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SHORT FORM ORDER

INDEX No. 09-10973
CAL No. 11-02026MM

SUPREME COURT - STATE OF NEW YORK
I.A.S. PART 48 - SUFFOLK COUNTY

PRESENT:

Hon. HECTOR D. LaSALLE
Justice of the Supreme Court

MOTION DATE 2/16/12 (#003)
MOTION DATE 2/23/12 (#004)
ADJ. DATE 5-22-12
Mot. Seq. # 003 - MG
004 - MG

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JENNIFER VERTULLO,

Plaintiff,

- against -

LESLAW JOZEF GREDYSA, M.D., PECONIC SURGICAL GROUP, P.C., BRADLEY S. GLUCK, M.D., HAMPTON RADIOLOGY, P.C., EAST END RADIOLOGY, P.C., RADIOLOGICAL HEALTH SERVICES, P.C., NORTH FORK RADIOLOGY, P.C., SOUTHAMPTON RADIOLOGY, P.C., BARRY R. ARMANDI, M.D. and THE SOUTHAMPTON HOSPITAL ASSOCIATION,

Defendants.

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Upon the following papers numbered 1 to 33 read on this motion and cross motion for summary judgment ; Notice of Motion/ Order to Show Cause and supporting papers (003) 1 - 16 ; Notice of Cross Motion and supporting papers (004) 17- 33 ; Answering Affidavits and supporting papers _____; Replying Affidavits and supporting papers _____; Other ___; (~~and after hearing counsel in support and opposed to the motion~~) it is,

ORDERED that motion (003) by the defendants, Bradley S. Gluck, M.D., Hampton Radiology, P.C., East End Radiology, P.C. f/k/a Radiological Health Services, P.C., North Fork Radiology, P.C., Southampton Radiology, P.C., and Barry R. Armandi, M.D., pursuant to CPLR 3212 for summary judgment dismissing the

complaint is granted and the complaint is dismissed with prejudice as asserted against them; and it is further

ORDERED that motion (004) by the defendant, The Southampton Hospital Association, pursuant to CPLR 3212 for summary judgment dismissing the complaint is granted and the complaint as asserted against it is dismissed with prejudice.

In this medical malpractice action, the plaintiff, Jennifer Vertullo, seeks damages for personal injuries which she alleges she sustained due to the defendants' negligent departures from the standard of care and their failure to provide her with informed consent. She also alleges that Southampton Hospital negligently employed health care providers who departed from accepted standards of care and treatment. The plaintiff alleges that the defendants negligently performed and interpreted an abdominal x-ray and an abdominal CT on November 29, 2006, at Southampton Hospital, where she was hospitalized from November 25, 2006 through November 30, 2006. Due to the alleged departures, it is asserted that the defendants negligently failed to diagnose and to timely treat post-surgical fluid collection in her abdomen and pelvis as a result of a leaking gastroduodenal repair; negligently repaired and patched a gastroduodenal ulcer, and failed to timely diagnose and treat an infection and intra-abdominal and pelvic abscesses. She alleges that these departures caused, among other things, wound dehiscence, massive abdominal biliary contamination, enterocutaneous fistula, abdominal compartment syndrome, and necrotic abdominal wall fascia. As a result, the plaintiff alleges that she was caused to suffer multiple abdominal exploratory laparotomies, antecolic gastrojejunostomy, an abdominal wash, debridement of abdominal necrotic fascia, antrectomy with wound vac, placement of vicryl mesh, Jackson Pratt drain insertion, bronchoscopy, tracheostomy, intubation, and blood transfusions. The plaintiff thereafter had multiple hospitalizations at New York Presbyterian Hospital and the New York Presbyterian Weill Cornell Acute Inpatient Rehabilitation. She was 34 years of age at the time this cause of action accrued. Her mother, Emily Lia, has been her health care proxy since 1998.

It is noted that none of the defendants' answers contain cross claims against any other defendant.

The proponent of a summary judgment motion must make a prima facie showing of entitlement to judgment as a matter of law, tendering sufficient evidence to eliminate any material issues of fact from the case (***Sillman v Twentieth Century-Fox Film Corporation***, 3 NY2d 395, 165 NYS2d 498 [1957]). The movant has the initial burden of proving entitlement to summary judgment (***Winegrad v N.Y.U. Medical Center***, 64 NY2d 851, 487 NYS2d 316 [1985]). Failure to make such a showing requires denial of the motion, regardless of the sufficiency of the opposing papers (***Winegrad v N.Y.U. Medical Center***, *supra*). Once such proof has been offered, the burden then shifts to the opposing party, who, in order to defeat the motion for summary judgment, must proffer evidence in admissible form...and must "show facts sufficient to require a trial of any issue of fact" (CPLR 3212[b]; ***Zuckerman v City of New York***, 49 NY2d 557, 427 NYS2d 595 [1980]). The opposing party must assemble, lay bare and reveal his proof in order to establish that the matters set forth in his pleadings are real and capable of being established (***Castro v Liberty Bus Co.,*** 79 AD2d 1014, 435 NYS2d 340 [2d Dept 1981]).

The requisite elements of proof in a medical malpractice action are (1) a deviation or departure from accepted practice, and (2) evidence that such departure was a proximate cause of injury or damage (***Holton v Sprain Brook Manor Nursing Home***, 253 AD2d 852, 678 NYS2d 503 [2d Dept 1998], *app denied* 92 NY2d 818, 685 NYS2d 420). To prove a prima facie case of medical malpractice, a plaintiff must establish that defendant's negligence was a substantial factor in producing the alleged injury (*see,* ***Derdiarian v Felix***

Contracting Corp., 51 NY2d 308, 434 NYS2d 166 [1980]; ***Prete v Rafla-Demetrious,*** 221 AD2d 674, 638 NYS2d 700 [2d Dept 1996]). Except as to matters within the ordinary experience and knowledge of laymen, expert medical opinion is necessary to prove a deviation or departure from accepted standards of medical care and that such departure was a proximate cause of the plaintiff's injury (*see,* ***Fiore v Galang***, 64 NY2d 999, 489 NYS2d 47 [1985]; ***Lyons v McCauley,*** 252 AD2d 516, 517, 675 NYS2d 375 [2d Dept 1998], *app denied* 92 NY2d 814, 681 NYS2d 475; ***Bloom v City of New York,*** 202 AD2d 465, 465, 609 NYS2d 45 [2d Dept 1994]).

To rebut a prima facie showing of entitlement to an order granting summary judgment by the defendant, the plaintiff must demonstrate the existence of a triable issue of fact by submitting an expert's affidavit of merit attesting to a deviation or departure from accepted practice, and containing an opinion that the defendant's acts or omissions were a competent-producing cause of the injuries of the plaintiff (*see*, ***Lifshitz v Beth Israel Med. Ctr-Kings Highway Div.***, 7 AD3d 759, 776 NYS2d 907 [2d Dept 2004]; ***Domaradzki v Glen Cove OB/GYN Assocs.***, 242 AD2d 282, 660 NYS2d 739 [2d Dept 1997]).

A hospital generally cannot be held liable, other than derivatively, for another's malpractice. Thus, a plaintiff must establish that the hospital, through its own agents, was guilty of malpractice or other tort concurring in causing the harm (***Fiortino v Wenger,***, 19 NY2d 401, 280 NYS2d 373 [1967]; ***Belak-Redi v Bollengier***, 74 AD3d 1110, 903 NYS2d 508 [2d Dept 2010]; ***Welch v Scheinfeld***, 21 AD3d 802, 801 NYS2d 277 [1st Dept 2005]). A hospital or other medical facility is liable for the negligence or malpractice of its employees (*see,* ***Birdell Hill v St. Clare's Hospital,*** 67 NY2d 72, 499 NYS2d 904 [1986]).

Whether an action for lack of informed consent is viewed as a malpractice action based on negligence or as a malpractice action based on common-law principles of assault and battery, it is nevertheless a tort action and requires poof of a causation relation between the defendant's disputed conduct and the resulting injury to the plaintiff. In an action alleging lack of informed consent, there are two separate causation elements: the "but for" and the proximate cause. If it is found that a physician has failed to adequately inform the patient of the attendant risks of and alternatives to a medical procedure, the jury must then ascertain whether the treatment would not have occurred "but for" the doctor's failure to inform properly. Once the "but for" relation is established, and it is concluded that the treatment would not have taken place, a second inquiry is then directed at whether injury in fact resulted from the disputed treatment, for obviously there can be no recovery without actual damages to the plaintiff. It must be proven that no fully informed reasonable person would consent to the treatment and that the plaintiff in fact suffered an injury which medically was caused by treatment (*see* generally ***Flores v Flushing Hospital & Medical Center***, 109 AD2d 198, 490 NYS2d 770 [1st Dept 1985]).

In motion (003), Bradley S. Gluck, M.D., Hampton Radiology, P.C., East End Radiology, P.C. f/k/a Radiological Health Services, P.C., North Fork Radiology, P.C., Southampton Radiology, P.C., and Barry R. Armandi, M.D., seek summary judgment dismissing the complaint asserted against them on the bases that they did not deviate from the relevant standards of care in their interpretation of the studies performed on November 29, 2006 and November 30, 2006, and that there was nothing that they did or did not do which proximately caused the plaintiff's injuries. They further contend that defendants Gluck and Armandi of Southampton Radiology, P.C. provided radiology interpretation services at Southampton Hospital pursuant to an employment agreement between Southampton Hospital and Southampton Radiology, P.C., and thus, defendants Hampton Radiology, P.C., East End Radiology, P.C., Radiological Health Services, P.C., and North Fork Radiology, P.C. bear no liability in this action.

In support of this application (003), the defendants have submitted, inter alia, an attorney's affirmation, copies of the summons and complaint, the answer served by defendants Gluck, Hampton Radiology, East End Radiology, Radiological Health, and North Fork Radiology, the answer served by defendant Armandi, each without cross claims; plaintiff's verified bill of particulars; plaintiff's unsigned transcript of her examination before trial dated April 7, 2010; a certified copy of the Southampton Hospital record; radiology reports dated November 30, 2006; unsigned but certified copy of the transcript of the examination before trial of defendant Leslaw J. Gredysa, M.D. which is considered (see ***Zalot v Zieba***, 81 AD3d 935, 917 NYS2d 285 [2d Dept 2011]); and the unsigned copy of the transcript of non-party witness Emily Lia, which is not in admissible form as required by CPLR 3212 (*see*, ***Martinez v 123-16 Liberty Ave. Realty Corp.***, 47 AD3d 901, 850 NYS2d 201 [2d Dept 2008]; ***McDonald v Maus***, 38 AD3d 727, 832 NYS2d 291 [2d Dept 2007]; ***Pina v Flik Intl. Corp.***, 25 AD3d 772, 808 NYS2d 752 [2d Dept 2006]), is not accompanied by an affidavit pursuant to CPLR 3116, and is not considered on this motion; a copy of plaintiff's living will; the unsigned but certified copy of the transcript of the examination before trial of moving defendant Gluck which is considered as adopted as accurate by him (*see*, ***Ashif v Won Ok Lee,*** 57 AD3d 700, 868 NYS2d 906 [2d Dept 2008]); the affidavit of Barry Armandi, Jr., M.D. dated December 20, 2011; the affirmation of Evan Dillon, M.D. dated November 22, 2011; and the Radiology Services Agreement dated November 6, 2002 between Southampton Hospital Association and Southampton Radiology P.C.

In motion (004), Southampton Hospital seeks summary judgment dismissing the complaint and any cross claims asserted against it on the bases that when the plaintiff was seen in the emergency room, she was diagnosed as having a perforated gastric ulcer and was promptly referred to Dr. Gredysa who was board certified in, and specialized in, gastrointestinal surgery; that Dr. Gredysa was not an employee of Southampton Hospital; that Dr. Gredysa was not the surgeon on call the day the plaintiff was admitted to the emergency room, but the plaintiff's mother specifically requested that Dr. Gredysa attend to her daughter. In addition, defendant Southampton Hospital argues that it is not vicariously liable for the actions of independent contractor physicians; and that there is no ostensible or apparent authority by the independent contractors to act on behalf of the principal.

In support of motion (004), Southampton Hospital has submitted, inter alia, an attorney's affirmation; the affidavit of Thomas H. Magnuson, M.D.; a copy of the summons and complaint and defendants' respective answers, none of which assert a cross claim against the other; the unsigned and uncertified copies of the transcripts of the examinations before trial of Jennifer Vertullo dated April 7, 2010, and Emily Lia dated July 7, 2010, which are not in admissible form; the unsigned but certified copy of the transcript of the examination before trial of Leslaw J. Gredysa dated August 26, 2010 which is in admissible form and the unsigned but certified copy of the transcript of the examination before trial of Bradley S. Gluck dated September 30, 2010, which are considered; a certified copy of the Southampton Hospital medical record for Jennifer Vertullo; a copy of the Southampton Hospital monthly emergency call schedule; and a copy of the plaintiff's living will.

Bradley S. Gluck testified to the extent that he is licensed to practice medicine in New York and has been board certified in radiology since 1992. In November 2006, he had hospital privileges with Southampton Hospital and was employed by Southampton Radiology. He stated that Southampton Radiology had a contract with Southampton Hospital to provide radiology services to the hospital. At the time, he was also affiliated with North Fork Radiology, Hampton Radiology, and East End Radiology which changed its name to Radiological Health Services, P.C., all of whom did not provide radiology services to Southampton Hospital. He became involved with the care of Jennifer Vertullo on November 29, 2006 at Southampton Hospital as the radiologist on call, when he reviewed portable x-rays of her abdomen and chest, a non-contrast CT scan of her brain, and a non-contrast CT scan of her abdomen and pelvis, all of which were performed on November 26, 2006. He

additionally reviewed her chest x-ray from November 27, 2006. After he reviewed those studies, computerized images as opposed to films, he also reviewed a CT of the abdomen and pelvis taken November 25, 2006, the date of her admission to Southampton Hospital.

Dr. Gluck continued that a CT would be best to determine if there is fluid intra-abdominally, but an ultrasound could also be used. Either bone or soft tissue windows can indicate the presence of fluid. The technologist determines the settings and the reconstruction algorithms to be used for the CT scan. At the time, the standard slice was seven and a half millimeters. Whether contrast is used for the study is determined by the ordering physician based upon the risk of the contrast material posing an increasing danger to the patient. He did not have any recollection concerning whether he was involved in the determination to use contrast material.

Dr. Gluck testified that the CT of the abdomen indicated that the contrast was not observed distal to the stomach, so he thought that either the NG (nasogastric) tube had been on suction and suctioned the contrast material out, or the stomach was so dilated that there was a possibility that it could have lost its tone and did not have the muscle coordination to advance the contrast out of the stomach. That there was no indication as to whether there was bowel leakage preventing the contrast from advancing to the distal stomach. He continued that additional moderate density just inferior to the stomach most likely represented fluid and debris, which he thought could be fluid that was remaining in the stomach. There was no finding of an intra-abdominal abscess. There was loculated air noted in the ventral abdominal wall for which he gave the differential diagnosis of normal post-operative change. He stated it was as if the sutures were taken out and the wound was left open, which cannot be distinguished from a wound infection or a continuity with pneumoperitoneum. No additional imaging was required, but he did direct the clinical doctor to evaluate the cause since it was so close to the skin. He did not believe that a CT scan could specifically determine a wound infection from a sterile collection by itself.

Dr. Gluck testified that his custom and practice would have been to immediately call the physician and provide the report, his impression, and to try to be directive and helpful in further management of the patient. He had no independent recollection of recommending to Dr. Gredysa to order an upper GI series or a barium swallow. When shown page one of the CT of the abdomen, exhibit 3A, he stated that there was no indication that there was an intra-abdominal abscess within the abdomen. Exhibit 3B did not demonstrate leakage within the abdomen, but showed fluid which could be residual fluid from surgery, or leakage from the bowel viscus, which cannot be distinguished. In image 27, sequences 2, 28, 29, 30, 31, 32, 33, 35, 36, and 37, he stated that in the strict sense of an abscess being in a contained pocket, there was no fluid collection, however, in images 21 through 35, it was possible that there was an abscess in the abdominal wall. Exhibits 3C, 3D and images 41 through 49 did not show any indication of an intra-abdominal abscess, but images 61 and 62 showed fluid collection. His impression included "moderate air collection within the ventral abdominal wall. Directed physical exam is recommended, as a post-operative change cannot be distinguished from a wound infection." Dr. Gluck also stated that he referred to leakage wherein he stated there was "[p]ersistent pneumoperitoneum and ascites, more than would be expected five days following surgery. Clinical correlation with regard to perforated viscus is recommended." He testified that the abdominal wall was so close to the surface, that the value of this finding directs the surgeon to diagnose necrosis, so he gave the differential of whether it was a normal finding, a wound infection, or continuity from the free air.

Barry Armandi, Jr. M.D. testified to the extent that he is a physician licensed to practice medicine in New York and has been board certified in radiology since 2000. He has been employed by North Fork Radiology, Southampton Radiology and Hampton Radiology since July 2001, and has been a partner in these entities since

2003. He was also employed at Radiological Health Services, and as a partner, but it ceased to exist as a legal entity in 2005. East End Radiology came into existence in 2005, and he has been a partner and employee therein from its inception. On November 30, 2006, the last day of the plaintiff's admission to Southampton Hospital, he served as the interpreting radiologist for the performance of a limited upper GI series to rule out a leak, and also reviewed a CT scan of the abdomen/pelvis. Thereafter, he had no further involvement in the plaintiff's care during that admission. He interpreted those two studies in his capacity as an attending radiologist at Southampton Hospital, and as an employee of Southampton Radiology, P.C. pursuant to the service agreement between Southampton Hospital and Southampton Radiology, P.C.

Dr. Armandi stated that he did not prepare the x-ray settings utilized in generating the limited upper GI series as this was the duty of the technician employed by Southampton Hospital. Oral contrast, Gastrografin, was injected into the plaintiff's nasogastric tube. His impression was that of ill-defined peripyloric contrast collection. An abdominal CT was performed subsequent to the study to exclude contrast extravasation. There was right flank subcutaneous air foci, which was further detailed on the CT report. There was also noted dextroscoliosis of the thoracolumbar spine. Dr. Armandi stated that he could not fully determine whether there was a true collection from an extravasation, or if the contrast from the prior CT scan of November 29, 2006 was within the normal bowel loop. Since there was nothing more definitive that could be determined from the limited upper GI series, the follow up CT scan of the abdomen/pelvis was performed.

Dr. Armandi continued that his impression from the CT scan performed on November 30, 2006 was that there was no evidence of contrast extravasation on the study. There was postoperative ileus, free intraperitoneal air and fluid, and subcutaneous air. There was interval progression of bibasilar air space disease, with etiologies including pneumonia and atelectasis, for which he recommended clinical correlation. He noted resolving left pleural effusion. The remainder of the abdomen and upper pelvis appeared unchanged. Dr. Armandi adhered to the findings and commentaries from his reports, and stated that his overall impression was that there was no leak forming outside the bowel loops which thereby did not suggest extravasation, perforation, or a leak, showing improvement consistent with the post-surgical changes that take time to resolve.

Evan Dillon, M.D., the expert for defendants Gluck, Armandi, and the various radiology groups named as defendants, affirms that he is licensed to practice medicine in New York and has been board certified in radiology since 1987. He set forth his education, training, and clinical experience, and stated that he is fully familiar with the standards of care as they existed in 2006 regarding performance and interpretation of various radiological studies, including CT scans of the abdomen and pelvis, abdominal x-rays, and upper GI series. He set forth the materials which he reviewed and opined with a reasonable degree of medical certainty that at no time did Dr. Bradley Gluck or Dr. Barry Armandi depart from the accepted standards of medical/radiological care and practice, and that there is nothing which they did or did not do which proximately related to the injuries claimed on behalf of the plaintiff. Dr. Dillon stated that both Dr. Gluck and Dr. Armandi possessed the degree of skill, ability, competence, and experience commensurate with those radiologists performing the same radiological functions in the medical/radiological community.

Dr. Dillon stated that when Jennifer Vertullo, then a 34 year old female, arrived at Southampton Hospital emergency room on November 25, 2006, she presented with complaints of chest pain on a scale of 10/10 radiating to her neck and down her left arm, and was observed to have complaints of abdominal pain. She was in moderate distress, writhing in pain. Her abdomen was tender with guarding and decreased bowel sounds. A CT scan performed that morning revealed free intraperitoneal air and fluid, consistent with perforation of an intra-abdominal viscus. In reviewing those films, he noted an area of free air in the peritoneal cavity, as opposed

to bowel loops, with stomach distention. This free air, stated Dr. Dillon, essentially represents an escape of air from the bowel due to a hole/perforation. There was also evidence of liquid which spilled out into the peritoneal cavity. Thus, with a combination of markedly dilated stomach, there was a clear bowel perforation. Dr. Gredysa therefore performed an exploratory laparotomy, based on a preoperative diagnosis of a perforated viscus/perforated prepyloric gastric ulcer (area of the stomach connecting to the duodenum) which was closed using a Graham patch.

Dr. Dillon continued that status post-laparotomy, the plaintiff developed low blood pressure (hypotension), probable fluid depletion (hypvolemia), experienced ongoing abdominal pain, and was placed on wrist restraints. Dr. Gredysa was aware on November 29, 2006, that the plaintiff's mother, Emily Lia, was making arrangements for her daughter's transfer to New York Cornell Hospital. On November 29, 2006, a chest x-ray taken at 6:31 a.m., revealed a diminished inspiratory effort. Upon taking a portable bedside abdominal x-ray at 6:32 a.m., a nasogastric tube was properly placed into the stomach whereupon it was noted that there was "air distention of the stomach" but no free air or intestinal obstruction. Based upon his review of that x-ray, Dr. Dillon opines that there was no evidence that the Graham patch was not working.

Thereafter, Dr. Gredysa observed a worsening change in the plaintiff's condition. She was febrile with a temperature of 101.3 after being afebrile for forty eight hours. Therefore, a CT scan of the brain without IV contrast, and CT scans with and without oral contrast of the abdomen and pelvis were ordered. Dr. Dillon opined that it was fully appropriate for oral contrast to be used in this instance as IV contrast can sometimes create an increased risk for kidney failure and would not create a clearer image than oral contrast. The CT slice thickness was standard and appropriate. His review of the images demonstrated black areas interspersed with subcutaneous fat in the subcutaneous tissue, representing air. Additionally, there was air in the peritoneal cavity, much more than one would expect to see under the circumstances, and continguity of the air in the subcutaneous fat. He continued that this constellation of findings can only mean that the Graham patch was failing or had failed, and that there was a possibility of perforation for which clinical correlation was recommended. Dr. Dillon opined that Dr. Gredysa's interpretation was proper in all respects, and that a radiologist, who could not be named, advised Dr. Gredysa that the CT scan did not definitively demonstrate a leak, but that the findings were suspicious for a perforated viscus. Dr. Gredysa recommended to the plaintiff's mother that the plaintiff be taken to the operating room, however, Mrs. Lia was emphatic that she would not permit her daughter to be operated upon at this hospital and was arranging for her daughter's transfer. At 3:30 p.m., Dr. Gredysa authored a note which stated that the "[w]ound opened. Large amount of greenish material evacuated. Culture and sensitivity obtained."

Dr. Dillon continued that on November 30, 2006, at 9:30 a.m., Dr Gredysa ordered an abdominal CT with Gastrografin via nasogastric tube administration to rule out a gastric leak. A photo timer was used to generate the settings for the studies. Dr. Armandi properly interpreted the upper GI series films within accepted standards of medical/radiological care. Dr. Armandi indicated that he could observe a peripyloric contrast collection, meaning that the contrast material was pooling in or around the gastric pylorus. Consequently, a repeat CT of the abdomen and pelvis was performed, and it was within accepted standards to do so, opined Dr. Dillon. Dr. Dillon also stated that the CT slice thickness was standard and appropriate, and that Dr. Armandi properly interpreted the films within accepted standards of medical/radiological care in commenting that he observed resolving and decreased free air. Dr. Dillon stated that this would have been due to Dr. Gredysa's interval removal of skin staples from the prior day, causing free air to escape. The plaintiff was transferred that same day to New York Cornell Medical Center where an exploratory laparotomy was performed the evening of transfer.

Dr. Dillon concluded that there is nothing that Dr. Gluck or Dr. Armandi did or did not do that caused injury to the plaintiff. Dr. Gluck provided Dr. Gredysa with sufficient information regarding the plaintiff's status based upon his interpretation of the CT films, such that Dr. Gredysa wanted to proceed to surgery on November 29, 2006, however, Mrs. Lia refused to permit surgery to be done at Southampton Hospital. He continued that Dr. Armandi's interpretation of the CT films on November 30, 2006 is superfluous to the situation, given that Mrs. Lia already declined surgery for her daughter and had plans in place to transfer her. Dr. Dillon opined that the plaintiff's results from the surgery performed at New York Cornell Medical Center would not have been any different had it been done on November 29th or 30th, 2006.

Based upon the foregoing, Dr. Gluck, Dr. Armandi, and Southampton Radiology have demonstrated prima facie entitlement to summary judgment dismissing the complaint as asserted against them. The plaintiff has not opposed this motion and has otherwise failed to raise a triable issue of fact to preclude summary judgment from being granted to the moving defendants.

Accordingly, that branch of motion (003) by Dr. Gluck, Dr. Armandi, and Southampton Radiology, P.C. which seeks summary judgment dismissing the complaint is granted and the complaint as asserted against them is dismissed with prejudice.

It has further been established prima facie that Dr. Gluck and Dr. Armani were employed by Southampton Radiology, P.C. which provided radiology services to Southampton Hospital. No radiology services were provided to Southampton Hospital by defendants Hampton Radiology, P.C., East End Radiology, P.C. f/k/a Radiological Health Services, P.C., and North Fork Radiology, P.C.

Accordingly, that branch of motion (003) wherein Hampton Radiology, P.C., East End Radiology, P.C. f/k/a Radiological Health Services, P.C.,and North Fork Radiology, P.C. seek summary judgment dismissing the complaint is granted and the complaint as asserted against them is dismissed with prejudice.

In motion (004), the expert for Southampton Hospital, Thomas H. Magnuson, M.D. averred that he is licensed to practice medicine in Maryland and is board certified in surgery, and stated that the affidavit is not intended to criticize the care and treatment rendered by Leslaw Jozef Gredysa, M.D. He set forth the records and materials which he reviewed, and opined to a reasonable degree of medical certainty that the care and treatment rendered by the doctors, nurses, and staff at Southampton Hospital to Jennifer Vertullo was not the proximate cause of the plaintiff's alleged injuries, including a perforated duodenal ulcer, a failed gastroduodenal ulcer repair/Graham patch repair, sepsis, hypotension, respiratory failure, congestive heart failure, wound dehiscence, multiple intra-abdominal abscess, pelvic abdominal abscess, massive abdominal biliary contamination, enterocutaneous fistula, abdominal compartment syndrome, the need for intubation, a nasogastric tube, multiple exploratory laparotomies, tracheostomy, antecolic gastrojejunostomy, the transfusion of packed red blood cells, intra-abdominal wound infection, and delirium and/or agitation.

Dr. Magnuson stated that Jennifer Vertullo presented to the Southampton Hospital emergency department at 6:58 a.m. on November 25, 2006 with complaints of chest pain and Charley horses all over. She had a past medical history for neuroblastoma as a child and underwent chemotherapy and radiation after surgery for the neuroblastoma. She also had a left subclavian clot and lymphedema, and multiple spinal surgeries. She had a history of depression which was being addressed with medications. She was triaged in the emergency room at 7:10 a.m. and seen by Dr. Hunt, the emergency room physician, before 7:20 a.m. Dr. Hunt, upon examination, noted that she was in extreme pain and had decreased bowel sounds in the right abdominal area. Chest x-ray

revealed lucency below the hemidiaphragm, which was highly suspicious for free intraperitoneal air. Thus, a CT can was ordered. Dr. Hunt's impression was that of a perforated abdominal viscus. The CT scan, completed at 8:46 a.m., resulted in an impression of intraperitoneal air and fluid, findings consistent with perforation of an intra-abdominal viscus. Dr. Gredysa reviewed those films. The plaintiff signed a consent for an exploratory laparotomy, possible bowel resection, and possible colostomy, after having been informed of the risks, complications, and benefits involved, as well as the alternatives. She also signed the consent for general anesthesia, which advised of the risks, benefits, and complications, as well.

Dr. Magnuson continued that the exploratory laparotomy was performed between 10:30 a.m. and 1:00 p.m. by Dr. Gredysa, who found that she had spillage of gastric content throughout the peritoneal cavity. Food particles were suctioned prior to examination of the abdomen. Further exploration revealed a perforation in the lesser curvature in the prepyloric area. Dr. Gredysa utilized a section of the omentum to patch the perforation site, then copiously irrigated the abdomen with 5 liters of saline and 1 liter of Clindamycin. A nasogastric tube was placed, and she remained stable in PACU during her stay. The pathology report by Dr. Tamsen documents that the tissue submitted was consistent with a perforated ulcer. The biopsied material was interpreted to represent an acute ulcer and connective tissue with edema, neovascularization and reactive changes consistent with a perforated ulcer. She was admitted to ICU at 2:45 p.m. Dr. Magnuson stated that detailed records were maintained concerning the plaintiff's care and treatment. Dr. Sklarek saw the plaintiff on pulmonary consult. His impression was that the plaintiff probably had abdominal sepsis related to a gastric ulcer, hypotension, and probable hypovolemia, for which she was treated with fluids, medication and antibiotics.

Dr. Magnuson stated that the plaintiff was also seen by Dr. Gary S. Rosenbaum on an infectious disease consult. He noted she had an increasing white blood cell count on post-operative day 3, and had concerns that she had a possible sepsis from a possible intra-abdominal source. It was also thought that she may have a central nervous system infection, however, the family refused a lumbar puncture. Antibiotic coverage was then switched. Dr. Magnuson continued that on November 28, 2006, the plaintiff developed a firm, distended abdomen and loose stools which continued on November 29, 2006. An abdominal x-ray revealed no evidence of free air or intestinal obstruction, though there was air distention within the stomach. A CT of the abdomen and pelvis on November 29, 2006, interpreted by Dr. Gluck, showed moderate air collection within the ventral abdominal wall. A directed physical exam was recommended, as normal post-operative changes could not be distinguished from a wound infection. Contiguity with pneumoperitoneum could not be excluded and there was persistent pneumoperitoneum and ascites, more than would be expected five days following surgery. Clinical correlation with regard to perforated viscus was recommended; sigmoid mural thickening raised the possibility of uncomplicated colitis; there was suspected moderate fluid distention despite the presence of a nasogastric tube, and questionable nasogastric tube dysfunction. Also noted was diffuse ileus.

Dr. Magnuson stated that Dr. Gredysa opened the wound on November 29, 2006, and a large amount of green bile poured out of the wound, which was then irrigated with normal saline and packed. An EEG, as suggested by the neurologist, Dr. Pflaster on November 29th, was declined by the plaintiff's mother. The plaintiff was reporting decreased pain relief and was noted to have agitation and discomfort. On November 29th, the plaintiff was also seen by the pulmonologist, and for infectious disease, and pain management consultants. When the plaintiff was seen on November 29th by Dr. Patel, her primary care doctor, the family requested that the plaintiff be transferred to New York Hospital/Cornell, however, no beds were available, so the plaintiff was monitored. On November 30th, a CT of the abdomen and pelvis and upper GI series was noted by Dr. Armandi to show no evidence of contrast extravasation; right flank subcutaneous air foci was appreciated; resolving post-operative ileus, and free intraperitoneal air and fluid and subcutaneous air were also noted. Dr. Armandi then

obtained an upper GI Series on November 30th and noted that this study revealed an ill-defined peripyloric contrast collection. The family continued to request the plaintiff's transfer. A bed became available at New York Hospital/Cornell on November 30, 2006, and the plaintiff was transferred at 5:15 p.m. According to Dr. Gredysa's last entry into the plaintiff's chart, there was no evidence of bile leak from the gastric site, and Dr. Armandi had found no evidence of contrast extravasation on the CT scan.

The evidentiary submissions establish prima facie that Dr. Gredysa was an employee of Peconic Surgical Group with privileges at Southampton Hospital, and was not an employee of Southampton Hospital. He had been called in at the plaintiff's mother's request that he evaluate her daughter when she was in the emergency room at Southampton Hospital and during her admission. He was not on call for the hospital that evening. Dr. Gredysa's credentials, board certification, and experience establish his qualifications upon which privileges were granted to him to practice medicine at Southampton Hospital. He was fully qualified to perform the subject surgery and possessed more than sufficient experience, skill and training to perform the exploratory laparotomy and repair of the perforated gastric ulcer on November 25, 2006. It has also been established prima facie that Dr. Gredysa provided informed consent to the plaintiff for the surgical procedure performed on her. Based upon the forgoing, it has been established prima facie that Southampton Hospital is not vicariously liable for the acts of Dr. Gredysa as an independent, private physician, and that they did not negligently hire him.

It has already been established that there is no cause of action against the radiologists, Dr. Gluck and Dr. Armandi, and/or against Southampton Radiology, P.C. Southampton Hospital is not vicariously liable for their performances and/or interpretations of the various radiology diagnostic testings or studies. It is also determined that Dr. Gluck and Dr. Armandi were qualified to interpret the radiology studies performed at Southampton Hospital and that they possessed more than sufficient experience, skill, and training to interpret said studies during the plaintiff's admission to Southampton Hospital. There is nothing to show that Southampton Hospital hired anyone, or gave privileges to anyone who was unfit, inexperienced, and/or incompetent to practice, or that it failed to properly train or supervise its employees or staff, or require skill and competence within the medical community. Dr. Magnuson has stated that he found no evidence to support a contention that the hospital failed to promulgate those necessary and proper rules, regulations, bylaws, protocols, and guidelines necessary to those functions and activities at the hospital, or that any such alleged failure was a proximate cause of any of the alleged injuries sustained by the plaintiff.

Dr. Magnuson has also established prima facie that the nursing staff and employees of Southampton Hospital did not depart from good and accepted standards of care and treatment. They appropriately followed instructions and directions given by the ordering physicians. They properly apprised Dr. Gredysa of the plaintiff's condition in a timely and competent fashion. There was no failure to provide adequate staff or failure for a consultant to timely and competently provide care and treatment to the plaintiff. The hospital and its employees and staff, and Dr. Gredysa, Dr. Gluck and Dr. Armandi, did not violate any rules, regulations, bylaws, protocols, and/or guidelines typically enforced at New York Hospitals. He continued that the care and treatment by the defendants and the staff and employees at Southampton Hospital did not depart from the accepted standard of medical care and practice and did not proximately cause injury to the plaintiff.

Based upon the foregoing, it is determined that Southampton Hospital has demonstrated prima facie entitlement to dismissal of the complaint. The plaintiff has not opposed this motion or otherwise raised a factual issue to preclude summary judgment from being granted to Southampton Hospital.

Accordingly, motion (004) is granted and the complaint as asserted against Southampton Hospital is dismissed with prejudice.

The foregoing constitutes the Order of this Court.

Dated: July 6, 2012
Central Islip, NY

HON. HECTOR D. LASALLE, J.S.C.

____ FINAL DISPOSITION __X__ NON-FINAL DISPOSITION