Brinkley v Nassau Health Care Corp.
2012 NY Slip Op 30961(U)
April 3, 2012
Supreme Court, Nassau County
Docket Number: 8532/09
Judge: Michele M. Woodard
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SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NASSAU

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KRISTA BRINKLEY,

Plaintiff,

-against-

NASSAU HEALTH CARE CORPORATION, NASSAU UNIVERSITY MEDICAL CENTER, GOOD SAMARITAN HOSPITAL MEDICAL CENTER, LAMBROS ANGUS, M.D., SASHA SOTIROVIC, M.D., and MARIA SPIZZIRRI, M.D.,

Defendants.

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MICHELE M. WOODARD
J.S.C.
TRIAL/IAS Part 8
Index No.: 8532/09
Motion Seq. Nos.: 01 & 02

DECISION AND ORDER

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In motion sequence number one, defendant Good Samaritan Hospital Medical Center moves for an order pursuant to CPLR §3212 granting it summary judgment dismissing the complaint against it.

In motion sequence number two, defendants Nassau Health Care Corporation s/h/a Nassau Health Care Corporation and Nassau University Medical Center, Lambros Angus, M.D., Sasha Sotirovic, M.D., Tariq Kelker, M.D., Yuriy Zhurov, M.D. and Maria Spizzirri, M.D. move for an order pursuant to CPLR §3212 granting them summary judgment dismissing the complaint against them.

The plaintiff in this action seeks to recover damages for medical malpractice and lack of informed consent. She underwent gastric bypass surgery at Nassau University Medical Center ("NUMC") by the defendant Lambros Angus, M.D. on July 23, 2008 and she was discharged on July 28, 2008. On the morning of July 29, 2008, she was transported to Good Samaritan Hospital via ambulance because she was suffering from severe abdominal pain. She was treated at Good Samaritan Hospital for eight hours. While there, she was examined and tests were conducted including a CT scan of her abdomen. Dr. Cussatti, a bariatric surgeon at Good Samaritan Hospital, conducted a surgical consult via telephone. His primary differential diagnosis included post-operative pain along with anxiety of recent surgery, some form of intra-abdominal process, infection or inflammation. The possibility of an anastomotic leak was also considered. Dr. Cussatti's recommendations were fluid resuscitation and transfer to NUMC as that was where the surgery had been performed. A 500 ml IV bolus of normal saline was given on July 29th at approximately 11:20 a.m.

While at Good Samaritan, the plaintiff developed a fever and her abdominal pain worsened. Her temperature went from normal to 102.6; her pulse rate increased to 130; and, her oxygen saturation dropped from 96% to 90%. Upon determining that a possible bowel perforation could not be ruled out, Dr. Cussatti conferred with Dr. Angus and together they concluded that in light of her stable condition and Dr. Angus' history of treating her, Brinkley should be transferred to NUMC via ambulance. Dr. Zimmerman signed the emergency department inter-hospital transfer form transferring her to NUMC.

The plaintiff arrived at NUMC at 8:10 p.m. on July 29th hemo-dynamically stable. Dr. Ting attended to her in the Emergency Room. Upon admission, she had complaints of fever, sweating, chest pressure, shortness of breath and a productive cough with brown phlegm. She was in mild respiratory distress and had abdominal tenderness. Because her oxygen saturation was 84% by pulse oximetry, she

was given 100% oxygen via non-rebreather mask and her oxygen saturation improved to 90%. The plaintiff was noted to be in acute distress. Her incision from the bypass procedure had serious drainage and her breath sounds bilaterally were decreased in the lower fields. Her abdomen was soft, diffuse, distended and tender in the lower part of the wound. Blood tests and urinalysis were performed and her white blood cell count at the time was 14.5. She was hydrated with IV infusion of normal saline at 100 ccs per hour via two peripheral lines. She was given IV Flagyl at 8:30 and Levaquin at 9:55 p.m. on July 29th. Dr. Ting's differential diagnosis included abdominal pain generalized, obstruction of the bowel and a perforation of the intestines.

Dr. Zhurov, a resident at NUMC, saw the plaintiff at 10:00 p.m. on July 29th as did Dr. Angus. A chest x-ray was done at 10:01 p.m. which revealed pneumoperitoneum, possibly post-operative, as a result of which CT scans of the lower extremities, chest, abdomen and pelvis were done. Radiology reports indicated moderate pneumoperitoneum and complex fluid in the left upper quadrant as well as the pelvis, possibly post-operative. An anastomotic leak could not be ruled out and bibasilar atelectasis was noted.

Ms. Brinkley was admitted to the surgical intensive care unit at midnight on the 29th into the 30th for sepsis and possible pneumonia under the care of Dr. Angus. She was given IV Zosyn and was receiving IV lactated ringers at 250 ccs per hour and was maintained on 40% oxygen via face mask.

Dr. Angus informed Ms. Brinkley of the CT scan findings and recommended surgical intervention to investigate a possible bowel leak. Dr. Angus' differential diagnosis at the time that the surgery was recommended included leakage, possible pneumonia and possible pulmonary embolism. Surgery was initially refused despite the CT scan findings, which although highly suggestive of a leak, were not conclusive. Ms. Brinkley indicated that she did not want additional surgery unless Dr. Angus

could demonstrate without question that there was leakage in the abdomen.

The chief surgical resident Deborah Solnick, M.D.'s note indicated a small opening along the aspect of Brinkley's wound with serosanguinous drainage and the gastrostomy tube drained less that 100 ccs of bilious fluid. The plaintiff was sent for an upper GI series at 1:30 a.m. on July 30th.

An anastomotic leak was confirmed via an upper GI series which was completed by 2:05 a.m. on July 30th. The tests showed free extravasation of oral contrast from the proximal gastric bypass anastomotic site. Since the plaintiff had reported that the pain had started in the morning of the 29th, based upon the plaintiff's symptomatology and his doctor's training, Dr. Angus' opined that the anastomotic leak started when the patient was at home during the morning of the 29th when she experienced a pop and abdominal pain. Once the upper GI series was completed, Dr. Angus advised Ms. Brinkley that the upper GI series documented an anastomotic leak and advised her that she required the exploratory laparotomy. However, because she was dehydrated, Ms. Brinkley needed to be resuscitated prior to subjecting her to the risk of anesthesia. At 5:00 a.m., the surgical resident Dr. Zhurov noted that the plaintiff had dyspnea with decreased breath sounds and diffuse abdominal distention. Her oxygen saturation was 94% on 60% oxygen and 300 ccs of biliary fluid had drained from the gastrostomy tube. The plan was to continue IV fluids and antibiotic therapy, to monitor the heart rate, to perform repeat abdominal exams and to provide DVT and GI prophylaxis.

The plaintiff was returned to the operating room on July 30, 2008 at 8:00 a.m. for repair of the gastrojejunostomy leakage under general anesthesia. She underwent exploratory laparotomy, lysis of adhesions and repair of the anastomosis by Dr. Angus with the assistance of surgical resident Dr. Tantawi.

The operative report indicates that dehiscence of the gastrojejunostomy was seen in the upper

epigastric region with significant inflammation of the tissues. Cultures of the abdominal fluid were collected. After the procedure was performed, Methylene blue dye was used to test for leakage and no gross leakage was noted. A tongue of the omentum was placed over the repair and secured. Four Jackson-Pratt drains were placed in the upper abdomen, the abdomen was closed and an abdominal binder was applied. A chest x-ray and CT scan of the chest, abdomen, pelvis and lower extremities were ordered by Dr. Ting.

During the surgical procedure, Dr. Angus determined that there had been a separation of the attachment of the small intestine to the stomach that had been done during the gastric bypass procedure. This was noted to be an acute perforation. The anterior surface of the connection was separated.

Complications developed and the plaintiff remained at NUMC until September 17, 2008 during which time she was treated for sepsis, Adult Respiratory Syndrome and Psedomonas pneumonis. These conditions necessitated prolonged support including a tracheostomy, the need for a PIC line for IV access, percutaneous drainage of collections of intra-abdominal fluid, fungemia, bacteria, and a gastrostomy tube leak. The defendants Drs. Sotirovic, Kelker, Zhurov and Spizzirri were all residents at NUMC who aided Dr. Angus in various capacities in his care of the plaintiff during her hospitalization.

All of the defendants seek summary judgment dismissing the complaint against them.

"On a motion for summary judgment pursuant to CPLR §3212, the proponent 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." *Sheppard-Mobley v King*, 10 AD3d 70, 74 (2d Dept 2004), *affd as mod.*, 4 NY3d 627 (2005), *citing Alvarez v Prospect Hosp.*, 68 NY2d 320, 324 (1986); *Winegrad v New York Univ. Med. Ctr.*, 64 NY2d 851, 853 (1985). "Failure to make such *prima*

facie showing requires a denial of the motion, regardless of the sufficiency of the opposing papers." *Sheppard-Mobley v King, supra*, at p. 74; *Alvarez v Prospect Hosp., supra; Winegrad v New York Univ. Med. Ctr., supra*. Once the movant's burden is met, the burden shifts to the opposing party to establish the existence of a material issue of fact. *Alvarez v Prospect Hosp., supra*, at p. 324. The evidence presented by the opponents of summary judgment must be accepted as true and they must be given the benefit of every reasonable inference. *See, Demishick v Community Housing Management Corp.*, 34 AD3d 518, 521 (2d Dept 2006), citing *Secof v Greens Condominium*, 158 AD2d 591 (2d Dept 1990).

"The essential elements of medical malpractice are (1) a deviation or departure from accepted medical practice, and (2) evidence that such departure was a proximate cause of injury (quotations omitted)." *Faicco v Golub*, 91 AD3d 817 [2d Dept 2012]; *see also, Roca v Perel*, 51 AD3d 757, 758 (2d Dept 2008); *DiMitri v Monsouri*, 302 AD2d 420, 421 (2d Dept 2008); *Flaherty v Fromberg*, 46 AD3d 743, 745 (2d Dept 2007). "Thus, [o]n a motion for summary judgment dismissing the complaint in a medical malpractice action, the defendant doctor has the initial burden of establishing the absence of any departure from good and accepted medical practice or that the plaintiff was not injured thereby. *Faicco v Golub, supra*, at p. 817; *see also, Roca v Perel, supra*, at p. 458-579; *Chance v Felder*, 33 AD3d 645, (2d Dept 2006); *Stukas v Streiter*, 83 AD3d 18, 24 (2d Dept 2011). "Once a defendant physician has made such a showing, the burden shifts to the plaintiff to 'submit evidentiary facts or materials to rebut the *prima facie* showing by the defendant . . . so as to demonstrate the existence of a triable issue of fact.' " *Savage v Quinn*, 91 AD3d 748 (2d Dept 2012), quoting *Alvarez v Prospect Hosp.*, 68 NY2d 320, 324 (1986); *see, Stukas v Streiter, supra*, at p. 24. "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 (citations

omitted)." *Savage v Quinn, supra*. "In determining a motion for summary judgment, the court must view the evidence in the light most favorable to the nonmoving party." *Caggiano v Cooling*, 92 AD3d 634 (2d Dept 2012), citing *Stukas v Streiter*, *supra*, at p. 23. 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. *Thompson v Orner*, 36 AD3d 791 (2d Dept 2007); *see also, Dimitri v Monsouri*, 302 AD2d 420 (2d Dept 2003).

A hospital cannot be held vicariously liable for the malpractice of a private attending doctor. *Sita v Long Island Jewish Medical Center*, 22 AD3d 473 (2d Dept 2005). In addition, "[w]hen supervised medical personnel are not exercising their independent medical judgment, they cannot be held liable for medical malpractice unless the directions from the supervising superior or doctor so greatly deviates from normal medical practice that they should be held liable for failing to intervene." *Bellafiore v Ricotta*, 83 AD3d 632 (2d Dept 2011), citing *Soto v Andaz*, 8 AD3d 470 (2d Dept 2004); *Costello v Kirmani*, 54 AD3d 656 (2d Dept 2008); *Crawford v Sorkin*, 41 AD3d 278 (2d Dept 2007).

> " To establish a cause of action [to recover damages] for malpractice based on lack of informed consent, plaintiff must prove: (1) that the person providing the professional treatment failed to disclose alternatives thereto and failed to inform the patient of reasonably foreseeable risks associated with the treatment, and the alternatives, that a reasonable medical practitioner would have disclosed in the same circumstances, (2) that a reasonably prudent patient in the same position would not have undergone the treatment if he or she had been fully informed, and (3) that the lack of informed consent is a proximate cause of the injury.' "

Foote v Rajadhyax, 268 AD2d 745 (3d Dept 2000), citing Public Health Law § 2805-d; *King v Jordan*, 265 AD2d 619, 620 (3d Dept 1999). "[I]t [is] the duty of the injured plaintiff's private physician and not [NUMC] to obtain the plaintiff's informed consent." *Sita v Long Island Jewish Medical Center, supra,* at p. 743, citing Public Health Law § 2805-d, *Fiorentino v Wenger*, 19 NY2d 407, 417 (1967).

In support of its motion, Good Samaritan Hospital has submitted the affirmation of Dr. Robert H. Leviton. He is Board Certified in Emergency and Family Medicine. Having reviewed the pertinent medical and legal records, he opines to a reasonable degree of medical certainly that the care provided the plaintiff at Good Samaritan Hospital was reasonable and within the standard of care and that nothing Good Samaritan Hospital's staff did or failed to do proximately caused the plaintiff's injuries. More specifically, he notes that Good Samaritan Hospital's staff properly evaluated the plaintiff; provided IV fluids and treated her pain; and, conducted tests including a CT scan of her abdomen which returned with evidence of intra-abdominal free air, mild abdominal and pelvic ascites which indicated that a perforation of the bowel could not be ruled out. He opines that a surgical consult with Dr. Cussati was appropriately performed and he appropriately recommended the plaintiff's transfer to NUMC. He notes that Dr. Angus was also appropriately consulted with and he concurred. He further notes that prior to transferring her, Dr. Zimmerman evaluated the plaintiff and found her to be hemodynamically stable and he appropriately concluded "within reasonable medical probability, no material deterioration to the patient [was] likely to result from the transfer." Dr. Leviton notes that the transport went smoothly and that the plaintiff arrived at NUMC in stable condition. In sum, Dr. Leviton opines that "the eight hours that it took to examine and evaluate the patient, perform numerous tests on her, wait for her to drink contrast material in order to have the CT scan performed (it takes two hours after drinking the contrast before the study can be done), come to a diagnosis, consult a surgeon, communicate with her own doctor and get her safely transferred to NUMC was absolutely appropriate, and had no bearing on the timing of her surgery once she was returned to Dr. Angus."

The defendant Good Samaritan Hospital has established its entitlement to summary judgment thereby shifting the burden to the plaintiff to establish the existence of a material issue of fact.

In support of their motion, NUMC and Drs. Angus, Sotirovic, Kelker and Spizzirri ("NUMC defendants") have submitted the affidavit of Dr. Thomas Magnuson, a Board Certified Surgeon. Having reviewed the pertinent legal and medical records, he opines to a reasonable degree of medical certainty that the NUMC defendants did not deviate from the accepted standard of care in their care of the plaintiff and that in any event, their care of her was not the proximate cause of her gastrointestinal leak and dehiscence of the gastrojejunostomy anastomosis.

As for the plaintiff's consent, Dr. Magnuson notes that on her risk advisory sheet which she acknowledged at her examination-before-trial having signed on July 15, 2008, the list of potential risks included a leak from stomach, intestine or other surgical areas that could cause peritonitis; abscess formation; fistula; sepsis; abdominal abscess or gaut; injury to esophagus, stomach, spleen, liver or other organs which could necessitate additional surgery or treatment; wound complications such as infection, seroma, hematoma, dehiscence or hernia of incision, bleeding or hemorrhage from any surgical area which could result in the need for transfusion or other treatment; respiratory depression; death; ulcer formation which can result in inflammation, scarring, bleeding or perforation; and, additional procedures, such as re-operation or endoscopy.

Similarly, he notes that on the written obesity surgery patient examination which the plaintiff also acknowledged at her examination-before-trial having signed on June 16, 2008, the plaintiff stated that it was false that "staple or suture lines never leak or result in infection or communication between the stomach or intestine in the skin"; that it was true that it was possible

that she "could require intensive care, short or long-term, in the hospital after gastric bypass surgery"; and, likewise, that it was true that "re-operation is sometimes necessary, due to bleeding, hernias, ulceration, bursting of stitches or staples, leakage or blockage of the intestines or stomach and from other causes." She also acknowledged that it was false that gastric bypass surgery is not a very serious or risky procedure. In addition, reflecting on both the plaintiff and Dr. Angus' testimony at their examinations-before-trial, Dr. Magnuson further notes that all of the risks were fully explained to the plaintiff.

Dr. Magnuson notes that the gastric bypass surgery for which the plaintiff's informed consent was obtained was performed on July 23, 2008 by Dr. Angus with resident surgeons defendants Dr. Sotirovic and Dr. Kelker assisting. He notes that while her white blood court ("WBC") was elevated post-operatively, it continued to decline up to July 26th. He also notes that an upper GI series performed on July 25th ruled out any leaks from anastomosis sites. He notes that while she had a fever of 102.4 and high arterial blood oxygen levels on July 25th, at discharge on July 28th, her temperature was normal and her pulse rate was within normal limits. Similarly, while serous drainage from the abdominal wound was noted during the night of July 26th, the incision opening was packed in the morning and her diet and ambulatory skills progressed appropriately. More specifically, Dr. Magnuson notes that the plaintiff was ambulatory with a steady gait, tolerating a full liquid diet and had positive bowel signs with an abdominal binder in place on July 28th at 2:00 p.m.. He opines that despite surgical incision infection, there was no evidence of intra-abdominal complications and mild serous fluid drainage from the incision with erythema without tenderness on July 27th indicated that the infection of the surgical incision was resolving. Dr. Magnuson notes that other than that, the plaintiff did not evidence any additional

complications at discharge on the 29th of July: She was stable, her heart rate was normal and she was afebrile.

As for the plaintiff's transfer from Good Samaritan Hospital to NUMC, Dr. Magnuson notes that Dr. Angus reliance on the information provided him by the staff at Good Samaritan Hospital regarding her suitability for transfer was appropriate.

Dr. Manguson carefully details the care provided by the NUMC defendants upon the plaintiff's return there, much of which is no longer at issue here. What the plaintiff continues to maintain is that the need for surgery was not diagnosed in a timely fashion, which lead to an unacceptable delay and ensuing consequences which could have been avoided had a timely diagnosis been made.

Dr. Magnuson opines that at no point before the surgery was undertaken on July 30th did it become an emergency.

In sum, Dr. Magnuson notes that Dr. Angus advised the plaintiff of the risks attendant to the surgery, in particular the possibility of a leak at the site of the anastomosis as well as an infection and the possibility of dehiscence of the wound and a breakdown of the connection between the small intestine and the stomach that was formed during the surgery. He also notes that a battery of tests were done to establish that the plaintiff was a proper candidate for the surgery and a consent form was executed, as was a risk advisory sheet and informative questionnaire. Thus, Dr. Magnuson opines that the plaintiff's lack of informed consent claim falls short.

Additionally, Dr. Manguson opines to a reasonable degree of medical certainty that with the assistance of hospital staff, Dr. Angus properly performed the July 23rd gastric bypass surgery

and checked the anastomosis with Methylene dye which revealed no leak.

As for her discharge on July 28th, Dr. Manguson notes that despite the fever of July 25th and an infection at the site of the incision, there was no evidence of intra-abdominal complications during her hospitalization from July 23 to July 28, 2008. He notes that an upper GI series was in fact performed to confirm that there was no leakage. Blood cultures were negative, plaintiff's WBC declined and the incision had no erythema and was not tender indicating that the infection of the incision was resolving. He further notes that the plaintiff's temperature and pulse rate were normal and her WBC continued to decline when she was discharged. He notes that Augmentin was prescribed to continue to treat the infection and that at the time of Brinkley's discharge, other than the "superficial" incision infection, there was no evidence of leakage from the anastomosis or any other intra-abdominal complications of the surgery. He opines that the sero-sanguinis wound drainage from the incision site was not indicative of a gastrajejunal anastomotic leak and was properly treated with antibiotics up to and after her July 28th discharge. He therefore opines that the plaintiff was stable and appropriately discharged on July 28th.

Dr. Magnuson further opines that even if the plaintiff had not been discharged on July 28th, the course of events would have been the same. He opines "that the care and treatment required during the second hospitalization was a product of an anastomotic leak which arose on the morning of July 29, 2008 . . . [and] [h]ad the [plaintiff] remained in the hospital, she would have undergone the same course of treatment, would have suffered the same complications from the anastomotic leak, which were appreciated during the second admission at [NUMC]." He also opines that the time that elapsed from the plaintiff's arrival on July 29th at 8:10 p.m. until the time of surgery at 8:00 a.m. on July 30th had no effect whatsoever on the plaintiff. In other words, even

if the operation had been done earlier, the sequence of events would have been the same. Dr. Manguson similarly opines that the July 30th laparotomy was properly performed.

More specifically, Dr. Magnuson opines that the plaintiff was properly evaluated and diagnosed upon her return to NUMC on July 29th and that the gastrojejunal anastomatic leak was properly treated. He notes the plaintiff's resistance to surgery and insistence on additional confirming tests. He attributes the delay in operating from 2:05 a.m. until 8:00 a.m. to the need to fully resuscitate the plaintiff from dehydration with IV fluids and antibiotics in order to stabilize her for general anesthesia. He opines that had this not been done, the plaintiff would have been at an increased risk of complications from surgery including death. He opines that in any event, had the surgery been done at 2:00 a.m., the outcome would have been the same: No additional injuries occurred on account of the delay. He also opines that her post-surgical care conformed to medical standards. More specifically, a series of CT scans, x-rays and upper GI series established that the leak was stabilized as was the plaintiff rendering her suitable for discharge on September 17th.

Upon review of Dr. Angus' Curriculum Vitae and the other pertinent records, Dr. Manguson opines that there is no evidence that NUMC granted privileges or allowed unqualified doctors to perform there.

NUMC and Drs. Angus, Sotirovic, Kelker, Zhurov and Spizzirri have also established their entitlement to summary judgment dismissing the complaint against them thereby shifting the burden to the plaintiff to establish the existence of a material issue of fact.

The plaintiff has submitted the affidavit of Dr. Peter J. Wilk. He is Board Certified in General and Colon & Rectal Surgery. Having reviewed the pertinent legal and medical records, he opines to a reasonable degree of medical certainty that the defendants departed from good and

accepted medical practice in their care of the plaintiff as follows:

Dr. Wilk notes that on July 25, 2008, two days post-op, the plaintiff developed a urinary tract infection and ran a fever of 101.4 which spiked to 102.9 and her white blood count (WBC) was elevated at 15.7. Her incision was open and draining. However, an upper GI series revealed no evidence of an obstruction or leak. The following day, July 26th, Brinkley continued to run a low temperature of 100.2 and her WBC was 13.8. He represents that when the dressing over her surgical wound was removed, a "copious" amount of drainage was observed. On July 27th, her maximum temperature was 99.9 and she was discharged on July 28th and instructed to follow up with the surgical clinic in a week. Dr. Wilk notes that upon arrival at Good Samaritan Hospital in the morning of July 29th when she was seen by Dr. Zimmerman, her oxygen saturation was 94% on room air, and her temperature was 98.8. The drain in her left upper abdomen was noted to have bilious drainage. Dr. Zimmerman's differential diagnosis was bowel obstruction, gastroparesis and surgical infection but at his deposition, he testified that he had additional differential diagnoses that were not written in the hospital record, including a perforation of the GI tract, and a disconnection of anastomosis, *i.e.*, a connection between the intestine and the stomach which was formed during Dr. Angus' gastric bypass procedure. Her vital signs were checked at 11:24 a.m., 2:17 p.m. and 6:38 p.m. and her heart rate increased from 104 to 130, her temperature increased from 98.8 to 102.6, her respirations increased from 20 to 28/minute, her oxygen saturation worsened from 94% to 84%, but increased to 90% when oxygen was administered and her blood pressure fell from 160/90 to 122/90. Dr. Zimmerman ordered blood tests, a urinalysis, a CT scan and a chest x-ray. The plaintiff's WBC was 14.1, the urinalysis was negative and her chest x-ray showed ateletic changes. The CT scan showed the presence of intra-abdominal free

air. Dr. Zimmerman called upon Dr. Cussati for a surgical consult via telephone who declined to examine the plaintiff himself and instead recommended that she be transferred to NUMC.

Dr. Wilk notes that the plaintiff arrived at NUMC on July 29, 2008 with a temperature of 102 and a pulse oximeter reading of 84% oxygen saturation but she reacted positively when given oxygen. A CT scan of her abdomen revealed mild abdominal and pelvic ascites with post-operative changes. She was put on antibiotics and admitted to the intensive care unit. An upper GI series revealed extravasation of contrast from the proximal gastric anastamosis at about 2:05 a.m. on July 30th. IV fluids and monitoring were recommended. According to the plaintiff's hospital record, ICU resident Dr. Spizzirri discussed the results of the upper GI with a surgical resident who recommended a follow-up CT scan and upper GI series. Ultimately Dr. Angus recommended surgery at 6:30 a.m.. Surgery commenced at approximately 8:00 a.m.. During surgery, Dr. Angus noted a near complete dehiscence of the staple line of the gastrojejunostomy which he repaired and tested with methylene blue and no leaks were noted. Dr. Wilk notes that the plaintiff's ensuring medical course was plagued by many complications including sepsis, Adult Respiratory Syndrome and Psedomonas pneumonis. He opines that conditions necessitated prolonged support including a tracheostomy, the need for PIC line for IV access, percutaneous drainage of collections of intra-abdominal fluid, fungemia, bacteria, and a gastrostomy tube leak.

Dr. Wilk opines to a reasonable degree of medical certainty that Dr. Angus and the hospital departed from good and accepted medical practice by discharging the plaintiff on July 28th because she had developed a urinary tract infection, her WBC was elevated and when the abdominal dressing was removed on July 26th, there was "copious" drainage from the wound which he opines is called "dehiscence,", *i.e.*, the parting of sutured lips of a surgical wound, and

"is evidence that there may be an intra-abdominal leak," the cause of which "may have been related not to the urinary tract infection, [but] rather may have been related to a failure of the stomach to heal properly in the face of infection or to technical errors in constructing the anastamosis that did not show up on the GI series." In light of the evidence of an infection and the copiously draining wound, Dr. Wilk opines that the plaintiff was discharged from NUMC prematurely. He opines that the diagnosis of anastomotic leak could have been made as early as July 26th, and Brinkley should not have been discharged when she was.

Dr. Wilk also faults Good Samaritan Hospital's treatment of the plaintiff on account of the delay of "operatic intervention." He opines that Good Samaritan Hospital failed to recognize that free air revealed in a CT scan one week after surgery was evidence of an intra-abdominal problem, particularly since it was coupled with "fluid in the abdominal cavity." He also faults Good Samaritan Hospital for not recognizing that the plaintiff's hemodynamic status was worsening there, as evidenced by her increasing heart and respiratory rates despite intravenous resuscitation, her worsening oxygen saturation and development of a fever. He opines that emergency surgery was needed; not a transfer for which he opines that the plaintiff was not well suited.

Finally, Dr. Wilk faults NUMC for the delay in performing surgery upon her return there from 2:00 a.m. on July 30th until 8:00 a.m. that day. As for the harm caused by all of these acts and omissions, Dr. Wilk opines as follows:

> "An anastomotic leak under the circumstances of this case is a surgical emergency, and time is of the essence. Every hour that passes with such a leak makes the recovery for the patient that much harder. . . . [T]he delays here were significant factors in causing significant complications in this patient, including sepsis, Adult Respiratory Syndrome, Pseudomonas pneumonis, the need for prolonged respiratory support, the need for PIC lines for IV access, percutaneous drainage of intra-abdominal fluid collections,

fungemia, bacteremia, the need for a tracheostomy, a gastrostomy tube leak, and hospitalization for about two and a half months until discharge on September 27, 2008."

In short, he opines that the defendants departed from good and accepted medical practice by delaying the identification and treatment of gastrojejunal anastamotic leak thereby causing significant complications, all of which could have been avoided.

The plaintiff has not established any issues of fact with respect to her claim of lack of informed consent. That claim is ***dismissed*** as against all defendants.

Similarly, an issue of fact with respect to negligent privileging, hiring and/or retention has not been established *vis-a-vis* NUMC. That claim is ***dismissed*** as well.

The plaintiff has failed to establish the existence of a material issue of fact with respect to the defendant Drs. Sotirovic, Kelker, Zhurov and Spizzirri. They acted under the direction of the plaintiff's primary care doctor Dr. Angus and the plaintiff has failed to identify anything in his treatment of the plaintiff that was contra indicated or warranted their intervention. The defendants Drs. Sotirovic, Kelker, Zhurov and Spizzirri's motions for summary judgment are ***granted*** and the complaint against them is ***dismissed***.

In faulting NUMC and Dr. Angus' for the plaintiff's July 28th discharge, Dr. Wilk concedes that there was no evidence of obstruction or leak on the post-operative upper GI series. He opines however that there was "copious drainage" from the surgical wound on July 26th which may have been caused by a leak (as opposed to a surgical wound infection). This, however, ignores the fact that on July 27th at 6:00 a.m. there was only mild serous fluid draining from the incision without erythema (redness) or tenderness, along with a declining WBC and temperature which were all indicative of the wound infection resolving. Moreover, upon discharge, the

plaintiff had no comments or complaints regarding the incision. And, it was the morning of July 29th that the plaintiff experienced sudden severe sharp diffused pain in her abdomen. That is when the draining fluids became bilious, not before. Thus, an issue of fact regarding the NUMC's care and discharge of the plaintiff during her first admission has not been established.

As for the plaintiff's return, the propriety of NUMC's actions in confirming the anastomotic leak via a CT scan and upper GI series which were completed at 2:00 a.m. has not been called into question. While there was a further delay of six hours before the surgery was undertaken, NUMC maintains that that delay was necessitated by the need to maximize the plaintiff's ability to successfully withstand the surgery via hydration and antibiotics to which the plaintiff has not responded. This, Dr. Wilk has failed to address.

Furthermore, Dr. Wilk's opinion that the six hour delay caused profound complications without any detailed explanation is unacceptably conclusory. *Flanagan v Catskill Regional Center*, 65 AD3d 563 (2d Dept 2009); *Rebozo v Wilen*, 41 AD3d 457 (2d Dept 2007); *Thompson v Orner*, 36 AD3d 791, 792 (2d Dept 2007).

The plaintiff has failed to establish the existence of a material issue of fact with respect to the care provided the plaintiff by Dr. Angus and NUMC. Their motion for summary judgment is ***granted*** and the complaint against them is ***dismissed***.

As for Good Samaritan Hospital, while there are issues of fact concerning the propriety of her transfer and the delay in surgical intervention that ensued on account thereof, again, the proximate cause issue purported to exist by the plaintiff's expert is unacceptably conclusory requiring dismissal of the complaint against Good Samaritan Hospital as well. As such, it is hereby

ORDERED, that the defendants' motions for summary are ***granted*** and the complaint against them is ***dismissed***.

This constitutes the Decision and Order of the Court.

DATED: April 3, 2012
Mineola, N.Y. 11501

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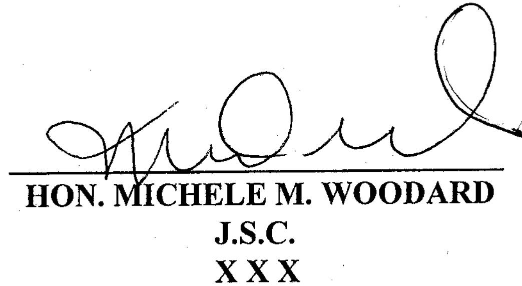

HON. MICHELE M. WOODARD
J.S.C.
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