St. Surin v Mercy Med. Ctr.
2024 NY Slip Op 34885(U)
September 16, 2024
Supreme Court, Queens County
Docket Number: Index No. 717599/2020
Judge: Tracy Catapano-Fox
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SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF QUEENS
--X
MARIE J. SAINT SURIN as Administrator of the Estate of JOSEPH SAINT SURIN,

Plaintiff,

-against-

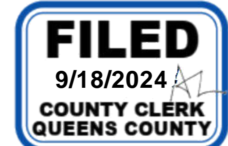
MERCY MEDICAL CENTER, ALEXANDER TELIS, M.D., KINGA RAMOS, P.A.-C, PAUL J. KUBIAK, M.D., and ANDREW FINKELSTEIN, M.D.,

Defendants.
--X

Index No. 717599/2020

Part MDP
Motion Date: August 21, 2024

Calendar No. 22
Sequence No. 5



The following papers numbered EF-94 to EF-151 read on this motion by defendant PAUL J. KUBIAK, M.D. for summary judgment and dismissal of plaintiff's Complaint pursuant to CPLR §3212.

	Papers Numbered
Notice of Motion, Affirmation, Exhibits……………	EF94-EF118
Affirmation in Opposition, Exhibits………………...	EF145-EF149
Reply Affirmation…………………………………..	EF150-EF151

Upon the foregoing papers, it is ordered that this motion is determined as follows:

Defendant Paul J. Kubiak, M.D.'s motion for summary judgment and dismissal of plaintiff's Complaint pursuant to CPLR §3212 is denied, as there are issues of fact with respect to whether he departed from good and accepted standards of care and proximately caused or contributed to decedent's injuries and death. (*See generally M.C. v. Huntington Hosp.*, 175 A.D.3d 578 [2d Dept. 2019].)

Plaintiff commenced this medical malpractice and wrongful death action arising out of decedent Joseph Saint Surin's total left knee replacement surgery performed on May 9, 2019 by defendant Dr. Kubiak at co-defendant Mercy Medical Center's facility. Plaintiff filed the Summons and Complaint on October 5, 2020 and issue was joined by moving defendant via the filing of his Answer on December 18, 2020. It is noted that the medical records show Mr. Saint Surin passed away on May 10, 2019.

Defendant Dr. Kubiak argues that he is entitled to summary judgment and dismissal of plaintiff's Complaint and presents the pleadings, decedent's medical records, the parties' deposition testimony, and expert affirmation of Fred D. Cushner, M.D. in support of his motion. Defendant Dr. Kubiak argues that there are no triable issues of material fact, as the evidence shows he rendered care and treatment in accordance with the standard of care and did not proximately cause plaintiff's injuries. Dr. Kubiak further argues that his recommendation for a total knee replacement and pre-surgical clearance was in accordance with the standard of care. Dr. Kubiak further argues that he performed the total knee replacement and rendered limited post-operative treatment in accordance with the standard of care. Dr. Kubiak argues that venous thromboembolism is a known and accepted complication of any surgical procedure and was not caused by Dr. Kubiak's actions or omissions. Dr. Kubiak also argues that any derivative claims for loss of services cannot be maintained, once the main action is dismissed.

Defendant Dr. Kubiak presents the expert affirmation of Dr. Fred D. Cushner in support of his motion. Dr. Cushner affirmed to being a physician licensed in New York and board-certified in orthopedic surgery. Dr. Cushner further opined to reviewing plaintiff's Bill of Particulars and decedent's medical records in rendering his opinions. Dr. Cushner opined within a reasonable degree of medical certainty that defendant Dr. Kubiak rendered care and treatment to decedent within the standard of care and did not proximately cause his injuries.

Dr. Cushner reviewed decedent's medical history and affirmed he presented to Jamaica Family Medicine for bilateral knee pain on frequent occasions between December 2016 through April 2019. On January 3, 2019, defendant Dr. Kubiak saw decedent for a follow-up visit regarding his bilateral knee pain with arthritis. Decedent inquired into surgical treatment, as previous cortisone injections were minimally helpful and decedent continued to have pain with daily activity. Dr. Kubiak performed a physical examination of decedent that revealed effusion and crepitus with range of motion, and recommended a left total knee replacement surgery. Decedent underwent pre-surgical testing on April 29, 2019 and was referred to Dr. Marjorie Duque for medical clearance due to an abnormal EKG. On May 6, 2019, decedent underwent a complete cardiac evaluation revealing normal left ventricular function and no evidence of ischemia. Dr. Cushner noted that Dr. Marian David opined decedent was at low risk for cardiac events and could proceed with the scheduled knee surgery.

The records show decedent presented to Mercy Medical Center on May 9, 2019, where he denied having a history of bleeding or clotting abnormalities and his informed consent for the surgery was obtained. The knee surgery was performed under general anesthesia without complication, and decedent had normal post-operative vitals and signs. Later on May 9th, decedent complained of some pain, and was treated with ice application and repositioning. The following day, decedent was examined and found to have normal vital signs and functions, and was

administered oxycodone for pain. At 1:00pm, decedent began occupational therapy, but reported a period of dizziness and became unresponsive and lost consciousness. A stroke code and cardiac arrest code were called and decedent was administered multiple rounds of epinephrine but passed away at 3:06pm. An autopsy was performed at NYU Winthrop Hospital on May 14, 2019, which set forth final diagnoses of bilateral acute pulmonary thromboembolism status post left total knee arthroplasty and bilateral deep venous thrombosis of the popliteal veins.

Dr. Cushner opined within a reasonable degree of medical certainty that Dr. Kubiak rendered care and treatment in accordance with the standard of care, and Dr. Kubiak did not proximately cause or contribute to decedent's injuries. Dr. Cushner opined that decedent's total knee replacement surgery was indicated given decedent's history of osteoarthritis of his left knee and failed conservative treatment. Dr. Cushner reasoned that osteoarthritis is a degenerative joint disease that often causes the breakdown of joint cartilage and adjacent bone in the knees, which leads to the need for knee replacement surgery. Dr. Cushner further reasoned that conservative treatment is the first line of defense and when that fails, surgical intervention in the form of a total knee replacement is available. Dr. Cushner further reasoned that decedent suffered from left knee osteoarthritis for approximately ten years and conservative treatment failed to relieve his pain, and the surgery was therefore warranted. Dr. Cushner also opined to a reasonable degree of medical certainty that decedent's pre-surgical clearance was properly obtained prior to the surgery. Dr. Cushner reasoned that decedent's pre-surgical testing results on April 29, 2019 were unremarkable and within normal limits with the exception of crepitus in the left knee warranting the surgery. Dr. Cushner noted decedent had a complete cardiac evaluation on May 6, 2019 during which he underwent a nuclear stress test that revealed stable findings with no evidence of ischemia. He also noted that on May 7, 2019, decedent was evaluated by his primary care physician Dr. Duque, who indicated he was "stable" and medically cleared for surgery. Dr. Cushner opined that it was appropriate for Dr. Kubiak to rely on decedent's cardiac and medical clearances and proceed with the total left knee replacement.

Dr. Cushner also opined to a reasonable degree of medical certainty that the total knee replacement was properly performed and decedent's informed consent for the surgery was properly obtained. Dr. Cushner reasoned that the risks, benefits, and alternatives were all explained to decedent. Dr. Cushner explained the surgical procedure for a knee replacement, and noted the standard of care required final x-rays be taken in the operating room to determine appropriate alignment and ensure there are no factors. He opined to a reasonable degree of medical certainty that with respect to the surgery, Dr. Kubiak performed the surgery properly with computer guidance and took x-rays in the operating room that demonstrated appropriate alignment and no fractures.

Dr. Cushner also opined to a reasonable degree of medical certainty that the post-operative venous thromboembolism (hereinafter referred to as "VTE") prophylaxis was in accordance with

good and accepted practice and standards of care. Dr. Cushner reasoned that VTE is a risk associated with any orthopedic surgery including total joint replacement surgery. Dr. Cushner further reasoned that when a patient plans to undergo orthopedic surgery, the applicable standard of care requires a pre-operative assessment as to the patient's risk for VTE and implementation of VTE prophylaxis. He further reasoned that for a patient such as decedent who did not have a history of VTE and was not at an increased risk for VTE, the standard of care requires the use of anticoagulation medication. He opined that decedent was not a high risk for VTE, and such determination was appropriate based upon Dr. David's cardiac evaluation and decedent's pre-anesthesia evaluation. Dr. Cushner opined within a reasonable degree of medical certainty that the VTE prophylaxis utilizing aspirin and SCDs was consistent with the standard of care based upon decedent's pre-operative surgical clearance and pre-operative complete cardiac evaluation. Dr. Cushner further opined that there was no indication for the use of a different coagulant such as Lovenox, as aspirin has been shown to be equally effective. He also opined that it was appropriate to order post-operative physical therapy with weight bearing as tolerated and pain management, and the parties' deposition testimony showed decedent wanted to proceed with therapy.

Dr. Cushner opined to a reasonable degree of certainty that there was no clinical indication of a VTE event such as deep vein thrombosis (hereinafter referred to as "DVT") or a pulmonary embolism (hereinafter referred to as "PE"). Dr. Cushner reasoned that following surgery, decedent was in stable condition and under proper prophylaxis for DVT and PE, as he was receiving 325 mg daily of ASA, had SCDs on his lower extremities, and was constantly being monitored. Dr. Cushner further reasoned that during decedent's clinical evaluations, there was no documentation of swelling, discoloration, desaturation, tachycardia, or complaints of pain. Dr. Cushner further reasoned that when decedent lost consciousness during his occupational therapy session, he was safely lowered to the floor to keep his head and neck protected and supported, but before that, that there was no indication or concern of a DVT or PE. Dr. Cushner also opined within a reasonable degree of medical certainty that Dr. Kubiak's limited involvement in decedent's care and treatment following his loss of consciousness was within the standard of care, because his care was limited to being at bedside and he appropriately deferred to and relied upon the recommendations and management of the intensivist and critical care teams including the ICU Team and Rapid Response Team.

Dr. Cushner also opined to a reasonable degree of medical certainty that Dr. Kubiak did not cause or contribute to decedent's injuries. Dr. Cushner reasoned that the surgery was unremarkable and done within a reasonable amount of time, with no signs of impending DVT or PE. Dr. Cushner further reasoned that even if decedent had been on Lovenox instead of aspirin, that only would have reduced the likelihood of developing further thrombi and would not have prevented existing thrombi from embolizing. Dr. Cushner also explained that without clinical signs and symptoms, there was no indication for further evaluation or additional treatment such as tPA. Based upon the foregoing, defendant Dr. Kubiak argues that he is entitled to summary

judgment and dismissal of plaintiff's Complaint.

Plaintiff opposes the motion, arguing defendant Dr. Kubiak failed to establish a prima facie entitlement to summary judgment, and there are triable issues of fact regarding whether he departed from accepted standards of care and proximately caused decedent's injuries and death. She presents the expert affirmations from Jeffrey S. Stein, M.D. and Tyler S. Lucas, M.D. in support of her opposition. Plaintiff concedes there is no lack of informed consent claim, nor is plaintiff arguing that the surgery was not indicated or negligently performed. Rather, plaintiff argues that Mr. Saint Surin's death was preventable and a result of defendants' negligence and malpractice in decedent's perioperative care. Plaintiff argues that defendant failed to present a prima facie case because the expert's opinions are conclusory and not based upon evidence in the medical records. She further argues that there are issues of fact based upon the experts' conflicting opinions that Dr. Kubiak failed to appreciate decedent's high risk for DVT and failure to timely diagnose and treat plaintiff for PE, thereby causing his injuries and death. Plaintiff further argues that since the claims for medical malpractice and wrongful death should not be dismissed, her derivative claims should also not be dismissed.

Plaintiff presents the affirmation of Dr. Jeffrey S. Stein in opposition to defendant Dr. Kubiak's motion. Dr. Stein affirmed to being a physician licensed in New York and board-certified in vascular surgery. Dr. Stein further affirmed to reviewing decedent's medical records, the parties' deposition testimony, and Dr. Cushner's expert affirmation in rendering his opinions. Dr. Stein opined to a reasonable degree of medical certainty that Dr. Kubiak departed from accepted standards of care in his treatment of decedent, and caused decedent's injuries and death.

Dr. Stein reviewed decedent's medical records and noted that decedent had a history of hypertension, obesity, asthma, smoking, limited mobility due to osteoarthritis of the bilateral lower extremities, and an abnormal EKG. He noted that post-surgery, decedent complained of pain in and around his knees on several occasions. Dr. Stein further noted that during an occupational therapy session on May 10, 2019, decedent experienced dizziness, complained of chest pain, became incontinent and lost consciousness, after which he woke up, became confused and agitated, complained of pain before developing bradycardia, agonal breathing and cardiac arrest. He further noted that defendants' employees provided rescue and resuscitative care to decedent for ninety minutes, but opined that the obvious and most likely diagnosis of pulmonary embolism was not acted upon by Dr. Kubiak. Dr. Stein noted that decedent was not given intravenous heparin or thrombolytic therapy which he opined more than likely would have saved decedent's life.

Dr. Stein opined to a reasonable degree of medical certainty that defendant Dr. Kubiak failed to appropriately assess, evaluate and appreciate decedent's high risk for VTE prior to his surgery. Dr. Stein reasoned that based upon the clinical events that led up to decedent's death as well as the autopsy report, decedent had developed lower extremity venous thrombi prior to his

episode of collapsing and cardiac arrest. Dr. Stein further reasoned that had Dr. Kubiak conducted an appropriate assessment of decedent's risk for VTE, he would have determined that decedent was at high risk for its development and would have implemented a more effective VTE prophylaxis.

Dr. Stein explained that the standard of care for the perioperative assessment and performance of orthopedic surgery, particularly in lower extremity joint replacement, requires an overall assessment of operative risk and a preoperative assessment of a patient's risk for VTE and the implementation of VTE prophylaxis. Dr. Stein further explained that decedent had numerous risk factors for VTE which placed him in the highest risk category for developing perioperative DVT and PE. Dr. Stein further explained those risk factors included decedent's history of hypertension, history of asthma, age over sixty, obesity, major surgery lasting more than forty-five minutes, tourniquet time for more than forty-five minutes, immobility, and surgical trauma. Dr. Stein also explained that Dr. Kubiak should have sought out a specialist such as a vascular surgeon or hematologist to conduct a preoperative evaluation in light of decedent's medical history. Dr. Stein also reasoned that given decedent's clinical factors, it would have been prudent to obtain a preoperative venous ultrasound to determine if decedent already had existing lower extremity venous thrombi due to immobility resulting from his osteoarthritis and knee pain. Dr. Stein further reasoned that if this had been done and DVT was already present, it would have been found at a treatable stage.

Dr. Stein disagreed with Dr. Cushner's opinions regarding Dr. Kubiak's preoperative evaluation and surgical clearance. Dr. Stein explained that he did not disagree with Dr. Cushner's conclusions based on the preoperative evaluation, but rather opined that the preoperative evaluation was inadequate and incomplete. Dr. Stein also disagreed with Dr. Cushner's opinion that decedent was not at high risk for VTE given he denied any history of bleeding or clotting abnormalities and reasoned that that is only one of many risk factors for perioperative VTE.

Dr. Stein also opined that because Dr. Kubiak failed to assess and appreciate decedent's high risk for VTE, he caused decedent to not receive appropriate perioperative VTE prophylaxis. Dr. Stein explained that perioperative prophylaxis is the standard of care in orthopedic surgery, particularly joint replacement surgery. Dr. Stein reasoned that DVT and PE incidents have been significantly reduced with the use of perioperative VTE prophylaxis including pharmacological prophylaxis and mechanical prophylaxis such as intermittent pneumatic compression devices. Dr. Stein also reasoned that many clinical studies have found that aspirin is less effective than heparin in preventing VTE in high-risk patients, such as decedent. Dr. Stein therefore disagreed with Dr. Cushner's opinion that the use of aspirin in lieu of an anticoagulant was appropriate and noted that even the study Dr. Cushner cited to indicated that heparin should be administered to certain patients. Dr. Stein also disagreed with Dr. Cushner's opinion that decedent did not display any signs or symptoms of a VTE event and reasoned that both pain and swelling in the operated leg

are signs of DVT. Dr. Stein explained that a venous duplex ultrasound should have been performed the day after surgery which would have revealed DVT in time to allow for treatment.

Dr. Stein also opined to a reasonable degree of medical certainty that Dr. Kubiak departed from good and accepted medical practice in failing to consider and diagnose a pulmonary embolism when decedent presented with obvious signs and symptoms of chest pain, dizziness, loss of consciousness, respiratory distress, and cardiac failure. Dr. Stein also opined that if the diagnosis of PE had been appropriately considered in a timely fashion, there was a substantial opportunity to immediately administer heparin and initiate thrombolytic therapy with intravenous tissue Plasminogen Activator (hereinafter referred to as "tPA"), which would more likely than not have saved decedent's life. Dr. Stein reasoned that if there is a clinical suspicion of a PE, immediate anticoagulation must be initiated before diagnosis is confirmed because early anticoagulation is associated with reduced mortality. Dr. Stein further reasoned that in light of decedent undergoing joint replacement and his clinical history, he should have been given heparin immediately within ten to fifteen minutes of collapsing while decedent was still awake and responsive.

Dr. Stein disagreed with Dr. Cushner's opinion that decedent was at a low risk for VTE, and opined decedent had numerous risk factors that placed him in the highest risk category for developing perioperative DVT and PE. He further opined that Dr. Kubiak should have sought a preoperative evaluation by a specialist in vascular surgery or hematologist. Dr. Stein also disagreed with Dr. Cushner's opinion that decedent did not display any signs of symptoms of a VTE event, noting decedent complained of pain and swelling on the operated leg that are signs of DVT. Dr. Stein disagreed with Dr. Cushner's opinion that Dr. Kubiak had limited involvement in decedent's care and treatment following his loss of consciousness and was within the standard of care to defer to the critical care team. Dr. Stein reasoned that Dr. Kubiak was decedent's primary physician during his admission to Mercy Hospital for the purpose of this orthopedic surgery, and was therefore responsible to make a proper diagnosis of pulmonary embolism. Dr. Stein further reasoned that since Dr. Kubiak was present at decedent's bedside and responded right away immediately upon learning that decedent had collapsed, he was in the best position to formulate a diagnosis to save decedent's life.

Dr. Stein also opined to a reasonable degree of medical certainty that Dr. Kubiak's departures deprived decedent of a substantial chance of survival. He further opined that Dr. Kubiak departed from the standard of care in not immediately engaging in a differential diagnosis, including PE, but instead disengaged from decedent's care. Dr. Stein reasoned that intravenous heparin is effective within minutes and immediately prevents the formation of new clots while the body's endogenous thrombolytic mechanisms start to dissolve the thrombus unopposed by new clot formation. Dr. Stein further reasoned that there are several effective and lifesaving interventional therapies that include catheter directed thrombolytic therapy and catheter thrombo-

embolectomy. Dr. Stein further reasoned that had a PE been timely diagnosed, plaintiff could have been treated with intravenous heparin and systemic thrombolytic therapy which most likely would have saved his life. Dr. Stein also reasoned that the fact that decedent was resuscitated after his cardiac arrest further supports his opinion that decedent's chances of survival were good if proper therapy for PE had been instituted.

Plaintiff also presents the affirmation of Dr. Tyler Lucas in opposition to defendant Dr. Kubiak's motion. Dr. Lucas affirmed to being a physician licensed in New York and board-certified in orthopedic surgery. Dr. Lucas further affirmed to reviewing decedent's medical records, the parties' deposition testimony, and Dr. Cushner's expert affirmation in rendering his opinions. Dr. Lucas opined to a reasonable degree of medical certainty that Dr. Kubiak departed from the standard of care by failing to appreciate decedent's high risk for VTE. Dr. Lucas reasoned that decedent's clinical history of hypertension, asthma, obesity, advanced age, and limited mobility, combined with the extended anesthesia and tourniquet during the surgery put him at an obvious and high risk for development of VTE, which was within the scope of a competent orthopedic physician to assess and appropriately treat. Dr. Lucas opined that Dr. Kubiak departed from accepted standards of care by failing to timely diagnose decedent with PE after he collapsed, despite signs of chest pain, dizziness, loss of consciousness, respiratory distress, and cardiac failure indicative of PE. He argued that decedent's high risk for VTE and the symptoms exhibited in the ninety minutes before decedent's death should have immediately indicated to Dr. Kubiak that decedent was suffering from a PE and life-saving treatment could be provided. Dr. Lucas further opined that Dr. Kubiak should have consulted with a specialist if he lacked the knowledge or experience to assess clinical factors related to VTE risks. Dr. Lucas reasoned that there was a substantial opportunity to immediately administer systemic thrombolytic therapy which would more likely than not have saved decedent's life. He opined that Dr. Kubiak departed from the standard of care by disengaging with decedent and deferring to the rapid response team, arguing Dr. Kubiak was in the best position to make the appropriate diagnosis. Based upon the foregoing, plaintiff argues that the evidence shows there are triable issues of fact regarding whether Dr. Kubiak departed from accepted standards of care and proximately caused or contributed to decedent's injuries, and his motion should therefore be denied.

Pursuant to CPLR §3212, a motion for summary judgment "shall be granted if, upon all the papers and proof submitted, the cause of action or defense shall be established sufficiently to warrant the court as a matter of law in directing judgment in favor of any party." (*Smith v. City of New York*, 210 A.D.3d 53, 68 [2d Dept. 2022].) The proponent of a summary judgment motion must 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. (*Morejon v. New York City Tr. Auth.*, 216 A.D.3d 134, 136 [2d Dept. 2023].) If there is any doubt as to the existence of a triable issue of fact, the motion must be denied. (*Id.*) The failure to make such a prima facie showing requires a denial of the motion, regardless of the sufficiency of the opposition papers.

(*Winegrad v. N.Y. Univ. Med. Ctr.*, 64 N.Y.2d 851, 853 [1985]; *see also Antonyuk v. Brightwater Towers Condo Homeowners' Assn., Inc.*, 147 A.D.3d 711, 712 [2d Dept. 2017].) In determining a motion for summary judgment, evidence must be viewed in the light most favorable to the nonmoving party, and all reasonable inferences must be resolved in favor of the nonmoving party. (*Matter of New York City Asbestos Litig.*, 33 N.Y.3d 20, 25 [2019].) Additionally, the court's function in determining a motion for summary judgment is not to resolve issues of fact or determine matters of credibility, but merely to determine whether such issues exist. (*Reyes v. S. Nicolia & Sons Realty Corp.*, 212 A.D.3d 851, 852-853 [2d Dept. 2023].) Once the moving party has demonstrated a prima facie entitlement to summary judgment, the burden then shifts to the non-moving party to demonstrate the existence of material issues of fact. (*See generally Coscia v. Mosca*, 203 A.D.3d 695 [2d Dept. 2022].)

In moving for summary judgment in a medical malpractice action, the defendant must establish a prima facie case that there was no departure from good and accepted medical practice or that the plaintiff was not injured thereby, and the plaintiff in opposition must submit evidentiary facts or materials to demonstrate the existence of a triable issue of fact. (*Stukas v. Streiter*, 83 A.D.3d 18, 24 [2d Dept. 2011].) In presenting opposition to raise a triable issue of fact, the plaintiff is required to provide an affidavit of merit by a medical expert, and the failure to submit an affidavit by a medical expert competent to attest to the meritorious nature of the plaintiff's claims requires dismissal of the Complaint. (*Id.* at 28.) Summary judgment is not appropriate in a medical malpractice action where the parties adduce conflicting medical expert opinions. (*Buch v. Tenner*, 204 A.D.3d 635, 638 [2d Dept. 2022].) In general, a hospital may be vicariously liable for the negligence or malpractice of its employees acting with the scope of employment under the doctrine of *respondeat superior*. (*See Valerio v. Liberty Behavioral Mgt. Corp.*, 188 A.D.3d 948 [2d Dept. 2020].)

In an action to recover damages for wrongful death, the decedent's personal representative must establish that the defendant's wrongful act, neglect or default caused the decedent's death. (*Eberts v. Makarczuk*, 52 A.D.3d 772, 772-773 [2d Dept. 2008].)

Defendant Dr. Kubiak established a prima facie entitlement to summary judgment. Dr. Kubiak demonstrated through his production of the documentary evidence and affirmation of Dr. Cushner that he rendered care and treatment in accordance with good and accepted standards of care and did not proximately cause or contribute to decedent's injuries. Defendant Dr. Kubiak demonstrated through Dr. Cushner's affirmation that decedent was properly given operative clearance after a pre-operative assessment and complete cardiac check-up and the total knee surgery was properly performed. He also demonstrated the surgery was indicated and properly performed after obtaining decedent's informed consent. Dr. Cushner also demonstrated prima facie that appropriate VTE prophylaxis was implemented and followed and despite the prophylaxis in place, the VTE and PE could neither have been anticipated nor prevented based upon decedent's

lack of clinical signs and symptoms. Defendant Dr. Kubiak further demonstrated that even had decedent been on a more "stringent" prophylaxis regiment such as an anticoagulant, it would not have made a difference in terms of the VTE and PE that occurred. Defendant also established that decedent was continuously monitored and sought physical therapy, and it was appropriate to order it, as decedent had no clinical signs of a DVT or PE. Defendant also established that it was appropriate for him to defer to the critical care team in rendering care to decedent after his collapse. He further established that his actions or inactions were not the proximate cause of decedent's injuries and death. Based upon the foregoing, defendant Dr. Kubiak demonstrated a prima facie entitlement to summary judgment.

However, plaintiff raised triable issues of fact with respect to whether defendant Dr. Kubiak departed from accepted standards of care and proximately caused decedent's injuries. Specifically, there are triable issues of fact with respect to whether Dr. Kubiak failed to appropriately assess and appreciate decedent's level of risk for DVT prior to his surgery, whether Dr. Kubiak implemented appropriate VTE prophylaxis, and whether Dr. Kubiak failed to recognize the signs and timely diagnose and treat decedent for PE, and whether these departures were the proximate cause of decedent's injuries and death. Plaintiff agreed that the knee replacement surgery was indicated and properly performed after obtaining decedent's informed consent. However, plaintiff raised triable issues of fact by presenting the expert affirmations of Dr. Stein and Dr. Lucas that specifically rebutted Dr. Cushner's opinions with regard to Dr. Kubiak's actions and inactions. (*See Loccisano v. Ascher*, 195 A.D.3d 610, 613 [2d Dept. 2021].) While Dr. Cushner opined that decedent was properly given surgical clearance with a low risk of DVT, Dr. Stein sufficiently challenged this opinion by presenting decedent's underlying medical history that demonstrated a higher risk of DVT. Dr. Stein also demonstrated that the pre-operative evaluation was incomplete and several other factors could have been considered in determining decedent's risk for VTE and implementing a more stringent prophylaxis regimen that included an anticoagulant. Dr. Stein also demonstrated that an ultrasound could have been done immediately following surgery in light of decedent's high risk for VTE that would have shown the impending episodes and would have allowed for further treatment.

Plaintiff also established through expert testimony that decedent demonstrated signs of impending PE and raised issues of fact whether if he had been administered heparin within ten to fifteen minutes of losing consciousness he would have had a good chance of surviving, especially in light of the fact that he was resuscitated after his cardiac arrest. Additionally, while Dr. Cushner opined that Dr. Kubiak had limited involvement with decedent's care after he lost consciousness, Dr. Stein and Dr. Lucas disagreed and opined that based upon the standard of care, Dr. Kubiak as primary care physician, should have suspected the PE and implemented measures rather than deferring to the critical care team. As there are conflicting expert opinions presented by Dr. Kubiak and plaintiff regarding whether Dr. Kubiak departed from accepted standards of care and proximately caused decedent's injuries, there are material issues of fact necessitating a jury

determination. (*See Mehtvin v. Ravi*, 180 A.D.3d 661, 664 [2d Dept. 2020][holding that summary judgment is not appropriate in a medical malpractice action where the parties adduce conflicting medical expert opinions, as issues of credibility are properly left to a jury for its resolution].)

Accordingly, defendant Paul J. Kubiak, M.D.'s motion for summary judgment and dismissal of plaintiff's Complaint pursuant to CPLR §3212 is denied. It is noted that this matter is scheduled for a pretrial conference on Wednesday, September 18, 2024 at 9:30am in Courtroom 48.

This constitutes the decision and Order of the Court.

Dated: September 16, 2024

Hon. Tracy Catapano-Fox, J.S.C.