint further alleged that NYPH was vicariously liable for the negligence of Diuguid and Marchi, and that it was responsible for negligently hiring, supervising, and training its medical and health-care personnel by, among other things, compelling them to work an excessive number of hours without break.

The complaint additionally contained allegations that these departures from good and accepted practice, and the failure properly to hire, supervise, and train medical personnel, caused the decedent to suffer a stroke several weeks after he was discharged from NYPH, and deprived him of a better chance for recovery after he sustained the stroke.

The bills of particulars reiterated the allegations of negligence as set forth in the complaint virtually verbatim. In a supplemental bill of particulars, the plaintiff alleged that the NYPH defendants' negligence caused or contributed to the decedent's stroke and all of the sequellae described above, including the hemicraniectomy, the limitation of use of the decedent's arm, and the need for rehabilitation services.

IV. THE SUMMARY JUDGMENT MOTION

In support of their motion, the NYPH defendants submitted the pleadings, the bills of particulars, the transcripts of the parties' depositions, relevant medical and hospital records, the note of issue, the decedent's death certificate, an attorney's affirmation, and the expert affirmations of hematologist/oncologist David L. Green, M.D., and neurologist/neurosurgeon Stanley Tuhrim, M.D. The NYPH defendants argued, among other things, that Marchi could not be held liable to the plaintiff because she was merely a fellow who acted solely under Diuguid's supervision, and exercised no independent judgment.

Dr. Green provided a detailed summary of the decedent's treatment at Mather, NYPH, and Stony Brook. He opined that none of the NYPH defendants departed from good and

accepted medical practice in their examinations, diagnoses, and treatment of the decedent, or in their formulation of medical plans for the decedent. Dr. Green further opined that none of the acts or omissions of the NYPH defendants caused or contributed to the decedent's stroke or any exacerbation of his polycythemia.

In his affirmation, Dr. Green asserted that the decedent was properly admitted to NYPH as a cardiac transplant patient, and appropriately administered an electrocardiogram, transesophageal echocardiogram, and chest X-ray. He asserted that NYPH properly arranged for consultations with a cardiologist, with an infectious disease specialist to rule out infectious endocarditis, and with hematologists/oncologists due to laboratory results indicating polycythemia. Dr. Green interpreted the relevant medical records as indicating that there was nothing of concern that was revealed by the cardiology or infectious disease workups. He also noted that, during Marchi's treatment of the decedent, she was always working under the direct control of Diuguid.

As Dr. Green explained it, primary, or cancer-related, polycythemia is treated with frequent blood withdrawals, known as phlebotomies, or with drugs such as hydroxyurea, while secondary, or EPO-related, polycythemia focuses upon treating the underlying condition causing the polycythemia, and does not involve phlebotomies. According to Dr. Green, Marchi obtained a full and proper medical history of the decedent, including his history of obstructive sleep apnea, and properly noted that the decedent's spleen and kidneys evinced no adenopathy or swelling and that the decedent was afebrile. He explained that Marchi appropriately suspected that the decedent was suffering from secondary polycythemia and, thus, properly ordered EPO testing to assess whether that was the correct diagnosis, inasmuch as a high EPO level, together with high hematocrit and hemoglobin levels, might confirm that diagnosis. When the EPO levels were found to be within the reference range, it was appropriate, according to Dr. Green, for Marchi to order genetic mutation testing to determine whether the decedent was at high risk for primary polycythemia. Dr. Green concluded that this test was timely ordered and

performed, and noted that, in any event, the decedent already had undergone almost identical testing at Mather only a few days earlier. Since the new and more extensive mutation testing was anticipated to take several weeks to complete, and because he characterized polycythemia as a chronic condition that is generally managed on an outpatient basis, Dr. Green asserted that, from a hematological perspective, there was no reason for the decedent's continued hospitalization, notwithstanding the splenic and renal infarcts that the decedent had sustained. Hence, he opined that the decedent's discharge from NYPH on August 5, 2016 was well within the applicable standard of care, and did not deviate from good and accepted practice. Moreover, Dr. Green noted that blood-clot testing yielded normal results and that the decedent was being medically managed with the antithrombotic and anti-platelet drug Plavix. Consequently, he concluded that the decedent was not at risk for excessive or dangerous clotting upon his discharge from NYPH.

As Dr. Green further explained it, when the mutation testing came back negative, and the decedent, on August 25, 2016, thereupon scheduled a follow-up appointment with Diuguid for August 29, 2016 to discuss the results, any particular treatment for polycythemia would not have commenced immediately in any event. Rather, according to Dr. Green, a diagnosis of secondary polycythemia would have been presumed, "management would have been focused upon treatment of the patient's underlying conditions of obesity and sleep apnea," and Diuguid would not have been involved in the management of the patient at that point, but "would have referred him to primary care to formulate a plan of management." As Dr. Green characterized it, "management of obesity and sleep apnea does not come with an overnight solution." He concluded that, as such, "even if the patient had seen Dr. DIUGUID before August 29th, this would not have resulted in any treatment which would have prevented the stroke he ultimately suffered on August 29th."

Dr. Green continued that, although the decedent was treated with phlebotomies at Stony Brook *after* he suffered the stroke, this treatment was within the "judgment of the practitioners

given the events which had occurred," despite the fact that the mutation testing results had yet to be reported so as to rule in or out primary polycythemia. In this regard, he noted that a hematologist at Stony Brook thereafter concluded that the decedent had secondary polycythemia, and that phlebotomies should not be performed where a patient, like the decedent, had a hemoglobin level of less than 60%. In other words, Dr. Green concluded that, prior to his stroke, phlebotomy was not an appropriate treatment for the decedent. Dr. Green further explained that, although the decedent's hematocrit and hemoglobin levels dropped dramatically after only one phlebotomy, rather than after multiple phlebotomies, as would be the treatment appropriate for primary polycythemia, such a consequence was further evidence that the decedent suffered from secondary polycythemia.

In his affirmation, Dr. Tuhrim opined that the decedent's stroke was not caused by polycythemia. In this regard, he asserted that he did not find any indication that the decedent's stroke could have been predicted or prevented during his stay as an inpatient at NYPH between August 2, 2016 and August 5, 2016. Dr. Tuhrim explained that the decedent's post-stroke brain-imaging studies from Stony Brook were not consistent with the pattern typically seen in a stroke caused by polycythemia. As he described it, in a stroke caused by polycythemia, multiple small strokes in multiple arterial territories would be observed, while, in the decedent's case, imaging revealed that he sustained one stroke referable to a "demonstrable arterial occlusion." Hence, Dr. Tuhrim asserted that the decedent's stroke was caused by an embolic event, rather than by polycythemia. Dr. Tuhrim further opined that

> "I also found no indication to place the patient on anticoagulation at NYPH from August 2-5, 2016. Generally, polycythemia is not treated with anticoagulation. Further, the patient was taking an anti-thrombotic, Plavix. The Plavix was appropriate medication already being administered for purposes of preventing stroke and cardiac ischemia in this patient."

In opposition to the motion, the plaintiff relied on the same documentation that had been submitted by the NYPH defendants, and also submitted an attorney's affirmation, a

memorandum of law, and the expert affidavit of a hematologist/oncologist who had treated numerous patients with polycythemia.

In the affidavit, the expert opined that the NYPH defendants deviated from good and accepted medical practice in failing to appreciate the decedent's medical history, specifically the findings on the Mather abdominal MRI scan of July 31, 2016, which depicted splenic and renal infarcts and "abnormal blood clots." The plaintiff's expert asserted that the NYPH defendants also failed "to appreciate the relationship between its own diagnosis of polycythemia and the increased risk of clots in patients with this condition," and that they failed to "evaluate and treat the plaintiff for the thromboembolisms that they were admittedly charged to do." The expert further opined that the NYPH defendants, when presented with those findings, departed from good and accepted practice by failing to administer the decedent an anticoagulant such as heparin while he was in the hospital, and placing or maintaining him on a regimen of such a drug upon his discharge. The expert asserted that, although the decedent was being managed with Plavix when he presented to NYPH, his recent development of infarcts and clots meant that "clearly the Plavix was not effective, and the patient now required a different medication, an anticoagulant, to stop the formation of clots." The expert concluded that these failures and departures resulted in the stroke that the decedent sustained on August 29, 2016.

The plaintiff's expert asserted that the affirmations submitted by Drs. Green and Tuhrim did "not address the medical issues and concerns in this case." As the expert characterized it,

> "[t]he affirmations by the defense experts are primarily focused on what polycythemia is, what the different types of polycythemia are, how to treat the condition and that polycythemia did not cause the stroke. None of the foregoing are claimed deviations. All parties agree that the plaintiff had secondary polycythemia, also known as Erythrocytosis. All parties agree that it is important to determine the type of polycythemia. All agree that polycythemia alone did not cause the plaintiff's stroke. All agree that the stroke was caused by a thromboembolic event consistent with a clot. Thus, the defense experts did not opine on the deviations from the standard of care that are the essence of this case."

Rather, the plaintiff's expert asserted that the alleged deviations essentially concerned the NYPH defendants' failure to appreciate the decedent's recent medical history of clot formation despite being on Plavix, and the increased risk of clot formation and resultant stroke in patients suffering from all types of polycythemia and coronary artery disease, as well as their failure to place the patient on anticoagulants in lieu of the apparently ineffective Plavix.

With respect to the decedent's multiple splenic and renal infarcts, the plaintiff's expert had no doubt that they were caused by blood clots. In this regard, the expert stated that the decedent

> "had no medical history as set forth in the hospital records that would account for any other cause of the death of the tissue, other than blood clots. In other patients, a history of a prior surgery where an artery was tied off or a trauma could cause death of tissue in the spleen and kidneys, but the plaintiff did not have any prior surgery and the medical records report that he had no trauma. These infarcts were spontaneous and continually forming and not caused by anything other than clots while he was taking Plavix."

Moreover, the expert explained that the MRI report described the observable lesions as "wedge-shaped," which the expert characterized as "the classic shape of dead tissue caused by a clot." The expert also noted that, since that report classified the infarcts as "evolving," both the clots and infarcts were "continuing," and required continued attention and treatment.

The plaintiff's expert criticized the NYPH defendants' expert affirmations, asserting that neither of the defendants' experts discussed the significance of the MRI scan generated at Mather a few days before the decedent presented to NYPH, the medical significance of the infarcts depicted on that scan, what those infarcts represented, what was meant by "evolving infarcts," and "the fact that patients with polycythemia and coronary artery disease are at a greater risk of clots and the risk the infarcts from clots," particularly in patients, such as the decedent, who were "already taking Plavix." The expert explained that anticoagulants, commonly referred to as blood thinners, suppress clotting factors found in the blood so as to interfere with the coagulation process, and thus provide a mechanism different from anti-platelet drugs such as Plavix. The expert asserted that the decedent had been placed on Plavix to

manage coronary artery disease, but was developing infarcts as result of clots, compelling the conclusion that Plavix was no longer effective. As the expert framed it, "[a]ccordingly, now the plaintiff required an anticoagulant which is considered to be a stronger medication than an antiplatelet to combat the formation of clots." The expert averred that the NYPH defendants "did absolutely nothing to prevent continued and future clots." The expert further asserted that, if a prescribed medication is no longer is effective, it should not be continued, but replaced by a new and different medication so that the condition can be treated, "and if you fail to do that you are unequivocally jeopardizing the health of the patient." The plaintiff's expert consequently concluded that the failure to replace Plavix with an anticoagulant was a departure from good and accepted practice.

With respect to the increased risk of clots in patients with polycythemia and coronary artery disease, the plaintiff's expert explained that

> "if a patient has an increased hemoglobin and hematocrit, as [the decedent] had, it is said that their blood is thick. Due to the amount of red blood cells and therefore the thickness of the red blood cells, the cells stick together. The adherence of these cells in turn can form clots which can appear anywhere in the body like the spleen, kidneys and brain/head. Thus, patients with all types of polycythemia are at an increased risk of forming blood clots compared to patients without conditions that give rise to clots."

Referring to a chart that Dr. Green included in his affirmation, showing that the decedent's hematocrit and hemoglobin levels had steadily increased over the years leading up to his admission to NYPH, the plaintiff's expert asserted that

> "[a]s a Hematologist, this chart, coupled with the MRI findings is very concerning. It demonstrates that the patient is generating more and more red blood cells. The more blood cells, the greater the risk for a blood clot since there is an increasing amount [sic] of cells which can potentially stick together and form a clot. In fact, the MRI now shows that due to the increasing red blood cell counts the patient is now forming clots in his spleen and kidneys while taking Plavix. This patient needed treatment. This patient needed anticoagulation to prevent new clots that Plavix was failing to prevent. For the defense to present this chart as a reason for no concern is contrary to the standard of care."

The plaintiff's expert also referred to Diuguid's deposition testimony and the NYPH hospital chart, which confirmed that the NYPH team of physicians was responsible for the

treatment of the decedent's "embolic showering," in which small portions of a larger emboli break off, enter the blood stream, and travel to various smaller vessels, where they block the blood flow through those smaller vessels. The expert further noted that the decedent's NYPH chart indicated that he was being treated for embolic disease. Inasmuch as the decedent's admission history stated that he was presenting with splenic abnormalities found on a CT scan, the plaintiff's expert concluded that NYPH was aware of the existing thromboembolisms, and was required to evaluate the decedent's embolic disease, but nonetheless focused primarily on determining the exact nature and cause of his polycythemia, to the exclusion of treating the embolic disease. Upon reviewing the NYPH chart and the NYPH defendants' deposition testimony, the plaintiff's expert concluded that the decedent "was not evaluated or treated for the embolic showering or splenic abnormalities that represented clots. The patient was worked up for polycythemia. But a work-up for polycythemia is not a work-up or evaluation for thromboembolisms." The expert thus opined that the NYPH defendants failed properly to evaluate and work up the decedent for thromboembolisms, thus departing from the applicable standard of care.

In reply to the plaintiff's opposition papers, the NYPH defendants submitted an attorney's affirmation, in which their attorney noted that, notwithstanding the allegations in the complaint and bill of particulars, the plaintiff was abandoning any claims that they failed timely to diagnose and treat polycythemia, that untreated polycythemia caused or contributed to the August 29, 2016 stroke, or that they negligently failed to undertake phlebotomies. The NYPH defendants' attorney further argued that Marchi, as an NYPH fellow under Diuguid's direct supervision who exercised no independent judgment, could not be held individually liable even if Diuguid were found to be negligent. She also asserted that the plaintiff "improperly relied upon misstatements of fact, assertions unsupported by competent evidence, hindsight reasoning, and speculation to advance the claim that decedent was negligently discharged from NYPH without anticoagulants having been started in the setting of renal and splenic infarcts."

V SUMMARY JUDGMENT STANDARDS

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

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

A. MEDICAL MALPRACTICE BASED ON DEPARTURE FROM ACCEPTED PRACTICE

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

A defendant physician moving for summary judgment must make a prima facie showing of entitlement to judgment as a matter of law by establishing the absence of a triable issue of fact as to his or her alleged departure from accepted standards of medical practice (*Alvarez v Prospect Hosp*., 68 NY2d 320, 324 [1986]; *Frye v Montefiore Med. Ctr*., 70 AD3d at 24) or by establishing that the plaintiff was not injured by such treatment (*see McGuigan v Centereach Mgt. Group, Inc*., 94 AD3d 955 [2d Dept 2012]; *Sharp v Weber*, 77 AD3d 812 [2d Dept 2010]; *see generally Stukas v Streiter*, 83 AD3d 18 [2d Dept 2011]). To satisfy the burden, a defendant must present expert opinion testimony that is supported by the facts in the record, addresses the essential allegations in the complaint or the bill of particulars, and is detailed, specific, and factual in nature (*see Roques v Noble*, 73 AD3d at 206; *Joyner-Pack v. Sykes*, 54 AD3d 727, 729 [2d Dept 2008]; *Koi Hou Chan v Yeung*, 66 AD3d 642 [2d Dept 2009]; *Jones v Ricciardelli*, 40 AD3d 935 [2d Dept 2007]). If the expert's opinion is not based on facts in the record, the facts must be personally known to the expert and, in any event, the opinion of a defendant's expert should specify "in what way" the patient's treatment was proper and "elucidate the standard of care" (*Ocasio-Gary v Lawrence Hospital,* 69 AD3d 403, 404 [1st Dept 2010]). Stated another way, the defendant's expert's opinion must "explain 'what defendant did and why'" (*id*., quoting *Wasserman v Carella*, 307 AD2d 225, 226 [1st Dept 2003]). Moreover, to satisfy his or her burden on a motion for summary judgment, a defendant must address and

rebut specific allegations of malpractice set forth in the plaintiff's bill of particulars (*see Wall v Flushing Hosp. Med. Ctr.*, 78 AD3d 1043 [2d Dept 2010]; *Grant v Hudson Val. Hosp. Ctr.*, 55 AD3d 874 [2d Dept 2008]; *Terranova v Finklea*, 45 AD3d 572 [2d Dept 2007]).

Once satisfied by the defendant, the burden shifts to the plaintiff to demonstrate the existence of a triable issue of fact by submitting an expert's affidavit or affirmation attesting to a departure from accepted medical practice and opining that the defendant's acts or omissions were a competent producing cause of the plaintiff's injuries (*see Roques v Noble*, 73 AD3d at 207; *Landry v Jakubowitz*, 68 AD3d 728 [2d Dept 2009]; *Luu v Paskowski*, 57 AD3d 856 [2d Dept 2008]). Thus, to defeat a defendant's prima facie showing of entitlement to judgment as a matter of law, a plaintiff must produce expert testimony regarding specific acts of malpractice, and not just testimony that contains "[g]eneral allegations of medical malpractice, merely conclusory and unsupported by competent evidence tending to establish the essential elements of medical malpractice" (*Alvarez v Prospect Hosp.,* 68 NY2d at 325; *see Frye v Montefiore Med. Ctr.*, 70 AD3d at 24). In most instances, the opinion of a qualified expert that the plaintiff's injuries resulted from a deviation from relevant industry or medical standards is sufficient to preclude an award of summary judgment in a defendant's favor (*see Murphy v Conner*, 84 NY2d 969, 972 [1994]; *Frye v Montefiore Med. Ctr.*, 70 AD3d at 24).

The NYPH defendants established their prima facie entitlement to judgment as a matter of law by demonstrating that, contrary to the allegations in the complaint and bills of particulars, Diuguid timely and properly diagnosed polycythemia and timely ordered numerous, detailed blood tests relevant to determining whether the decedent had primary or secondary polycythemia, normal platelet counts, and normal blood-flow timing, that NYPH quickly performed other testing and provided the decedent with consultations with specialists to rule out cardiac injury and infectious disease as a cause of his complaints, and that NYPH and Diuguid retained him in the hospital for an appropriate period of time before discharging him with appropriate instructions to follow up with both Diuguid and other specialists. Moreover, contrary

to the contention of the plaintiff's expert, Dr. Green noted that the decedent was on a maintenance dosage of Plavix while he was in the hospital, and Dr. Tuhrim expressly opined that there was no reason to switch the decedent from Plavix to an anticoagulant drug either during his hospital stay or upon his discharge, as Plavix was an appropriate drug to prevent excessive clotting. In addition, they established, prima facie, that phlebotomies would have been an inappropriate therapy for the decedent's condition. Moreover, the NYPH defendants made a prima facie showing that nothing that NYPH or Diuguid did or did not do caused or contributed to the decedent's stroke, and, more particularly, that neither polycythemia nor the failure to prescribe anticoagulants caused the stroke.

In opposition to that showing, the plaintiff's expert conceded that polycythemia did not cause the decedent's stroke, and that Diuguid did not depart from good and accepted practice in the timing of the diagnosis of polycythemia or the correctness of the diagnosis itself. The plaintiff's expert also essentially conceded that Diuguid timely and properly ordered blood testing with respect to the determination of the nature and cause of the decedent's polycythemia, and that NYPH administered other appropriate testing and provided consultations with appropriate specialists. In addition, he conceded that Diuguid's determination to forego phlebotomies did not constitute a departure from good practice.

Nonetheless, the plaintiff's expert raised a triable issue of fact as to whether Diuguid departed from good and accepted practice in light of the fact that the decedent was admitted to NYPH not primarily to address his polycythemia, but to address evolving emboli. In this regard, the expert raised a triable issue as to whether Diuguid departed from accepted practice by (a) failing fully to appreciate the significance of splenic and renal infarcts depicted on diagnostic imaging scans taken of the plaintiff's decedent, (b) failing fully to take into account the decedent's increased risk of blood clotting due to the fact that he had polycythemia and coronary artery disease, (c) failing to work up the decedent in connection with this risk, (d) failing to prescribe an anticoagulant drug to replace the maintenance dosage of Plavix that the

decedent was taking when he was admitted to NYPH, and (e) failing to prescribe a maintenance regimen of anticoagulants to the decedent upon his discharge from NYPH. The expert's affidavit also raised triable issues of fact as to whether these alleged departures caused the decedent to suffer from a stroke slightly more than three weeks after he was discharged from NYPH, or whether they contributed to that event. The court concludes that these opinions were more than speculative or based on mere hindsight, but that they had support in the record, and were based on the signs, symptoms, and diagnoses that the decedent presented to NYPH when he was first admitted.

In light of the foregoing, Diuguid is awarded summary judgment dismissing so much of the medical malpractice cause of action as was premised upon allegations that he failed timely to diagnose or treat polycythemia, failed to perform necessary diagnostic testing referable to polycythemia and other characteristics of the decedent's blood, and failed to perform phlebotomies. "'In general, under the doctrine of respondeat superior, a hospital may be held vicariously liable for the negligence or malpractice of its employees acting within the scope of employment, but not for negligent treatment provided by an independent physician, as when the physician is retained by the patient himself'" (*Valerio v Liberty Behavioral Mgt. Corp*., 188 AD3d 948, 949 [2d Dept 2020], quoting *Seiden v Sonstein*, 127 AD3d 1158, 1160 [2d Dept 2015]; *see Hill v St. Clare's Hosp*., 67 NY2d 72, 79 [1986]; *Dupree v Westchester County Health Care Corp*., 164 AD3d 1211, 1213 [2d Dept 2018]). Inasmuch as there is no dispute that Diuguid was NYPH's employee, NYPH may be held vicariously liable for Diuguid's negligence. Consequently, NYPH must be awarded summary judgment to the same extent as Diuguid, that is, it is awarded summary judgment dismissing so much of the medical malpractice cause of action as was premised upon allegations that Diuguid failed timely to diagnose or treat polycythemia, failed to perform necessary diagnostic testing referable to polycythemia and other characteristics of the decedent's blood, and failed to perform phlebotomies. NYPH also is

awarded summary judgment dismissing so much of the medical malpractice action as alleged that it did not perform other diagnostic testing or provide proper consultations with specialists.

That branch of the motion seeking summary judgment dismissing the remainder of the medical malpractice cause of action against Diuguid and NYPH is denied.

B. LIABILILTY OF HOSPITAL FELLOW

Marchi concededly was an NYPH fellow. The NYPH defendants established that, at all relevant times, she was working under Diuguid's supervision, and exercised no independent judgment of her own.

> "A resident or fellow who is supervised by a doctor during a medical procedure, and who does not exercise any independent medical judgment, cannot be held liable for medical malpractice unless the resident or fellow 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 or fellow commits an independent act that constitutes a departure from accepted medical practice"

(*Poter v Adams*, 104 AD3d 925, 927 [2d Dept 2013]; *see Murphy v Drosinos,* 179 AD3d 461, 462 [1st Dept 2020] [resident did not exercise her own medical judgment or otherwise operate outside the realm of ordinary prudence so as to trigger individual liability]; *Bellafiore v Ricotta*, 83 AD3d 632, 632 [2d Dept 2011]; *Lorenzo v Kahn*, 74 AD3d 1711, 1713 [4th Dept 2010]; *Soto v Andaz*, 8 AD3d 470, 471 [2d Dept 2004]; *Buchheim v Sanghavi*, 299 AD2d 229, 230 [1st Dept 2002]). In opposition to the NYPH defendants' prima facie showing that Marchi was immunized from liability in this action due to her status as a fellow, the plaintiff did not address the issue and, thus, failed to raise a triable issue of fact as to whether Marchi exercised independent judgment or whether Diuguid's orders were "so clearly contraindicated by normal practice that ordinary prudence requires inquiry into the correctness of the orders."

Hence, the NYPH defendants are awarded summary judgment dismissing the complaint insofar as asserted against Marchi.

C. NEGLIGENT HIRING, TRAINING, AND SUPERVISION

The NYPH defendants demonstrated that NYPH neither "knew, [n]or should have known," of their employees' "propensity for the sort of conduct which caused the [decedent's] injury" (*Sheila C. v Povich*, 11 AD3d 120, 129-130 [1st Dept 2004]; *see Kuhfeldt v. New York Presbyt./Weill Cornell Med. Ctr*., 205 AD3d 480, 481-482 [1st Dept 2022]). Inasmuch as the plaintiff did not address this issue in her opposition papers, she failed to raise a triable issue of fact in opposition to the NYPH defendants' prima facie showing in this regard. Hence, that branch of the NYPH defendants' motion seeking summary judgment dismissing the negligent hiring, training, and supervision cause of action insofar as asserted against them must be granted.

VI. CONCLUSION

In light of the foregoing, it is

ORDERED that the motion of the defendants David Diuguid, M.D., Enrica Marchi, M.D, and New York Presbyterian Hospital/Columbia University Medical Center is granted to the extent that they are awarded summary judgment (a) dismissing the complaint insofar as asserted against Enrica Marchi, M.D., (b) dismissing the negligent hiring and supervision causes of action asserted against all of them, (c) dismissing so much of the medical malpractice cause of action insofar as asserted against David Diuguid, M.D., and New York Presbyterian Hospital/Columbia University Medical Center as was premised upon allegations that they failed timely to diagnose or treat polycythemia, failed to perform necessary diagnostic testing, and failed to perform phlebotomies, and (d) dismissing so much of the medical malpractice cause of action insofar as asserted against New York Presbyterian Hospital/Columbia University Medical Center as was premised upon allegations that it failed to provide appropriate consultations with specialists, and the motion is otherwise denied; and it is further,

ORDERED that, on the court's own motion, the action against Enrica Marchi, M.D., is severed; and it is further

ORDERED that the Clerk of the court shall enter judgment dismissing the complaint insofar as asserted against Enrica Marchi, M.D.; and it is further,

ORDERED that all remaining parties shall appear for a pretrial settlement conference on October 17, 2023 at 11:00 a.m.

This constitutes the Decision and Order of the court.

9/14/2023
DATE

JOHN J. KELLEY, J.S.C.

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