Macias v Ferzli
2012 NY Slip Op 33813(U)
October 3, 2012
Supreme Court, Kings County
Docket Number: 500000/06
Judge: Marsha L. Steinhardt

At an IAS Term, Part 15 of the Supreme Court of the State of New York, held in and for the County of Kings, at the Courthouse, at Civic Center, Brooklyn, New York, on the 28th day of August, 2012.

PRESENT:

HON. MARSHA L. STEINHARDT,
Justice

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MILTON MACIAS and GLADYS RIVERA, as Co-Administrators of the Estate of JACQUELINE ANDRADE [Deceased], for the Benefit of her Infant Sons, MILLER AND ERICKSON,

Plaintiffs,

-against-

GEORGE FERZLI, M.D., GEORGE FERZLI, M.D., P.C., ARMANDO CASTRO, M.D., PETER GERARD BAUER, M.D., PAMELA BOWEN, M.D., "MARY" NALBANDIAN, M.D., EVELYN ANSA, M.D., "JUN" LI, M.D., "JOHN" MURALI, M.D., HUSAN RIMAWI, M.D., ALLEN COOPERSMITH, M.D., GHAZALI CHAUDRY, M.D., and LUTHERAN MEDICAL CENTER,

Defendants.

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DECISION AND ORDER

Index No. 500000/06

Mot. Seq. #14, 15, 16

The following papers numbered 1 to 21 read herein:	Papers Numbered
Notice of Motion/Order to Show Cause/ Petition/Cross Motion and Affidavits (Affirmations) Annexed	1-3, 4-6, 7-9
Plaintiffs' Opposing Affidavits (Affirmations)	10-11
Defendants' Reply Affidavits (Affirmations)	12, 13, 14-15
Plaintiffs' Supplemental Opposing Affidavits (Affirmations)	16-17
Defendants' Supplemental Reply Affidavits (Affirmations)	18, 19-20, 21

Defendants LUTHERAN MEDICAL CENTER, KANNAN MURALIKRISHNAN, M.D. (incorrectly sued herein as "JOHN" MURALI, M.D.), MARY NALBANDIAN, M.D., PETER GERARD BAUER, M.D., ARMANDO CASTRO, M.D., GEORGE FERZLI, M.D., and GEORGE FERZLI, M.D., P.C., move for summary judgment.[1] Plaintiffs oppose, except with respect to MARY NALBANDIAN, M.D.

Now upon the foregoing papers and after oral argument and due deliberation had thereon, the motion for summary judgment of the defendants LUTHERAN MEDICAL CENTER and KANNAN MURALIKRISHNAN M.D., incorrectly sued herein as "JOHN" MURALI, M.D., is DENIED (sequence No. 14); the branch of the amended motion of the defendants MARY NALBANDIAN, M.D. and PETER GERARD BAUER, M.D. is GRANTED (sequence No. 15); the cross motion of the defendants ARMANDO CASTRO, M.D., GEORGE FERZLI, M.D., and GEORGE FERZLI, M.D., P.C. is GRANTED (sequence No. 16). The action is severed and continued against the remaining defendants Lutheran Medical Center, Kannan Muralikrishnan, M.D. (incorrectly sued herein as "John" Murali, M.D.), Pamela Bowen, M.D., Husan Rimawi, M.D., and Ghazali Chaudry, M.D.

This is an action sounding in medical malpractice and lack of informed consent wherein plaintiffs claim that the moving defendants failed to obtain the decedent's informed consent to surgery, performed unnecessary surgery (more specifically, removal of a gastric band), failed to monitor her vital signs post-operatively, prematurely discharged her from the

[1] The action against the moving defendants JUN LI, M.D. and ALLEN COOPERSMITH, M.D. was dismissed for lack of personal jurisdiction by order of the Court in January 2012.

recovery room to the Labor & Delivery service, caused or permitted her to suffer an aspiration and respiratory distress, failed timely and properly to treat her oxygen deficiency, and caused her death as well as the death of her then 22-week-old fetus. The action against defendant Evelyn Ansa, M.D. was discontinued by stipulation of the parties. As noted, the action against the moving defendants JUN LI, M.D. and ALLEN COOPERSMITH, M.D. was dismissed for lack of personal jurisdiction by prior order of the Court. Defendants Pamela Bowen, M.D., Husan Rimawi, M.D., and Ghazali Chaudry, M.D. have not appeared in this action, but plaintiffs have sought no default judgment against them.

Background

Plaintiffs' decedent Jacqueline Andrade (the patient) was a 32-year-old Ecuadorian-born nursing aide who resided with her boyfriend and two children in Brooklyn. She was 5'1" tall and weighed about 255 pounds at the time when the events giving rise to this action occurred. Although severely obese, she apparently had no other health problems. Her heart and lungs were normal, and she had no diabetes. She abused no drugs or alcohol. She delivered her first child (a boy) via a C-section. She delivered her second child (also a boy) via a normal spontaneous vaginal delivery.

In October 2002, eighteen months prior to the events at issue in this action, she underwent a laparoscopic gastric band placement by Dr. Ferzli at Victory Memorial Hospital. A gastric band is a long-term surgical obesity treatment in which an inflatable silicone band is placed in a ring around the upper stomach, creating an upper stomach pouch to limit the

amount of food that can be consumed. The band is connected by tubing to an access port that is placed in a muscle layer beneath the skin. The tightness of the band regulates the opening of the upper stomach pouch. The degree to which food intake is restricted is changed by a percutaneous addition or removal of saline from the band through the access port from time to time in the months and years after placement of the band (Castro Tr at 13-14). When it is initially placed, the port contains no saline so as to make the band maximally unrestrictive.

One week post-surgery, the patient followed up with Dr. Ferzli in his office to remove sutures. She was a "no show" for all three follow-up appointments. She never had any subsequent surgery to reposition the gastric band or its port. She never had a band adjustment (a percutaneous injection of the gastric band with saline through the port). There is no claim in this action concerning Dr. Ferzli's initial implantation of the gastric band.

In February 2004, the patient became pregnant with her third child. Her estimated date of delivery was at the end of October 2004. Pregnancy is not a contraindication to having a gastric band.

In March 2004, the patient, then five weeks' pregnant, presented to the physicians' office of George Ferzli, M.D., P.C. She was seen by Dr. Castro, who was then employed as a fellow in laparoscopic surgery by the physicians' office and was practicing at Lutheran Medical Center (Castro Tr at 11-12, 37-38). She stated to Dr. Castro that she had difficulty when eating fast and that she had lost no weight since her gastric band surgery 16 months prior. Dr. Castro advised the patient that removal of a gastric band would be under general

anesthesia, which would be dangerous to the fetus in the first trimester. According to the physicians' office notes, the patient did not know whether she wanted her gastric band removed.

On June 7, 2004, the patient returned to the physicians' office where Dr. Ferzli examined her. His physicians' office note indicated that his evaluation of the patient revealed no abnormalities and that he wanted the patient to continue through her pregnancy without removing her gastric band. Although the patient considered to have the gastric band removed, Dr. Ferzli advised her to carry on with her pregnancy and to revisit the status of her gastric band after she delivered her baby. He scheduled a return visit in three weeks. At his pretrial deposition, he testified (at page 112) that removal of a gastric band was "not something we want to jump into . . . for any reason unless [it is] an emergency and in general, we should continue with the band [for] as long as possible . . ."

June 8-9, 2004 (Initial Visit to the Emergency Department; Overnight Stay; Discharge)

On June 8, 2004, at 5:31 P.M., the patient, then weighing 255 pounds, presented to the Emergency Department at Lutheran Medical Center (LMC), complaining of pain in the area of gastric band surgery and [pain] when swallowing. "Pain is right on top of the band," she stated. She was evaluated in the Labor and Delivery (L&D) service. Surgical consult was obtained from Dr. Chaudry, then a laparoscopic surgery fellow in the physicians' office of Dr. Ferzli and a colleague of Dr. Castro, but Dr. Chaudry recommended no CT scan or other imaging studies. The patient was kept overnight in the L&D service where she received IV

fluids, and, at night, an injection of Demerol (an opiate). She awoke at 7 A.M. and vomited once. Her diagnosis at 3 P.M. on June 9 was intrauterine pregnancy and nausea/vomiting. According to an untimed nursing note, her pain was not likely to be pregnancy-related. She was discharged home on June 9 with instructions to see her surgeon as soon as possible to evaluate the condition of her gastric band. At discharge, she was provided with a referral form indicating that she had vomited for the prior four days, she had lost 15 pounds in the preceding four weeks, and she needed hydration and an evaluation of her abdominal pain.

June 10, 2004 (Return to the Emergency Department; Admission to LMC)

On June 10, at 8:40 A.M., the patient returned to the Emergency Department at LMC, with complaints of nausea/vomiting and constipation for the prior four-five days. She explained that she had not experienced morning sickness during either her current pregnancy or her two prior pregnancies. She stated that she ate only small amounts of food, but that since the prior Sunday, June 6, 2004,[2] she had been unable to hold down any food, was retching "streaks with bloody sputum," and could feel her gastric band, which until then had not bothered her. The initial plans of the Emergency Department staff were a surgery consultation and IV hydration. She was admitted to the L&D service by an obstetrician, the defendant Husan Rimawi, M.D., with complaints of constipation, vomiting, tenderness, and epigastric pain in the area of the band. According to the physicians' orders section in her

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[2] June 10, 2004 was a Thursday. By the court's calculation, the prior Sunday fell on June 6, 2004. It is well-settled that courts will "notice that a particular date falls on a particular day of the week" (Jerome Prince, Richardson on Evidence § 2-204 [Farrell 11th ed 1995]).

hospital records, the patient was immediately placed on the NPO (nothing by mouth) status. The daily nursing antepartum assessment records indicated that the patient was NPO for the entire day of June 10. At 11:15 A.M., she was given Pepcid (an antacid) intravenously and a Tylenol suppository rectally. A standing order was issued for Pepcid intravenously twice a day at 10 A.M. and 10 P.M., for June 10 through 16. At 1:45 P.M., she received an injection of Demerol and Phenergan (an antihistamine). At 9 P.M., she received another injection of Demerol and Phenergan. Demerol and Phenergan were repeated at 11:35 P.M. and 11:40 P.M., respectively.

June 11-14, 2004 (Patient's Monitoring; Search for the Root Cause; Upper Endoscopy)

On June 11, the patient vomited in the morning. At 10:35 A.M., an ultrasound study of the patient's abdomen indicated that her pancreas was within the normal limits and showed no definite evidence of gallstones. A consulting nutritionist recommended that if the patient stopped vomiting, she should be given some soft/bland/low-fat food in six small meals, but that if she continued vomiting, she should receive total parenteral nutrition. At 10:20 A.M., she received Toradol (an anti-inflammatory). At 9 P.M., she received Demerol and Phenergan. The daily nursing antepartum assessment records indicated that the patient was NPO for the entire day, thereby suggesting that the patient either continued vomiting or was in danger of vomiting if fed.

On June 12, the patient continued NPO, according to the fluid balance records for that day. With few exceptions, no hospital records for that date have been provided to the Court.

On June 13, a 2 A.M. nursing noted indicated that the patient vomited about 30 cubic centimeters (or 1 fluid ounce). At 10:30 A.M., she was given a stool softener suppository, but she still had no bowel movement. A 4 P.M. obstetrics resident's note indicated that, according to the patient, she was unable to tolerate a clear liquid diet, and she complained of nausea, epigastric pain, and backache. The patient was continued on Pepcid. A 5 P.M. nursing note stated that the patient still complained of nausea and vomiting. The patient remained NPO, according to the fluid balance records for that date.

On June 14, an untimed nursing note directed that the patient was to be kept NPO. An untimed perinatology note stated that the patient had been vomiting all throughout the prior day (June 13), was not tolerating any diet, and had no bowel movement for the past six days. An assessment/plan for the patient was: (1) awaiting decision from the patient's surgeon, Dr. Ferzli, and (2) peripheral parenteral nutrition (with a question mark next to it) or surgery (also with a question mark next to it). A 1:20 A.M. note reflected that the patient was complaining of epigastric pain. Her oxygen saturation was 99% on ambient air. At 9 A.M., an upper endoscopy was ordered to rule out a potential gastric obstruction and to measure the size of her gastric opening. The patient was to be kept NPO. The patient was examined by Dr. Castro, who summarized his examination of the patient in the following untimed note:

> "Surgical attending. [Patient] still with persistent nausea/vomiting even with clears [*i.e.*, with a clear liquid diet] . . . Will consult Dr. Rivito for EGD [upper endoscopy].

> May require nasogastric tube. *Patient wishes to have lap band removed if nausea/vomiting persists*" (emphasis added).

Dr. Castro, in his pretrial testimony (at pages 50-51 of his deposition), listed four potential causes of why the patient suffered from nausea/vomiting:

> "[1] Her being pregnant, it could have been she was having hyper emesis [vomiting] from pregnancy or [2] that she was having dys[phagia] [difficulty swallowing] or [3] issues relating to the amount or the speed with which she took in fluids or solids that may have led to the nausea and vomiting . . .
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> . . . [4] It could have been an issue with the band itself."

A 10 A.M.-12 P.M. note indicated that the patient was complaining of lower flank back discomfort and a mild shortness of breath. At 1:10 P.M., she received Maalox (an antacid). A 3:45 P.M. nursing note stated, "NPO status reinforced." An untimed note from Dr. Rivito, the physician who performed an upper endoscopy on the patient, stated, in relevant part, "endoscopy with [a] *pediatric scope*[;] status post lap banding with narrowing of proximal body of her stomach. No difficulties in going into atrium and duodenum" (emphasis added). Dr. Rivito's typewritten report of the patient's upper endoscopy summarized his impressions and his recommendation:

> Impressions:
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> "1. The esophagus appeared normal.
> 2. Narrowing in the proximal body consistent with banding.
> 3. *Large amount of fluid in the body proximal to the banding.*
> 4. The duodenum appeared normal."
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> Recommendation:
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> "*Consider removing banding if vomiting persists*" (emphasis added).

A 6:10 P.M. note indicated that the results of the patient's upper endoscopy were reported to Dr. Ferzli. This note continued, "Dr. Ferzli to come and evaluate [the] patient in the morning and counsel her re tube feeding or removing the band. As per Dr. Ferzli, [the] patient could have [a] clear liquid diet." An untimed entry in the physicians' orders section stated, "clear liquid diet (no jello)." A 6:30 p.m. nursing note indicated that the "patient tolerated clear liquid diet with no jello, consumed approximately 90% of diet served. No hemoptysis [blood in sputum] noted . . ." However, the daily nursing antepartum assessment records noted that the patient's oral intake was only at 50-74% of liquid consumed. According to the fluid balance records, the patient received 120 cubic centimeters (or about four fluid ounces) of tea at 6-7 P.M. and 80 cubic centimeters (or about 2.7 fluid ounces) of water at 9-10 P.M. on that day. At 9 P.M., the patient received Demerol and Vistaril (an antihistamine and an anxiolytic). At 11 P.M., she received another dose of Vistaril.

June 15, 2004 (the Day Before Surgery; Patient's Consent)

On June 15, a 7 A.M. nursing note stated that the patient was spitting up a large amount of sputum. A 7 A.M. physician's note stated that the patient had a clear diet, vomited only once (as per a nurse, it was mostly "sputum like"), but had no bowel movement for the prior seven days. According to the physician's note, Dr. Ferzli was to evaluate the patient and counsel her regarding "tube feeding versus removal of the gastric band."

It was Dr. Castro, rather than Dr. Ferzli, who reviewed the results of the patient's upper endoscopy and saw the patient at LMC. According to Dr. Castro's pretrial testimony

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(at pages 57-58 of his deposition), at the time of his examination of the patient, he had ruled out all of the four potential causes of her nausea/vomiting:

> "[1] [T]he hyper emesis I would refer to the OB [obstetrics] service, and in reviewing the chart it seemed that she didn't have that with her previous pregnancies, nor was it usual for this pregnancy. So that was not likely the cause. [2-3] Relating to her . . . dys[phagia] . . .
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> [i]n recalling that she had previously mentioned in my [March 2004] visit in the office that she ate too much and she was having difficulty with that, obviously at this point, she wasn't really eating food, . . . she was only having liquids, or . . . that's the only issue she was having, the nausea and vomiting with it, would be unlikely that that was the cause. [4] The result of the EGD [upper endoscopy] indicated there wasn't an obstruction. They were able to pass the tube or scope easily, so *the likelihood of it being an obstruction caused by the band itself was highly unlikely*" (emphasis added).

At his pretrial deposition (at page 58), Dr. Castro admitted that he did not know the cause of the patient's continued nausea/vomiting, but decided that removal of the gastric band was appropriate as the last resort because the patient wanted it removed. As he explained (at page 58 of his pretrial deposition):

> "[I]t was difficult for me to understand why she would be having it [nausea/vomiting] at all, but the fact of the matter is that she was having it, and she was uncomfortable with it and she wanted her lap band [*i.e.*, gastric band] removed."

An untimed note by Dr. Castro reflecting his examination and advice to the patient on June 15 stated:

> "Surgery attending for Dr. Ferzli. Patient not tolerating liquid diet, with persistent nausea/vomiting. *Explained to patient*

> *options of placement feeding tube for nutritional support versus removal of lap band.* Risks/benefits/alternatives to removal of band [were] discussed with patient (including feeding tube), including bleeding, infection, intestinal injury, death, loss of pregnancy. Patient understands and wishes to have [the] lap band removed" (emphasis added).

Although the patient desired to have her gastric band removed, neither Dr. Castro nor his colleagues, Drs. Ferzli and Chaudry, considered this approach to be preferable to a feeding tube, which was less invasive and would have given her the required nutritional support (Castro Tr at 62-63). Dr. Castro testified (at pages 63-64 of his pretrial deposition) that he recommended to the patient to have a feeding tube placed, instead of having the gastric band removed. Despite his and his colleagues' medical judgment to the contrary, Dr. Castro agreed to perform surgery because the patient wanted surgery,[3] was "very adamant about wanting the band removed," and rejected his recommendation to have a feeding tube[4] (Castro Tr at 64, 71-72, 83). Dr. Castro explained (at page 65 of his pretrial deposition) that he could not exclude removal of the gastric band as part of his differential diagnosis because "she had something foreign in her GI tract . . . that we would want to exclude completely. We tried to exclude it functionally by getting an EGD [upper endoscopy]. The only way to exclude it without question would be to remove it altogether." Dr. Castro concluded (at page 66 of his pretrial deposition) that, in hindsight, "the band wasn't causing the

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[3] *See* Castro Tr at 62-63 (as corrected), stating, "As a matter of practice, unless there's overwhelming favor in one versus the other, I typically leave treatment decisions to the patient."

[4] *See* Castro Tr at 90, stating, "I wouldn't say that she was following my advice."

obstruction." He quantified (at page 67 of his pretrial deposition) at 50-50 the success of having the patient's nausea/vomiting resolved by the removal of the gastric band. Similarly (at page 69 of his pretrial deposition), he quantified at 50-50 the success of having the patient's nausea/vomiting resolved by the placement of a feeding tube. However, he testified (at pages 75-76, 84 of his pretrial deposition) that he owed no obligation to the patient *not* to pursue a course of treatment whose risks outweighed its benefits, unless such course of treatment subjected the patient to any "undue harm," which was not the case with this surgery. Thus, after the patient was seen at the bedside by all three surgeons (Drs. Castro, Ferzli, and Chaudry), the patient was scheduled for surgery the next day (Castro Tr at 80). In Dr. Castro's words, "we needed to offer her something," even if that offer ultimately "may or may not have done anything to relieve her symptoms" (Castro Tr at 78). The three surgeons (Drs. Castro, Ferzli, and Chaudry) "were all in agreement if this is the way the patient wanted to proceed, that's the way [they] would proceed," subject to the "operating room availability and timing and surgeon availability that someone in the[ir] group would perform the [band] removal" (Castro Tr at 88-89).

An 11:22 A.M. note on June 15 stated that the patient's physical examination was positive for tenderness in the left upper quadrant of her stomach. At 1 P.M., she received Maalox. At 2 p.m., the patient had an oral intake, which was "fair" (50-74%), according to the daily nursing antepartum assessment records. The fluid balance records reflected that the patient received 150 cubic centimeters (about 5 fluid ounces) of soup at 5-6 P.M. and an

additional 50 cubic centimeters (about 1.7 fluid ounces) of soup at 8-9 P.M. on that day. A 2:20 P.M. nursing note stated that the patient had no nausea/vomiting. A 4:25 P.M. anesthesia note stated, "no anesthetic complication noted." Some time in the evening (no time specified), the patient had another oral intake, which was also "fair," according to the daily nursing antepartum assessment records. In anticipation of the next day's surgery, the patient was placed NPO starting at midnight. At 9:30 P.M., she received Demerol and Vistaril for pain.

June 16, 2004 (Surgery; Recovery Room; Discharge to the L&D Service; Patient's Sudden Deterioration)

On June 16, a 3:30 A.M. nursing note stated that the patient had complained of slight nausea. She was spitting up white "fluid" (phlegm). The patient complained of discomfort in the left upper quadrant of her stomach. An untimed perinatology note stated that the patient was having mild to moderate abdominal pain and was positive for vomiting. According to the physicians' orders section of the hospital records, the patient received Demerol and Vistaril at 2:45 A.M. The patient remained NPO. A 9 A.M. nursing note indicated that the patient was not vomiting. According to the vital sign records, the patient's blood pressure, as measured at midnight, at 4 A.M., and at 8 A.M. ranged from 91/60 to 108/67.

A 9 A.M. nursing note stated that the patient understood the nature of surgery and consented to it. Between 9:45 A.M. and 10:45 A.M., Dr. Castro, with surgical assistance of Dr. Chaudry and with Dr. Bauer serving as the anesthesiologist, removed the gastric band.

Dr. Castro's operative report indicated that the patient's pre- and post-operative diagnoses were "gastric obstruction." According to Dr. Castro's operative report and his pretrial deposition testimony, the patient's surgery was uneventful. The operative anesthesia record by Dr. Bauer stated that the patient underwent 1½ hours of anesthesia from 9:30 A.M. to 11 A.M. An untimed pre-anesthesia note by Dr. Bauer indicated that the patient had a rating of III (a severe systemic disease, such as a morbid obesity) under the guidelines of the American Society of Anesthesiologists. At the conclusion of the patient's surgery at 10:45 A.M., Dr. Bauer administered Anzemet (an antinauseant and antiemetic) and Toradol. An operating room check for her gag reflex was positive, and no retching, vomiting, or obstruction was noted. A 10:45 A.M. nursing note stated, "as per surgery, [the] patient could have [a] clear liquid diet for [a] couple of days. Could be discharged home in A.M. if no complications are [identified]. Patient has [an] appointment with surgery next Wednesday [*i.e.*, one week after surgery]. Patient to be given Pepcid by mouth upon discharge." The plaintiff was extubated in the operating room and transferred to the recovery room in stable condition.

A recovery room nursing note stated that the patient was admitted to the recovery room at 11 A.M. and discharged at 12:30 P.M. An 11:00 A.M. recovery room admission note by Dr. Bauer stated that, upon admission to the recovery room, the patient's oxygen saturation was 100%. During her 1½-hour stay in the recovery room, the patient was on supplemental oxygen delivered by nasal cannula at 3 liters per minute. Her first reading of

oxygen saturation at 11 A.M. was 96%. Her last reading of oxygen saturation at 12:15 P.M. was 95%. Her oxygen supplementation was turned off at 1 P.M. It appears that her oxygen saturation was not measured between 1 P.M., when her supplemental oxygen was turned off, and 3:19 P.M. In the additional comments section of the recovery room nursing note, the nurse on duty (Nurse Melissa Weber) indicated that the patient was not complaining of pain and had not experienced nausea/vomiting. In the same section of her note, the nurse on duty indicated that the patient was "tolerating ice chips," thus suggesting that she provided the patient with ice chips. In an untimed recovery room discharge note, anesthesiologist Dr. Coopersmith approved the release of the patient to the L&D service. It does not appear from Dr. Coopersmith's note that the patient was connected to supplemental oxygen upon her discharge from the recovery room to the L&D service.[5]

The patient was admitted to the L&D service at 1 P.M. At 1:30 P.M., she was given Pepcid intravenously. At 3 P.M., she received Demerol and Phenergan intravenously. A 3:20 P.M. "late entry" nursing note indicated that the patient complained of difficulty breathing.[6] Dr. Muralikrishnan (an obstetrical resident), Dr. Li (an anesthesiologist), and an unnamed surgeon were then at the patient's bedside. According to this nursing note, the

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[5] According to Dr. Bauer (at pages 74-75 of his deposition), he did not recall whether the patient was receiving oxygen by nasal cannula when he arrived at her bedside at about 3:30 P.M.

[6] The assertion of plaintiffs' expert (in ¶ 19 of his/her supplemental affirmation) that a late entry nursing note made it clear that by 3:20 P.M. the patient was "continuing" to have difficulty breathing is without factual support. The note does not use the word "continuing" and does not suggest the existence of any respiratory difficulty before 3:20 P.M.

patient's oxygen saturation was at 80-82%.[7] In fact, the patient's oxygen saturation, as measured at 3:19 P.M., was 73.3%. Arterial blood-gas levels were obtained at 3:19 P.M., reporting that the patient's Po_2 was 38.7 mmHg (normal 80-100), which suggested oxygen deficiency. Dr. Bauer was summoned and he arrived at the patient's bedside in a "couple of minutes" at 3:30 P.M. (Bauer Tr at 72, 80). At 3:30 P.M., administration of oxygen by non-rebreather mask at ten liters per minute, as directed by Dr. Bauer, was in progress. An additional untimed nursing note stated that the patient's blood pressure was 74/32. Despite the administration of oxygen at 100% by non-rebreather mask, the patient remained in respiratory distress, although her blood pressure rose slightly to 95/50. Per Dr. Bauer's instructions, the patient then received Albuterol (a bronchodilator) by a nebulizer, but her oxygen saturation failed to improve. A few minutes later, Dr. Bauer intubated the patient and connected an Ambu-bag to her endotracheal tube. Dr. Bauer and others manually squeezed the Ambu-bag for at least one hour to deliver oxygen to her (Bauer Tr at 96). At some point, he transported her to the surgical Intensive Care Unit (ICU), with the assistance of, among others, the defendant Dr. Mary Nalbandian, for connection to a ventilator. The patient arrived at the ICU at or after 4:35 P.M., according to a note by the defendant Dr. Pamela Bowen. The patient was placed on a ventilator at 5 P.M. Dr. Bauer remained at the patient's bedside at the ICU until 5:15 P.M. when he wrote his note.

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7. "An oxygen saturation level below 90% is not normal, and a level below 88% is 'bad.' A level of 70% is indicative of hypoxemia, which shows that the blood has a low level of oxygen, and indicates a danger of respiratory distress" (*Cregan v Sachs*, 65 AD3d 101, 105 [1st Dept 2009]).

A 4:35 P.M. ICU/critical care medicine note by Dr. Pamela Bowen stated in the assessment/plan portion of her note, "respiratory failure/shock. Full ventilator support . . . Cannot rule out thromboembolitic disease, though likely ARDS [acute respiratory distress syndrome] etiology. [Question mark] aspiration." Dr. Pamela Bowen ordered a spiral CT scan to rule out pulmonary embolism. This scan was performed two days later on June 18.

A 5 P.M. ICU nursing note stated that the patient was received from the L&D service intubated, accompanied by an anesthesiologist, and Ambu-bagged at 100% of Fio_2 (concentration of oxygen in the inspired air). The note further stated that when the patient was connected to a cardiac monitor, she became restless. Her facial area was cyanotic. A 5 P.M. surgical attending note stated that, despite the ventilator settings of the positive end-expiratory pressure at 15 and Fio_2 at 100%, the patient's oxygen saturation was only at 92%. According to the critical care clinical records, the patient's oxygen saturation fluctuated between 81% and 93% in her first hour on the ventilator between 5 P.M.-6 P.M. According to the same records, her blood pressure was low at 80/31 at 5:45 P.M. and at 76/23 at 6 P.M., necessitating repeated injections of ephedrine. A 7 P.M. ICU nursing note stated that the patient's blood pressure dropped to 74/32. According to the ICU nursing note, when the patient failed to respond to a challenge of two liters of fluid via a nasogastric tube, she was started on Levophed (a vasopressor) to boost her blood pressure. She also was placed on Heparin (an anticoagulant) to prevent any clotting that could result from her immobility.

At 4:41 P.M., a chest X ray found pulmonary congestion and possible early infiltration of her right lower lobe. At 6 P.M., a chest X ray revealed that the patient's lungs contained "mild pulmonary venous congestion, small left pleural effusion and right and mid and lower lobe infiltrates with air bronchogram." At 9:49 P.M., a repeat chest X ray stated, "[t]here is interval increased in the pulmonary venous congestion and the small bilateral pleural effusion as compared to the [6 P.M.] exam . . ." An ultrasound of the patient's legs, performed at 9:38 P.M., found no evidence of deep venous thrombosis at or above of her popliteal veins. Arterial blood-gas levels at 7:44 P.M. and 11:23 P.M. were outside the normal range in each of the categories of Pco_2, Po_2, and Hco_3, indicative of the patient's ongoing respiratory distress, despite her oxygen saturation at 93.6-99.5% on the ventilator.

June 17-29, 2004 (Continuing Deterioration; Death)

On June 17, an untimed pulmonary attending note described adjustments in ventilator settings to increase the patient's oxygen saturation to 92-94%. Her blood pressure was 97/48, despite prior administration of Levophed. She continued on Propofol for sedation and on Heparin for anticoagulation. Her extremities were positive for edema (swelling). The assessment/plan were respiratory failure, acute respiratory distress syndrome secondary to aspiration versus pulmonary embolism. A 1:39 P.M. chest X ray noted an interval improvement of the pulmonary venous congestion as compared to the prior exam, but revealed that the endotracheal tube was incorrectly placed in the right main bronchus and should be pulled out by 3 cm. A 2:20 P.M. note stated, "Assessment/Plan: respiratory failure,

respiratory distress syndrome. Pulmonary embolism was less likely, but could not be excluded."

On June 18, a 2 A.M. nursing note stated, "suctioned off minimal to moderate amounts of blood tinged secretions." The patient remained on Levophed to maintain her blood pressure, which was then at 90/50-93/49. Her respiration rate was 14, and her oxygen saturation was 94-97%. A typewritten report of a spiral CT scan with infusion, performed on that date, stated that the radiologist could not be determined whether the patient had (or did not have) pulmonary embolism because of the suboptimal techniques used, and that the patient should undergo another spiral CT scan with proper techniques or, in the alternative, a lung ventilation/perfusion (V/Q) scan. No CT scan or a V/Q scan was subsequently performed to rule out pulmonary embolism. Rather, the treating physicians interpreted the CT scan results as a finding of no pulmonary embolism. Specifically, a 1:45 P.M. surgical attending note stated that a spiral CT scan, in a preliminary report, found no evidence of central pulmonary embolism. Unfortunately, a spiral CT scan found that the patient suffered from bilateral air space disease with ground glass opacities. An undated pulmonary attending note diagnosed the patient with acute respiratory distress syndrome/respiration pneumonia.

Between June 19 and 28, the patient continued on mechanical ventilation. By June 22, she incurred a barotrauma with bilateral pneumothorax (collapsed lungs), which required the placement of chest tubes. A June 22nd operative report by a staff physician concisely summarized the history of the patient's care at LMC:

> "This patient is a 32-year-old female who is approximately 20 weeks pregnant. She presented due to persistent and

> unrelenting nausea and vomiting. The patient had undergone laparoscopic banding of the stomach two years prior. This banding procedure was reversed on the 16th. Immediately postoperatively, she experienced respiratory distress requiring intubation and has been on a ventilator since then. She has required high PEEP on the ventilator. At 7:30 P.M. on the 21st of June, it was noted that the patient developed sudden desaturation with massive subcutaneous emphysema [*i.e.*, the presence of air or gas in the subcutaneous tissues]. Bilateral chest tubes were placed at that time. I was called at noontime on the 22nd due to concern over positioning of the right-sided chest tube. This chest tube required removal and new insertion of tube."

Further complications developed, and the patient died at LMC in the late evening of June 28. Her unborn child died with her.

The Standard of Review

"The proponent of a summary judgment motion must make a prima facie showing of entitlement to judgment as a matter of law, tendering sufficient [non-hearsay] evidence to eliminate any material issues of fact from the case" (*Winegrad v New York Univ. Med. Ctr.*, 64 NY2d 851, 853 [1985]). "Failure to make a prima facie showing requires denial of the motion, regardless of the sufficiency of the opposing papers" (*id.*). Once the proponent's burden is met, the burden shifts to the opposing party to establish the existence of a material issue of fact (*see Alvarez v Prospect Hosp.*, 68 NY2d 320, 324 [1986]).

To establish the liability of a physician for medical malpractice, "a plaintiff must prove that the physician . . . departed from accepted community standards of practice, and that such departure was a proximate cause of the plaintiff's injuries" (*Stukas v Streiter*, 83 AD3d 18, 23 [2d Dept 2011]). A defendant physician seeking summary judgment must

make "a prima facie showing that there was no departure from good and accepted medical practice or that the plaintiff was not injured thereby" (*id.* at 24). To defeat summary judgment, "the nonmoving party need only raise a triable issue of fact with respect to the element of the cause of action or theory of nonliability that is the subject of the moving party's prima facie showing" (*id.*). "General allegations that are conclusory and unsupported by competent evidence tending to establish the essential elements of medical malpractice are insufficient to defeat a defendant's motion for summary judgment" (*Savage v Quinn*, 91 AD3d 748, 749 [2d Dept 2012]). A plaintiff's expert must address all of the pivotal facts relied upon by the defendant's expert in order to establish the existence of a material issue of fact (*see Dimitri v Monsouri*, 302 AD2d 420, 421 [2d Dept 2003]).

LMC and Dr. Muralikrishnan

In support of their joint motion for summary judgment, defendants LMC and Dr. Muralikrishnan submit the uncertified, partially complete hospital records and an affirmation of their expert, Dr. Henry K. Prince, a board-certified obstetrician and gynecologist. Based on these uncertified and partially complete hospital records, as well as the deposition testimony, he opines to a reasonable degree of medical certainty that LMC and Dr. Muralikrishnan conformed with accepted standards of medical practice at all times and did not proximately cause any of the patient's injuries.

As to LMC, Dr. Prince opines that the LMC staff appropriately treated the patient for her initial complaints of nausea and vomiting on June 8 and 9, 2004. Dr. Prince states that the LMC staff: (1) appropriately kept the patient NPO in light of her inability to tolerate any

diet, (2) properly monitored the patient before and after her surgery, (3) appropriately intubated, extubated, and re-intubated the patient, (4) maintained her proper ventilation and respiration, (5) appreciated the significance of her complaints, signs, and symptoms, and (6) properly informed her of the risks concerning her treatment.

As to Dr. Muralikrishnan, Dr. Prince states that Dr. Muralikrishnan's treatment of the patient was appropriately limited to his area of obstetrics and gynecology, such as examining the patient and monitoring fetal movement and heart beat. Dr. Prince further states that Dr. Muralikrishnan properly deferred to the surgical team when he first saw the patient on June 14, 2004 and, after noting her vomiting and inability to tolerate any diet, referred her to the surgical service. According to Dr. Prince, Dr. Muralikrishnan also properly deferred to the surgical team when he next saw the patient on June 16 after her surgery. Dr. Prince emphasizes that Dr. Muralikrishnan rendered no treatment with respect to the gastric band removal and was not involved in the decision to intubate, extubate, or re-intubate the patient.

Dr. Prince's opinion that neither LMC nor Dr. Muralikrishnan deviated from the accepted standards of medical care is derived from his review of the hospital records. The hospital records, as submitted to the Court, are uncertified. They are also incomplete. For example, a June 16, 2004 Progress Notes states, "(*continued*) to MICU under Dr. Castro (Dr. Ferzli's associate)" (emphasis added). The preceding page in the hospital records is

missing. Dr. Castro at his pretrial deposition (at pages 158-159) so confirmed.[8] Dr. Ferzli further acknowledged at his pretrial deposition (at page 36) that some entries in the hospital records were missing.[9] The Court, in its own review of the hospital records, found that the entries for June 13, 2004 are largely missing. Curiously, a physician's report for a wrong individual is included in the patient's hospital records.[10] In this regard, the Court notes that LMC's counsel states (in ¶ 10 of his affirmation) that "relevant LMC records" are annexed.

As out-of-court declarations offered for their truth, the hospital records are hearsay documents and inadmissible unless they fall within an exception to the hearsay rule. It is well established that "entries made in a hospital record relevant to diagnosis and treatment qualify for admission as prima facie evidence of the facts contained in the record under a statutory business records rule (CPLR 4518 [a]), and special statutory provisions (CPLR 4518 [c], 2306)" (*Wilson v Bodian*, 130 AD2d 221, 229 [2d Dept 1987]).

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[8] The following colloquy at Dr. Castro's pretrial deposition is pertinent:

"Q. Doctor, with regard to this continued note that we have, did you ever see the rest of that note in the chart?
A. No.
Q. . . . Did you notice that it was missing?
A. I did not, no.
Q. When is the first time that you noticed that it was missing? . . .
A. In reviewing a copy of the chart.
Q. When was that?
A. A few days ago."

[9] When asked at his pretrial deposition (at page 36) whether "the chart we have here today that has been produced by the hospital doesn't have any notes for June 9th, 10th, 11th, 12th; is that correct," Dr. Ferzli answered, "I believe so, from what I reviewed, yes, with my attorney."

[10] This is a report of a chest X ray for a 50-year male patient with a history of broken ribs (*see* Medical Record No. L634340).

Accordingly, hospital records are routinely admissible by certification under CPLR 4518 (c) and 2306 (*id.*).[11]

Here, the LMC hospital records are not certified as required by CPLR 4518 (c) and, therefore, are inadmissible under that provision (*see JaJoute v New York City Health & Hosps. Corp.*, 242 AD2d 674, 676 [2d Dept 1997], *lv dismissed* 91 NY2d 887 [1998], *rearg denied* 92 NY2d 846 [1998] [without evidence in the record on appeal that the hospital records were certified, the hospital records did not appear to be in admissible form]; *Vazquez v Radnay*, 2012 WL 3134202, 2012 NY Slip Op 31872[U] [Sup Ct, Suffolk County 2012] [denying summary judgment to defendants on the alternative ground that the uncertified and partial hospital records were not in admissible form]).

Next, inasmuch as the LMC hospital records are inadmissible under CPLR 4518 (c), a foundation witness is required to establish compliance with the prerequisites of

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[11] CPLR 4518 (c) provides, in relevant part, that:

> "All records, writings and other things referred to in sections 2306 [hospital records] . . . are admissible in evidence under this rule and are prima facie evidence of the facts contained, *provided they bear a certification or authentication by the head of the hospital, laboratory, department or bureau of a municipal corporation or of the state, or by an employee delegated for that purpose or by a qualified physician*" (emphasis added).

CPLR 2306, which is referred to in the aforementioned provision, states, in relevant part, that:

> "(a) Where a subpoena duces tecum is served upon a hospital, or upon a department or bureau of a municipal corporation or of the state, or an officer thereof, requiring the production of records relating to the condition or treatment of a patient, a transcript or a full-sized legible reproduction, *certified as correct* by the superintendent or head of the hospital, department or bureau or his assistant, or the officer, may be produced unless otherwise ordered by a court" (emphasis added).

CPLR 4518 (a)[12] to ensure their admissibility as business records (*see People v Mertz*, 68 NY2d 136, 148 [1986] [statements concerning the validity of a medical test are admissible as a business record if there is "either proper foundation testimony under CPLR 4518 (a) *or* a proper CPLR 4518 (c) certificate"] [emphasis added]). The moving defendant LMC has proffered no foundation witness to establish the admissibility of its hospital records. Likewise, the moving defendant Dr. Muralikrishnan has failed to establish the admissibility of his individual entries in the hospital records because he has submitted no affidavit authenticating his individual entries.[13] Hence, Dr. Prince's opinion, which is based on the inadmissible, incomplete hospital records, cannot be considered in support of the summary judgment motion by LMC and Dr. Muralikrishnan. Accordingly, the joint motion of the defendants LMC and Dr. Muralikrishnan for summary judgment under sequence No. 14 is denied without regard to the sufficiency of plaintiffs' opposition papers (*see Winegrad v New York Univ. Med. Ctr.*, 64 NY2d 851, 853 [1985]).[14]

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[12] CPLR 4518 (a) provides, in relevant part, that:

> "Any writing or record, whether in the form of an entry in a book or otherwise, made as a memorandum or record of any act, transaction, occurrence or event, shall be admissible in evidence in proof of that act, transaction, occurrence or event, if the judge finds that it was made in the regular course of any business and that it was the regular course of such business to make it, at the time of the act, transaction, occurrence or event, or within a reasonable time thereafter."

[13] Dr. Muralikrishnan, to date, has not been deposed. He thus has had no opportunity, before making the instant motion, to authenticate his entries in the hospital records.

[14] The Second Department's decision in *Christopherson v Queens-Long Is. Med. Group, P.C.*, 17 AD3d 393 (2005), is distinguishable. In *Christopherson*, the Second Department granted a hospital's motion for summary judgment on the grounds that a referring physician was not its agent. The Second Department rejected the plaintiff's argument, raised for the first time on appeal,

Dr. Nalbandian and Dr. Bauer

Anesthesiologists Dr. Nalbandian and Dr. Bauer also move for summary judgment. With respect to Dr. Nalbandian, who has been deposed and whose only involvement in the patient's care was assisting in transporting the patient to the ICU, plaintiffs do not appear to oppose her motion, as their expert does not refer to her in the affirmations in opposition. Thus, the branch of the amended motion under sequence No. 15 for summary judgment dismissing all claims and cross claims insofar as asserted against Dr. Nalbandian is granted without opposition.

(I)

Dr. Bauer, as noted, provided anesthesia to the patient during her surgery, discharged her to the recovery room, subsequently re-intubated her in the L&D service and had her transported to the ICU. In support of the branch of the amended motion for summary judgment dismissing all claims and cross claims against Dr. Bauer, he submits expert affirmations of Wendy Silverstein, M.D., a New Jersey licensed physician and a board-

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that the hospital records were uncertified. In so ruling, the Second Department further held (at page 394) that the issue of certification of hospital records was irrelevant to the question of the referring physician's apparent agency. Here, however, the hospital records are not only uncertified, but they are also incomplete. The incompleteness of the hospital records goes to the heart of the matter of the propriety of the patient's care. The moving defendant LMC cannot make a prima facie showing of the propriety of the patient's care by its staff without submitting a complete set of its hospital records. Separately, the moving defendant Dr. Muralikrishnan cannot make a prima facie showing of the propriety of his care of the patient without submitting an affidavit authenticating his entries in the hospital records.

certified anesthesiologist.[15] Based upon her review of, among other things, the pleadings, deposition transcripts, and Dr. Bauer's entries in the hospital records, Dr. Silverstein opines that: (1) Dr. Bauer properly administered anesthesia to the patient during surgery, (2) the patient's stable condition in the recovery room indicated that Dr. Bauer's administration of anesthesia to her during surgery was appropriate and did not cause the patient's subsequent injuries, (3) the patient's symptoms at 3:20 P.M., while she was in the L&D service, were not related to the anesthesia delivered to her three-four hours prior on that day and that, if there had been a problem with anesthesia, the patient would have experienced it earlier while she was in the recovery room, (4) Dr. Bauer correctly decided to, and did, intubate the patient at about 3:30 P.M., and (5) Dr. Bauer appropriately transported the patient to the ICU.

The Court finds that Dr. Bauer has made a prima facie showing of his entitlement to judgment as a matter of law through the affirmation of his expert physician and his entries in the hospital chart. At his pretrial deposition, Dr. Bauer identified his entries in the hospital records and authenticated them, thereby rendering them admissible as business records pursuant to CPLR 4518 (c). The burden, therefore, shifts to plaintiffs to rebut Dr. Bauer's prima facie showing.

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[15] Pursuant to CPLR 2106, only a physician who is licensed to practice in New York is authorized to sign an affirmation; an out-of-state physician must make his or her statement by affidavit. Dr. Silverstein is licensed in the State of New Jersey, and as such, her affirmations are technically defective under CPLR 2106. However, this deficiency of form is deemed waived because plaintiffs have not raised the issue in opposition (*see Scudera v Mahbubur*, 299 AD2d 535 [2d Dept 2002]).

(2)

The Court finds that plaintiffs have failed to rebut Dr. Bauer's prima facie showing. First, plaintiffs criticize Dr. Bauer (in ¶ 20 of their expert's supplemental affirmation[16]) for not signing his 3:30 P.M. note until 5:15 P.M. However, as Dr. Bauer explained (at page 80 of his pretrial deposition), he arrived at the patient's bedside at 3:30 P.M., worked on her continuously from 3:30 P.M. until 5:15 P.M. to restore her breathing, and wrote his note when, at the conclusion of his efforts, she had already been connected to a ventilator in the ICU. Second, plaintiffs assert (in ¶ 20 of their expert's supplemental affirmation) that "the failure to timely attend to and intubate the patient by the hospital's *anesthesiologist* is an additional violation of safe and accepted medical practice . . ." (emphasis added). The word "anesthesiologist," as used in the supplemental affirmation of plaintiffs' expert, is susceptible of two meanings because at least two anesthesiologists were involved in the patient's care on June 16: Dr. Bauer initially provided anesthesia and subsequently intubated the patient at the L&D service, while Dr. Coopersmith had been in charge of the patient while she was in the recovery room and signed her out of the recovery room to the L&D service.[17] It is undisputed that Dr. Bauer intubated the patient promptly after he was called to her bedside in the L&D service and after his prior efforts to improve her oxygen saturation (oxygen via non-rebreather mask and Albuterol via nebulizer) had failed. The duty of Dr. Bauer as an

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[16] Because the supplemental affirmation of plaintiffs' expert subsumes in content their expert's initial affirmation, the Court refers to the supplemental affirmation only.

[17] In addition, anesthesiologist Dr. Li was at the patient's bedside at 3:20 P.M. on June 16.

anesthesiologist was limited to "those medical functions undertaken by the physician and relied on by the patient" (*Wasserman v Staten Is. Radiological Assoc.*, 2 AD3d 713, 714 [2d Dept 2003] [internal quotation marks omitted]).[18] His duty was limited to providing the patient with anesthesia during surgery and to providing her respiratory support when he was called to the patient's bedside. He was not required to monitor the patient continuously. The claim that Dr. Bauer did not owe any postoperative duty is supported by the hospital records indicating that Dr. Coopersmith, who was in charge of the recovery room, released the patient from the recovery room to the L&D service. It was the duty of Dr. Coopersmith, not of Dr. Bauer, to monitor the patient while she was in the recovery room and to determine whether she was ready to be released to the L&D service.

Third, plaintiffs contend (in ¶ 33 of their expert's supplemental affirmation) that "the [hospital] records indicate that the patient began having difficulty breathing while in the recovery room, yet no treatment for this condition was rendered by the hospital staff." However, the hospital records before the Court do not reflect that the patient was in any distress in the recovery room. To the contrary, the hospital records indicate that the patient was alert and oriented as to person, place and time, and that her oxygen saturation was within

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[18] In *Wasserman*, the Second Department held that an internist and three general surgeons established their prima facie entitlement to summary judgment by presenting evidence which showed that they did not depart from good and accepted medical practice by deferring to the orthopedic specialists for the assessment and treatment of the plaintiff's ankle, and that they could not be charged with a duty to diagnose a nerve disorder in the plaintiff's ankle, since they were not involved in this aspect of her care. In *Boone v North Shore Univ. Hosp. at Forest Hills* (12 AD3d 338 [2004]), the Second Department reaffirmed the holding in *Wasserman*, when it ruled that a urologist's duty of care did not extend to the treatment rendered by a general surgeon.

normal limits at the points of both her admission to, and discharge from, the recovery room. Significantly, plaintiffs fail to identify any of the hospital records from which their expert derived this conclusion (*see Lahara v Auteri*, 97 AD3d 799 [2d Dept 2012] [plaintiff's expert affirmation was conclusory, speculative, and without basis in the record, and, thus, was insufficient to defeat defendants' motion for summary judgment]; *Shahid v New York City Health & Hosps. Corp.*, 47 AD3d 800, 802 [2d Dept 2008] [rejecting the expert's opinion that was based upon a string of assumptions not supported by facts in the record]).[19]

Fourth, plaintiffs point out (in ¶ 18 of their expert's supplemental affirmation) to the recovery room nursing note in which a nurse on duty (Nurse Weber) indicated that the patient was "tolerating ice chips," thus suggesting that she provided the patient with ice chips while the patient was in the recovery room. According to an excerpt from Nurse Weber's deposition (at page 49 thereof), Nurse Weber gave the patient ice chips to alleviate the dryness of her mouth.[20] Plaintiffs characterize Nurse Weber's administration of ice chips to the patient – the volume of ice chips is not disclosed by the hospital record – as an egregious

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[19] Although the *Shahid* decision was subsequently criticized on other grounds in *Stukas v Streiter*, 83 AD3d 18 (2d Dept 2011), the specific holding for which this case is cited herein remains good law.

[20] Excerpts from Nurse Webber's deposition transcript are reproduced in Exhibits E, F, and G of the supplemental reply affirmation of LMC and Dr. Muralikrishnan.

violation of the applicable standards of medical care.[21] According to plaintiffs' expert (in ¶ 18 of his/her supplemental affirmation):

> "[N]either the *anesthesiologist* nor the [recovery room] nurse noted that the patient was to be NPO [nothing by mouth] in the [recovery room]. The failure of the *hospital anesthesiologist* and [the recovery room] personnel to place and maintain this patient on NPO status was a significant deviation from safe and accepted medical practice. Had the nurse not administered the ice chips, . . . the patient would not have vomited, aspirated, progress[ed] to multi-organ failure & ultimately died" (emphasis added).

The flaw in the expert's analysis is the imposition of a non-existing legal duty on Dr. Bauer. As stated, Dr. Bauer's involvement in the patient care was limited. It was Dr. Castro, the operating surgeon, not Dr. Bauer, who determined whether the patient should be placed on the NPO status post-operatively. It was Dr. Castro who, as per his pretrial deposition testimony, decided that the patient should no longer be kept NPO post-operatively. Moreover, it was Dr. Coopersmith, not Dr. Bauer, who monitored the patient's status in the recovery room and who signed her out to the L&D service. It was not Dr. Bauer's duty to check upon and override Dr. Castro's order to remove the patient from the NPO status. Nor

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[21] In his further reply (in ¶ 16), Dr. Bauer points out that the "ice chips" theory was never pleaded in plaintiffs' bills of particulars. However, the "use of an unpleaded defense in a summary judgment motion is not prohibited as long as the opposing party is not taken by surprise and does not suffer prejudice thereby" (*Rosario v City of N.Y.*, 261 AD2d 380, 380 [2d Dept 1999]). "[T]he key is not what is in the pleadings, but whether the moving party was surprised or prejudiced" (*Valenti v Camins*, 95 AD3d 519, 523 [1st Dept 2012]). Here, both Drs. Bauer and Castro were extensively questioned about the propriety of keeping the patient NPO post-operatively, thus indicating plaintiffs' concern with the patient receiving ice chips in the recovery room. Moreover, by leave of court, Drs. Bauer and Castro each submitted surreplies in which they addressed plaintiffs' "ice chips" theory.

was it Dr. Bauer's legal duty to check up on his fellow anesthesiologist Dr. Coopersmith. As set forth in the supplemental affirmation of Dr. Bauer's expert (Dr. Silverstein) in ¶ 24, "it is not the standard of care for an anesthesiologist to author a post-operative note regarding diet or NPO absent extreme circumstances that did not exist in this case." Therefore, because Dr. Bauer owed no duty to the patient upon his transfer of her from surgery to the recovery room, he cannot be held liable for Nurse Weber's administration of ice chips, particularly when the patient she was no longer NPO. Significantly, plaintiffs' expert does not opine that Dr. Bauer should have overridden Dr. Castro's order revoking the patient's NPO status.

Fifth, plaintiffs assert (in ¶ 32 of their expert's supplemental affirmation) that "the patient was clearly in respiratory distress by 3:30 P.M. while in the regular room. But again, the patient was not intubated until after suffering a prolonged period of hypoxia." However, Dr. Bauer merely responded to a hypoxic event, and he promptly intubated the patient after his less intrusive attempts at improving her oxygen saturation failed. According to Dr. Bauer's expert (in ¶ 40 of her supplemental affirmation), his being called at about 3:20 P.M. and his being at the patient's bedside by 3:30 P.M. constituted "timely attention according to accepted standards of care and clinical practice." More importantly, Dr. Bauer's expert maintains – and his entries in the hospital records so confirm – that Dr. Bauer could not have caused a hypoxic event because, by the time he arrived, the patient was already hypoxic (*see Kaplan v Hamilton Med. Assoc.*, 262 AD2d 609, 610 [2d Dept 1999] [granting summary

judgment to defendant physicians who demonstrated, by expert affidavit, that the patient was already in need of a medication by the time the patient first presented to the physicians]).

Lastly, plaintiffs contend (in ¶ 37 of their expert's supplemental affirmation) that the patient's death would have been avoided if she had been properly diagnosed and treated by Dr. Bauer, Dr. Muralikrishnan, and the LMC staff who were each responsible for monitoring and treating the patient following her surgery. This opinion on causation is unacceptably conclusory and does not adequately differentiate between the different defendants who treated the patient at different times (*see Micciola v Sacchi*, 36 AD3d 869, 871 [2d Dept 2007]).[22]

Accordingly, the branch of Dr. Bauer's amended motion under sequence No. 15 for summary judgment dismissing all claims and cross claims insofar as asserted against him is granted. The complaint and all cross claims, insofar as asserted against Dr. Bauer, are hereby dismissed.

Dr. Castro, Dr. Ferzli, and George Ferzli, M.D., P.C.

Dr. Castro, the operating surgeon, his employer, George Ferzli, M.D., P.C., and the employer's owner, Dr. Ferzli (collectively, the defendant surgeons), cross-move for summary judgment dismissing all claims insofar as asserted against them. In support of their cross

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[22] The Court is not concerned by the fact that plaintiffs' expert, a board-certified surgeon, criticizes the medical care rendered by an anesthesiologist. "A physician need not be a specialist in a particular field in order to qualify as a medical expert. Rather, any alleged lack of knowledge in a particular area of expertise is a factor to be weighed by the trier of fact that goes to the weight of the testimony" (*see Walsh v Brown*, 72 AD3d 806, 807 [2d Dept 2010] [internal citation omitted]).

motion, these defendants submit, among other things, the hospital records, the office records of George Ferzli, M.D., P.C., and pretrial deposition testimony of Dr. Castro and Dr. Ferzli. At their respective pretrial depositions, Dr. Castro identified and authenticated his individual entries in the hospital records and in the office records, while Dr. Ferzli identified and authenticated his individual entries in the office records. Accordingly, their respective individual entries in the LMC hospital records and in the office records, as applicable, are admissible as business records pursuant to CPLR 4518 (c).

(I)

In support of their cross motion, the defendant surgeons further submit expert affirmations of Dan Reiner, M.D., a New York state licensed physician who is board certified in surgery and surgical critical care. Dr. Reiner opines, to a reasonable degree of medical certainty, that the defendant surgeons acted in accordance with good and accepted surgical practice in obtaining the patient's consent, in performing surgery, and in providing post-operative care and treatment, and that the same was not a substantial factor in her injuries and death. With respect to the issue of the patient's consent and the need for surgery, Dr. Reiner asserts (in ¶ 10 of his opening affirmation) that, although the patient's upper endoscopy was within normal limits, "it is always an option for the patient to request and obtain removal of the lap band if other measures to reduce nausea and vomiting are unsuccessful." Dr. Reiner maintains (in ¶ 11 of his opening affirmation) that "[s]uch was the case for [the patient]," and "she requested, and consented to, laparoscopic removal of the lap band."

Next, Dr. Reiner opines that the defendant surgeons should be absolved from any responsibility regarding for the patient's post-operative care. "It is the responsibility of the recovery room team to determine when a patient is sufficiently recovered from anesthesia for discharge from the recovery room," Dr. Reiner opines (in ¶ 11 of his opening affirmation), and "[t]his facet of patient care is not the responsibility of the surgical team or surgeon." In this connection, Dr. Reiner distinguishes between a "surgical" and a "medical" event. According to Dr. Reiner (in ¶ 12 of his opening affirmation), "the record does not indicate that [the patient] subsequently suffered some type of *surgical* related event. Quite to the contrary, she suffered some type of *medical* event – namely some type of respiratory dysfunction which resulted in respiratory distress" (emphasis added). Dr. Reiner points out (in ¶ 14 of his opening affirmation) that the medical examiner's record suggests that the patient "sustained some type of respiratory event after the surgery after the patient was no longer in the acute surgical care of Dr. Castro." "It is for this reason," Dr. Reiner concludes (in ¶ 14 of his opening affirmation), that "the care and treatment by [the defendant surgeons] was not a substantial factor in the development of [the patient's] respiratory event, her pain and suffering, or her subsequent death." The Court finds that the defendant surgeons have made a prima facie showing of their entitlement to judgment as a matter of law through their expert's opening affirmation and their authenticated entries in the hospital records and in the office records.

(2)

In opposition, plaintiffs' expert disputes the validity of the contentions advanced by Dr. Reiner in his opening affirmation. With respect to the need for surgery, plaintiffs' expert contends that once the upper endoscopy revealed no obstruction, surgery to remove the gastric band became unnecessary and the patient, instead, could have been treated with intravenous fluids and vitamins until her nausea/vomiting was resolved. This general statement, however, lacks sufficient specificity or certainty to create a question of fact as to whether Dr. Castro's decision to perform surgery, in the face of the patient's continuing symptoms indicating an obstruction and Dr. Rivito's recommendation to consider removal of the gastric band, was a deviation from the standard of care (*see Helfer v Chapin*, 96 AD3d 1270, 1272 [3d Dept 2012]).

First, plaintiffs' expert fails to review the patient's history of complaints. Plaintiffs' expert ignores the fact that the patient was uncomfortable with her gastric band three months prior in March 2004 when, after more than a year's absence and three "no shows," she returned to the physicians' office and saw Dr. Castro. Plaintiffs' expert overlooks the fact that the patient complained of abdominal pain in the same location as was her gastric band during her initial visit to LMC on June 8, 2004. Plaintiffs' expert likewise overlooks the fact that the patient again complained of abdominal pain as well as of nausea/vomiting in her subsequent visit to LMC on June 10, 2004 and until her surgery six days later. In fact, the patient was in so much pain before (and after) surgery that she regularly received Demerol,

Phenergan, and Vistaril. In addition to pain and nausea/vomiting, the patient had reflux for which she received Pepcid and Maalox. Putting aside the patient's symptoms and suffering, plaintiffs' expert fails to address the technical aspects of the gastric band removal surgery, such as whether the gastric band had prolapsed or otherwise shifted and whether there were adhesions or other untoward complications from the initial placement of the gastric band. Surgery would have been prima facie unnecessary if plaintiffs' expert demonstrated that Dr. Castro, upon opening the patient, discovered that the gastric band was properly positioned.

Second, the results of the patient's upper endoscopy did not foreclose surgery. As an initial matter, plaintiffs' expert fails to note that the patient's upper endoscopy was performed with a *pediatric* endoscope, which is obviously thinner and shorter than a regular endoscope that is used on adults. The fact that a pediatric scope passed all the way through to the patient's duodenum merely ruled out a *complete* obstruction. Indeed, the upper endoscopy revealed a "[l]arge amount of fluid in the body proximal to [*i.e.*, above] the banding." If the patient had no obstruction whatsoever, she would not have had so much fluid in her esophagus and the performing physician Dr. Rivito would not have suggested removal of the gastric band.

Plaintiffs' expert focuses on distractions and grasps at straws in an attempt to bolster their position that surgery was unnecessary and unwarranted. In the view of plaintiffs' expert (in ¶ 16 of his/her supplemental affirmation), it was "*[a]pparently* unbeknownst to her [the

patient], this surgery was both unnecessary and unwarranted . . . ." (emphasis added). However, Dr. Castro's authenticated entries in the pertinent hospital, plus the consent form, indicate that the patient consented to surgery.[23] In this regard, the Court considers plaintiffs' position that surgery was not medically indicated as evidence of the allegedly negligent treatment and that plaintiffs do not have a separate claim for lack of informed consent (*see Benfer v Sachs*, 3 AD3d 781, 783 [3d Dept 2004]).

Next, plaintiffs' expert places undue emphasis on Dr. Castro's pretrial testimony (at pages 67-69 of his deposition) that the two alternatives which Dr. Castro presented to the patient – either surgery or a feeding tube – had an equal chance of success, even though surgery was obviously more risky than a feeding tube. Plaintiffs' expert posits (in ¶ 25 of his/her supplemental affirmation) that "[w]hen a doctor is confronted with a condition that can be treated in multiple ways, and each course of treatment, has roughly the same chance of success, the doctor must cho[o]se the course of treatment that poses the least risk to the patient." "Therefore," plaintiffs' expert maintains (in ¶ 25 of his/her supplemental affirmation), "the failure of Dr. Castro to cho[o]se the least risky course of treatment needless[ly] endangered this patient . . . [and] was a violation of safe and accepted medical practice [and] caused the patient's injuries . . . [and] death." Plaintiffs' argument proceeds from a wrong premise. The decision whether to have surgery, or not, was the patient's to

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[23] Plaintiffs have submitted no deposition testimony, if any, from the patient's boyfriend (the father of her unborn child) or her sister, both of whom visited the patient throughout her hospitalization, indicating that the patient did not want surgery or did not understand its risks.

make. The patient was the decision maker; Dr. Castro, her adviser and surgeon. Before the patient was admitted to LMC, Dr. Castro and Dr. Ferzli both suggested to the patient to take time to think about surgery. In March 2004, Dr. Castro informed the patient that surgery in her first trimester was contraindicated. In early June 2004, Dr. Ferzli advised the patient to wait until after delivery to revisit the status of her gastric band. During her admission to LMC, Dr. Castro advised the patient to consider non-surgical intervention. The patient, however, insisted that she wanted her gastric band removed. The patient was mentally competent. There was no evidence of a language barrier precluding her from understanding the risks and alternatives to surgery. Dr. Castro is bilingual in English and Spanish, the patient's native language. As the defense expert Dr. Reiner opines (in ¶ 4 of his reply affirmation), "[i]t was not the standard of practice . . . for Dr. Castro, when confronted with these circumstances, to refuse to perform the laparoscopic procedure (*nor does plaintiffs' physician say so*)" (emphasis added). More fundamentally, plaintiffs' expert fails to demonstrate that gastric band removal was not within applicable standards of practice as a treatment for the patient's symptoms if she chose surgery after being informed of its risks and alternatives.

Turning to the subject of the patient's post-operative care, plaintiffs' expert opines that the defendant surgeons failed timely and properly to monitor the patient after her surgery. As a threshold matter, plaintiffs' expert suggests (in ¶¶ 17 and 26 of his/her supplemental affirmation) that Dr. Castro abandoned the patient when he left for vacation

shortly after surgery and before the patient was discharged from the recovery room. However, this is not a case in which a physician left a patient without appropriate medical attention.[24] Rather, the patient was left in the care of, among others, Dr. Castro's surgical colleague, Dr. Chaudry.

Plaintiffs' expert next asserts (in ¶ 27 of his/her supplemental affirmation) that "[t]he records clearly indicate that when [the patient's] condition started to deteriorate . . . the *surgeons* were made 'aware[ ]' of her condition," and that "[a]s a result of the surgeon's not attending to [the patient] post operatively, she was cause[d] to sustain a hypoxic episode . . . ." This is factually incorrect. A 3:20 P.M. "late entry" nursing note indicates that the patient complained of difficulty breathing, that an unnamed surgeon, among others, were then present at the patient's bedside, and that the restoration of the patient's breathing (first via non-rebreather mask and thereafter by intubation/ambu-bag) was ongoing. It was not, as plaintiffs' expert implies, that "surgeons" were aware of the patient's respiratory distress but were standing at her bedside doing nothing. To the contrary, when the note was written Dr. Bauer had already been called and he had already been working on restoring the patient's breathing, all in the presence of only one (and unnamed) surgeon. Because that particular "surgeon" was never identified, it cannot be stated with certainty, as plaintiffs' expert does, that such surgeon was either Dr. Castro or Dr. Ferzli. Indeed, Drs. Castro and Ferzli, at their

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[24] *See Alvarado v Miles*, 32 AD3d 255, 257 (1st Dept 2006), *affd* 9 NY3d 902 (2007) (to establish a prima facie case of abandonment, there must be evidence of "an affirmative 'willful abandonment' or a refusal to treat the patient").

pretrial depositions, denied that either of them was the "surgeon" to which the 3:20 P.M. nursing note referred.

Lastly, plaintiffs' expert posits (in ¶ 26 of his/her supplemental affirmation) that "the surgeon remains responsible for the care and treatment of the patient even after the surgery is complete." This statement is inherently broad, as it contains no limitation as to the time and scope of surgeon's post-operative obligations. It disregards the necessary division of labor in hospital units, which, in this case, were surgery, recovery room, and L&D service. It presumes, with no medical support, that Dr. Castro (or his designee) was required to monitor the patient's condition at all times. Yet, even assuming that Dr. Castro (or his designee) were required to monitor the patient's condition at all times, plaintiffs' expert fails to articulate specifically what Dr. Castro did or failed to do that is alleged to have caused the patient's injuries, nor has plaintiffs' expert established a causal connection. Consequently, nothing in the record before the Court raises a triable issue of fact as to whether the alleged failures by Dr. Castro and other defendant surgeons delayed the discovery and, more importantly, worsened the outcome of the patient's respiratory distress (*see Garrett v University Assoc. in Obstetrics & Gynecology, P.C.*, 95 AD3d 823, 826 [2d Dept 2012]).

Significantly, plaintiffs' expert does *not* blame Dr. Castro for prescribing the patient a clear liquid diet after surgery, even though Dr. Castro testified (at pages 102-103 of his deposition) that, post-operatively, the patient retained a 50% probability of vomiting if she were given something to eat or drink, but that despite this 50% probability, he did not

consider the patient to be at an increased risk of vomiting (and, hence, aspiration), and thus took no precaution to maintain the patient NPO post-operatively. It is also significant that plaintiffs' expert does *not* blame Dr. Castro for retaining a standing order for Demerol and Phenergan which she concurrently received at 3 P.M., or about 20 minutes before her respiratory distress was discovered at 3:20 P.M. If, as plaintiffs' expert claims, Dr. Castro or other defendant surgeons were required closely to monitor the patient post-operatively, it follows that Dr. Castro should have precluded a concurrent administration of Demerol and Phenergan fours hours after her surgery and general anesthesia. It may be highly likely that something occurring after this surgery did cause the patient's aspiration and respiratory distress, but plaintiffs have not proved on this record that Dr. Castro or other defendant surgeons were responsible for it.

Because Dr. Castro is not directly liable to plaintiffs, Dr. Ferzli and his professional corporation George Ferzli, M.D., P.C. are not vicariously liable either. Accordingly, the amended cross motion of Dr. Castro, Dr. Ferzli, and George Ferzli, M.D., P.C. is granted, and the complaint insofar as asserted against these defendants is dismissed.

Plaintiffs

Plaintiffs' omnibus contention that all defense motions should be denied because additional discovery is outstanding is devoid of merit. Although, pursuant to CPLR 3214 (b), service of a notice of motion under CPLR 3212 stayed disclosure until determination of the motion unless the court orders otherwise, the Court granted plaintiffs leave, while the extant

motions for summary judgment were pending, to take a pretrial deposition of nonparty Nurse Webber, who provided ice chips to the patient in the recovery room. The Court further permitted plaintiffs to supplement their opposition papers, including their expert affirmation. Plaintiffs, however, have made a poor use of the Court's assistance. They have failed to attach a copy of the deposition transcript of Nurse Webber to their supplemental opposition papers. Their expert's supplemental affirmation failed to analyze the medical significance of the fact that Nurse Webber administered ice chips to the patient who had recently emerged from anesthesia. Instead, their expert advanced a conclusory opinion (in ¶ 18 of his/her supplemental affirmation) that "[h]ad the nurse not administered the ice chips, . . . the patient would not have vomited, aspirated, progress[ed] to multi-organ failure & ultimately died." Moreover, the record reflects that plaintiffs previously had filed a note of issue, thus certifying that discovery had been complete, but thereafter stipulated to withdraw same on account of the outstanding depositions. If discovery truly remained outstanding, plaintiffs should have sought leave to extend the note of issue filing date, rather than file a note of issue prematurely but then engage in discovery during the pendency of the extant motions. Contrary to plaintiffs' contention, the motions of Dr. Bauer, Dr. Castro, Dr. Ferzli, and George Ferzli, M.D., P.C. are not premature. Plaintiffs have failed to demonstrate that additional discovery may lead to relevant evidence or that the facts essential to oppose the motions by these defendants are exclusively within the knowledge and control of these defendants (*see* CPLR 3212 [f]; *see also Savage v Quinn*, 91 AD3d 748, 750 [2d Dept 2012]).

Lastly, plaintiffs' request (in ¶ 45 of their affirmation in opposition) that Dr. Coopersmith be compelled to respond to a subpoena is not properly before the Court because it was not made by way of a notice of motion or order to show cause (*see* CPLR 2211, 2214; *see also Bauer v Facilities Dev. Corp.*, 210 AD2d 992, 993 [4th Dept 1994] [affidavits submitted in opposition to defendants' motions were insufficient to constitute a cross motion]).

This constitutes the decision, opinion, and order of the Court.

ENTER,

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J. S. C.