SHORT FORM ORDER

INDEX No. 08-27212
CAL. No. 11-02549MM

SUPREME COURT - STATE OF NEW YORK
I.A.S. PART 33 - SUFFOLK COUNTY

PRESENT:

Hon. THOMAS F. WHELAN
Justice of the Supreme Court

MOTION DATE 5-2-12 (#007)
MOTION DATE 5-3-12 (#008)
MOTION DATE 5-16-12 (#009)
MOTION DATE 5-21-12 (#010)
ADJ. DATE 6-25-12
Mot. Seq. # 007 -MG # 008 - MG
009- MG # 010 -XMG

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ANTHONY LAPIANA, as Administrator of the Estate of JOHANNA LAPIANA, Deceased, and ANTHONY LAPIANA, Individually,

Plaintiffs,

- against -

ROBERT A.B. ROCHE, M.D., JOHN F. GALLAGHER, M.D., STEVEN SAMUELS, M.D., KENNETH D. GOLD, M.D., ROBERT T. CHATALBASH, M.D., STEVEN SAMUELS, M.D., P.C., JOHN F. GALLAGHER, M.D., P.C., SUFFOLK INTERNAL MEDICINE ASSOCIATES, P.C., HEMATOLOGY ONCOLOGY ASSOCIATES OF WESTERN SUFFOLK, P.C., WESTERN SUFFOLK GASTROENTEROLOGY, LLP, NORTH SHORE-LONG ISLAND JEWISH HEALTH SYSTEM, INC., and SOUTHSIDE HOSPITAL,

Defendants.

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Upon the following papers numbered 1 to 71 read on these motions for summary judgment; and this cross motion to preclude; Notice of Motion/ Order to Show Cause and supporting papers (007) 1-20; (008) 21-41; (009) 42-67; Notice of Cross Motion and supporting papers (010) 68-71; 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 (007) by defendants, North Shore-Long Island Jewish Health System, Inc. and Southside Hospital, pursuant to CPLR 3212 for summary judgment dismissing the complaint and all cross claims asserted against them is granted with prejudice; and it is further

ORDERED that motion (008) by defendants, John F. Gallagher, M.D., and John F. Gallagher, M.D., P.C., pursuant to CPLR 3212 for summary judgment dismissing the complaint and all cross claims asserted against them is granted with prejudice; and it is further

ORDERED that motion (009) by defendants, Steven Samuels, M.D., Steven Samuels, M.D., P.C., and Suffolk Internal Medicine Associates, P.C., pursuant to CPLR 3212 for summary judgment dismissing the complaint and all cross claims asserted against them is granted with prejudice; and it is further

ORDERED that motion (010) by the plaintiff, Anthony Lapiana, pursuant to CPLR Article 16 to preclude the remaining defendants from seeking apportionment of liability and contribution against any defendant for whom summary judgment has been granted, is granted, and the remaining defendants are precluded from asserting the limited liability provisions provided pursuant to CPLR Article 16 against defendants, North Shore-Long Island Jewish Health System, Inc. and Southside Hospital, John F. Gallagher, M.D., John F. Gallagher, M.D., P.C., Steven Samuels, M.D., Steven Samuels, M.D., P.C., and Suffolk Internal Medicine Associates, P.C., at the time of trial.

In this action premised upon the alleged medical malpractice and for the wrongful death of the plaintiff's decedent, Johanna Lapiana, the complaint sets forth causes of action premised upon the negligent departures from good and accepted standards of care and treatment of plaintiff's decedent, by the defendants, from October 19, 2006 through October 27, 2006, lack of informed consent, and a derivative claim on behalf of Anthony Lapiana, decedent's spouse. It is alleged that the defendants were negligent in their care and treatment of Johanna Lapiana in failing to properly diagnose and treat her for an infected and gangrenous gallbladder, and sepsis, and failing to timely perform surgery and administer antibiotics, as well as other necessary and indicated modalities for proper treatment of her condition, causing her condition to worsen and deteriorate, resulting in transfusions, abdominal pain, endotracheal intubation, percuctaneous drainage of the gallbladder, acute respiratory failure, biventricular failure, myocardial infarction, multi-organ failure, cardiac arrest, cerebral hypoxia, bleeding, and gangrene of the gall bladder, culminating in her death on October 27, 2006.

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. To grant summary judgment it must clearly appear that no material and triable issue of fact is presented (***Friends of Animals v Associated Fur Mfrs.,*** 46 NY2d 1065, 416 NYS2d 790 [1979]; ***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 [1999]). 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***, 224 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], *app denied* 92 NY2d 814, 681 NYS2d 475 [1998]; ***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]).

In motion (007), defendants North Shore-Long Island Jewish Health System, Inc. and Southside Hospital, have submitted the affidavit of Thomas H. Magnusun, M.D. in support of their application to dismiss the complaint and cross claims asserted against them. Dr. Magnusun avers that he is licensed to practice medicine in the State of Maryland and is board certified in surgery. He set forth his educational background and medical experience, and the materials and records which he reviewed. He opined with a reasonable degree of medical certainty that the doctors, nurses, and staff at North Shore-Long Island Jewish Health System, Inc. (NS-LIJ) and Southside Hospital (Southside) did not deviate from the accepted standard of care in medicine in the care and treatment of Johanna Lapiana, and that the care and treatment rendered by them did not proximately cause her alleged injuries and death.

Dr. Magnusun set forth that Johanna Lapiana was hospitalized at Southside Hospital from October 19, through October 27, 2006. He set forth her medical history of breast and skin cancer, diabetes, hypertension, chronic atrial fibrillation, chronic anemia, thalassemia, hysterectomy, and spinal surgery. She also had mitral valve replacement after a stroke and was maintained on Coumadin as prescribed by Dr. Donnelly, her hematologist. Defendant Dr. Robert Roche, certified in internal medicine, began treating plaintiff on April 25, 2005. On October 16, 2006, Dr. Roche saw and examined Ms. Lapiana for complaints of abdominal pain, fever, and nauseousness. His clinical impression was abdominal pain, questionable diverticulitis, or GERD, for which he ordered a CT scan of the abdomen, and referred her to be seen immediately by Dr. Mary Thomas, her gastroenterologist. Dr. Thomas ordered a CT of the gallbladder and admitted her through the emergency room to Southside Hospital on October 19, 2006, at about 5:00 p.m. The CT scan demonstrated that she had acute cholecystitis (inflammation of the gallbladder). Dr. Roche was her private attending physician during this admission to Southside Hospital. Dr. Gallagher's group was called in for a surgical consultation. Upon admission, her prothrombin time was 60.1 (normal 9.9-13.2), INR 3.88 (normal .88-1.15); hemaglobin 8.1

(normal 12.0-16); and a blood culture was negative for growth after 48 hours and after five days. An ultrasound of the abdomen on October 19, 2006 indicated hepatomegaly, marked splenomegaly, and a thickened gallbladder wall with gall stones. Further evaluation with a HIDA scan was recommended. A chest x-ray on that date revealed that the decedent had an enlarged heart and linear atelectasis, or scarring at the left lung base. Dr. Sacca saw her concerning her complaints of abdominal pain, and agreed with the plan for a HIDA scan. Dr. Sacca indicated the need to hold the Coumadin and provide Heparin after the INR normalized. Thus, she was not administered Coumadin during this hospital admission.

Dr. Magnusun continued that Dr. Gold, who was called in by Dr. Roche for a hematology consult on October 20, 2006, felt that holding the Coumadin was appropriate as she was above the therapeutic INR. However, Dr. Gold felt that although a transfusion was not urgent, it was necessary, so he wrote an order to transfuse the plaintiff's decedent with 2 units of packed cells, which Ms. Lapiana refused until the evening of October 20, 2006. Dr. Roche called in Dr. Catalbash, a partner at Gastroenterology Associates who was board certified in gastroenterology and internal medicine, for a gastroenterology consultation on October 20, 2006. Dr. Catalbash indicated a need to wait for the INR to be normalized before a cholecystectomy (removal of the gall bladder) could be safely performed. His partner ordered Invanz, a broad spectrum antibiotic, to treat the cholecystitis. Dr. Roche called a cardiac consultation by Dr. Reich on October 20, 2006. Dr. Reich found no evidence of congestive heart failure or acute coronary syndrome. Atenolol was prescribed for blood pressure control.

On October 21, 2006, Dr. Catalbash agreed with the plan for a cholecystectomy once the PT/INR corrected. Vitamin K was given due to mild hemorrhoidal bleeding. Dr. McCormick, also a cardiologist, saw the plaintiff's decedent on that date and advised that surgery could not be done due to the INR/PT. Due to difficulties starting an intravenous in the plaintiff's decedent's peripheral veins, she had no IV access on October 22, 2006, as noted by Dr. Roche, Dr. Reich, and Dr. Catalbash. Thus, she received no intravenous antibiotic. Dr. Catalbash was asked by Dr. Roche to re-evaluate the plaintiff's decedent on October 22, 2006 due to increased right upper quadrant pain. Dr. Catalbash ordered a hematology re-evaluation for fresh frozen plasma administration to bring down the PT so surgery could be performed. However, opined Dr. Magnusun, the standard of care did not require fresh frozen plasma to be administered to bring down the clotting time, and the patient's risk had not changed. She was stable, she was not septic, and she was being followed by gastroenterology and surgery. Dr. Chatalbash also ordered an increased dose of Vitamin K for the next three days to completely, and more rapidly, reverse the effects of Coumadin, though the need for maximal anticoagulation without lapses secondary to her prosthetic valve, atrial fibrillation, and anticardiolipin antibody, were noted. Dr. Roche was apprised by nursing staff of the INR of 1.77 and PT of 23 and PTT of 35.1, so the Vitamin K was held. That evening, Heparin was started as surgery was planned. Dr. Sacca decided to remove her gall bladder as soon as she was cleared by cardiology. Dr. Gold's partner, Dr. Hyman, saw the plaintiff's decedent on October 23, 2006. The plan was for the surgery to be performed on October 24, 2006, as she had been cleared by Dr. Kirschner, the cardiologist.

On October 23, 2006, the plaintiff's decedent signed the consent for an exploratory laparoscopic, possible open, cholecystectomy, and insertion of a triple lumen catheter. However, at 11:20 a.m, the nursing staff was unable to obtain the plaintiff's decedent's blood pressure, her skin was pale, and her fingertips and nail beds were bluish. Thus, stated Dr. Magnusun, she was not considered to be medically stable to proceed with surgical intervention, despite having been converted to Heparin. Blood work at 3:10 p.m. was suggestive of a myocardial infarction. She was transferred to Intensive Care and intubated at 6:15 p.m. on October 23, 2006. Dr. Samuels was called in by Dr. Roche for an infectious disease consultation that day. Dr. Samuels concluded

that she was on appropriate antibiotics, which he renewed. However, stated Dr. Magnusun, Dr. Samuels' concern was that the plaintiff's decedent might have early gangrene of the gallbladder, based on a white blood cell count of 20,000, and that she had an infection secondary to an intra-abdominal sepsis, likely due to gallbladder disease. Dr. Samuels felt she should go to surgery as soon as she was medically stable.

Dr. Magnusun continued that on October 24, 2006, cardiac markers confirmed an acute myocardial infarction. Dr. Gallagher, a partner at Great South Bay Surgical Associates and Vascular Lab, then became involved in the plaintiff's decedent's care and treatment. He determined that the plaintiff's decedent was in septic shock secondary to a problem referable to acute cholecystitis. She was noted to be intubated, with a blood pressure of 80/50, and central venous access had to be established. Dr. Magnusun, stated that when a patient is therapeutically anticoagulated, there is an increased risk of bleeding if one attempts to place a percutaneous central catheter. Thus, Dr. Gallagher stopped the Heparin and placed a triple lumen catheter in the right femoral vein under sonocontrol. A Quinton catheter was placed in the right femoral artery. These procedures were done without incident. An echocardiogram revealed she was in biventricular failure, and was considered to be too unstable to undergo gallbladder surgery. Dr. Magnusun stated that on October 25, 2006, Dr. Roche documented that she had generalized anasarca (swelling) with poor urinary output. Her abdomen was distended with no bowel sounds. The plan was for renal consultation with possible renal dialysis. Dr. Roche consulted with cardiologist, Dr. McCormick, and pulmonologist, Dr. Zwang. Her overall prognosis was poor. Because her heart ejection fraction was at 15%, due to the biventricular failure, she was noted to be unable to survive surgical intervention.

Dr. Magnusun stated that Dr. Samuels felt that at no time between October 23rd and 25th was the plaintiff's decedent stable enough medically for gallbladder surgery to be performed. On October 26, 2006, Dr. Roche spoke with the decedent's family. He noted she had no urinary output. She had atrial fibrillation, was not assisting the respirator, and was not responding to painful stimuli. On October 26, 2006, informed consent was obtained for a bedside cholecystostomy (a procedure to drain fluid from the gallbladder). Dr. Kranz, the interventional radiologist, placed the percutaneous catheter to aspirate the biliary drainage from the gallbladder, without complication. Due to her poor prognosis, a Do Not Resuscitate order was executed. The plaintiff's decedent died on October 27, 2006.

Based upon his review of the records, Dr. Magnusun opined that there are no bases upon which to conclude that there were any departures from the standard of care by the nurses, doctors, and staff at Southside Hospital/NorthShore-LIJ. He continued that all the prothrombin times were done and checked continuously; all blood work was timely performed; coagulation rates were properly monitored; the plaintiff's decedent was not permitted to become dehydrated; all medications were timely and properly administered or held as ordered by the physicians, including Coumadin and Heparin; all reasonable efforts were made to maintain and restart intravenous access; antibiotics, as ordered by the physicians, were appropriately administered; the decedent's physicians were timely notified of all blood work, including INR levels; gallbladder disease was timely and appropriately diagnosed; the hospital record is devoid of any evidence to support that the hospital failed to hire and adequately train competent personnel, and that privileges were granted to qualified and competent physicians; necessary and proper diagnostic tests were ordered and completed timely and properly; percutaneous catheter drainage of the gallbladder was performed by Dr. Gallagher and Dr. Kranz, and not by hospital staff or personnel, thus any allegation that the hospital staff improperly performed such procedure is without merit or basis; medical history and facts were properly ascertained, charted and considered by the hospital staff; Vitamin K was timely and appropriately administered; consultations were timely and appropriately made; the decision of whether or not to proceed with surgery rested with the physician and not the hospital staff; INR levels were

properly reduced to permit the administration of Heparin; no autopsy was performed, therefore it is unknown whether or not the plaintiff's decedent had gangrene of the gallbladder, thus such claim is unsupported by the record; that the decedent required surgery was charted, but she remained too unstable medically to perform such surgical intervention; and whether blood was to be transfused, or fresh frozen plasma or packed red cells to be administered, was a determination to be made by the physicians, and not the hospital staff who did not delay in administering the same as ordered. The family and patient were made aware of all reasonable risks. Dr. Magnusun set forth the basis for each opinion.

Based upon a review of the admissible evidence, and the expert opinion of Dr. Magnusun, it is determined that North Shore-Long Island Jewish Health System, Inc. and Southside Hospital have demonstrated prima facie entitlement to summary judgment dismissing the complaint. The plaintiff does not oppose this application and has thus failed to raise any factual issue to preclude summary judgment from being granted.

Accordingly, motion (007) is granted and the complaint and all cross claims asserted against North Shore-Long Island Jewish Health System, Inc. and Southside Hospital are dismissed with prejudice.

In motion (008), defendants John F. Gallagher, M.D., and John F. Gallagher, M.D., P.C., have submitted the expert affirmation of Evan Geller, M.D. who affirms that he is licensed to practice medicine in New York and is board certified in general surgery with a subcertification in critical care. He set forth his education, training, and experience in medicine, and the records and materials which he reviewed. He sets forth his opinions with a reasonable degree of medical certainty based upon his having treated hundreds of patients for gallbladder disease. He stated that he has frequently performed cholecystectomies.

Dr. Geller set forth the moving defendants' involvement with the decedent's care and treatment while she was hospitalized. It is Dr. Geller's opinion that patients on advanced life support benefit from long-term central access as it facilitates the administration of life-sustaining fluid, parenteral nutrition, and intravenous medication administration, and decreases the risk of infection and discomfort associated with repeat venipuncture. He continued that the standard of care requires that anticoagulants such as Heparin be held prior to attempting to insert central venous and arterial catheters to avoid the risk of bleeding from the procedure. Thus, he opined, it was proper and consistent with good and accepted medical and surgical practice for Dr. Gallagher to hold the Heparin for insertion of the catheters, which was accomplished without complication. He continued that Dr. Gallagher promptly responded and cared for the patient when he was notified.

Dr. Geller continued that Dr. Gallagher's determination that the patient was too unstable to undergo an open or laparoscopic cholecystectomy due to her hemodynamic instability, systolic blood pressure of 85/60 from the myocardial infarction, was proper and consistent with good and accepted surgical practice. He opined that Dr. Gallagher's recommendation for cholecystostomy, as an alternative to open or laparoscopic cholecystectomy, was prudent, reasonable, and within the standard of care in the surgical community based upon the patient's presentation, physical examination findings, including abdominal tenderness in the right upper quadrant upon deep palpation, and diagnostic and blood work results. He continued that cholecystostomy was necessary, indicated, and carried out in a manner consistent with good and accepted surgical practice. Dr. Gallagher properly reviewed the decedent's records, performed a thorough and proper physical examination, and properly communicated and collaborated with the patient's other attending specialists regarding his recommendation for percutaneoous cholecystostomy. Dr. Geller added that Dr. Gallagher timely contacted the interventional radiologist, Dr. Kranz, to request the bedside cholecystostomy, which was timely performed just one and one half hour following Dr. Gallagher's request.

Dr. Geller concluded that during the decedent's admission from October 19, 2006 through October 27, 2006, that Dr. Gallagher, M.D., and Dr. Gallagher, M.D, P.C., did not commit any affirmative acts of negligence and/or medical malpractice, or omit any care and treatment, that proximately caused injuries or the death of the plaintiff's decedent.

Based upon the foregoing, John F. Gallagher, M.D., and John F. Gallagher, M.D., P.C. have established prima facie entitlement to summary judgment dismissing the complaint. The plaintiff has not opposed this application and has thus failed to raise a factual issue to preclude summary judgment from being granted herein.

Accordingly, motion (008), which seeks dismissal of the complaint and all cross claims as asserted against John F. Gallagher, M.D., and John F. Gallagher, M.D., P.C., is granted.

In support of motion (009), defendants, Steven Samuels, M.D., Steven Samuels, M.D., P.C., and Suffolk Internal Medicine Associates, P.C., have submitted, inter alia, the corrected affirmation of their expert physician, Alan A. Pollock, M.D., who affirms that he is a physician licensed to practice medicine in New York and is board certified in internal medicine and the sub-specialty of infectious diseases, and further board certified by the National Board of Medical Examiners. Dr. Pollack set forth his education and experience, and the materials and records which he reviewed. He presents his opinions based upon a reasonable degree of medical certainty. It is Dr. Pollack's opinion that Steven Samuels, M.D., Steven Samuels, M.D., P.C., and Suffolk Internal Medicine Associates, P.C., who had seen the plaintiff's decedent for an infectious disease consult, acted in accordance with the accepted standards of medical care and treatment, and that they did not proximately cause the injuries to, and death of, the plaintiff's decedent.

Dr. Pollack set forth the decedent's history and presentation to Southside Hospital and the relevant course of treatment during her admission thereto. He continued that on October 23, 2006, when the decedent was seen by Dr. Samuels in the intensive care unit, he noted that she had a history of recent diagnosis of cholecystitis, and had been seen for cardiology, hematology/oncology, and gastroenterology consults. He noted her past medical history, inclusive of a hypercoagulable state with anti-cardiolipin antibodies, and that she was maintained on Coumadin. Dr. Pollack set forth the examination performed, the findings upon examination, and that he noted the patient was currently on an appropriate broad spectrum intravenous antibiotic, Invanz, at a dosage of 1000 mg daily. It was Dr. Samuel's impression that, although the plaintiff's decedent was on an appropriate antibiotic, given her white blood cell count of 20,000, she had early gangrene of the gall bladder. Dr. Samuels further recommended that she should have surgery as soon as she was medically stable and cleared by cardiology. He continued that although Dr. Samuels felt that a cholecystectomy was needed as soon as possible, that it must be tempered by the fact that she may have had an acute myocardial infarction. Thus, cardiology would ultimately make the decision on her clearance for surgery, and that it should be accomplished as soon as possible. Antibiotics were to be continued and her condition monitored. Her prognosis was guarded.

Dr. Pollack continued that on October 24, 2006, Ms. Lapiana was seen by Dr. Samuels' partner, non-party Dr. Lenefsky, who reviewed that the blood cultures were negative, and that the ejection fraction of her heart was 10-15%, thus she would not have been able to survive surgical intervention. He noted that a cholecystostomy to drain fluid from the gallbladder, had been performed the night before. When Dr. Samuels saw the plaintiff's decedent on October 26, 2006, he reduced the antibiotic Invanz to 500 mg daily due to her kidney dysfunction. He assessed that she had septic shock as she had multi-organ failure with shock involving the liver, lung, and kidneys. She was also suffering from anoxic encephalopathy. He noted her prognosis to be

grave. On October 27, 2006, he noted the blood cultures showed coagulase-negative staphylococci, contaminants from her skin. Ms. Lapiana subsequently expired on October 27, 2006.

Dr. Pollack set forth that all the care and treatment provided by Dr. Samuels conformed in all respects with accepted medical practice. His role as an infectious disease consultant was to select the appropriate antibiotic for the treatment of the cholecystitis, and she was prescribed a broad spectrum antibiotic which is used to treat bacteria that would cause cholecystitis. He continued that Dr. Samuels appropriately ordered blood cultures which were negative, indicating that the antibiotic therapy was correct. When she was noted to have kidney dysfunction, he appropriately ordered a reduced dosage of the antibiotic, and also ordered a Vancomycin level. Dr. Pollack further opined that there was nothing in Dr. Samuels' care and treatment of the plaintiff's decedent which was the proximate cause of any of the plaintiff's decedent's alleged injuries, or her death. Dr. Pollack set forth the bases for his opinions.

Based upon the foregoing, Steven Samuels, M.D., Steven Samuels, M.D., P.C., and Suffolk Internal Medicine Associates, P.C., have established prima facie entitlement to summary judgment dismissing the complaint. The plaintiff has not opposed this application and has failed to raise a factual issue to preclude summary judgment from being granted to the moving defendants.

Accordingly, motion (009) by Steven Samuels, M.D., Steven Samuels, M.D., P.C., and Suffolk Internal Medicine Associates, P.C. for summary judgment dismissing the complaint and all cross claims asserted against them is granted.

Turning to motion (010), the plaintiff seeks an order precluding the remaining defendants from seeking apportionment of liability and contribution against any defendant for whom summary judgment has been granted. None of the defendants have submitted expert affirmations asserting liability against any co-defendant against whom the action has been dismissed, thus, the limited liability protection afforded by Article 16 as to any remaining co-defendant at the time of trial is precluded as it relates to those defendants who have been granted summary judgment herein (*see, **Dembitzer v Broadwall Management Corp,*** 2005 NY Slip Op 50303U, 6 Misc 3d 1035A, 800 NYS2d 345, 2005NY Misc LEXIS 420; citing ***Hanna v Ford Motor Co.***, 252 AD2d 478, 479, 675 NYS2d 125 [2d Dept [1998]). Here, it would be cold comfort to the defendants against whom summary judgment has been granted, and to the plaintiff, if the remaining defendants were permitted to assert the limited liability protection afforded by Article 16 against the defendants where the complaint and cross claims have been dismissed against them. Each defendant has had the opportunity to present expert testimony against any co-defendant at this time of summary judgment, and have failed to do so. Thus, they are precluded from doing so at the time of trial.

Accordingly, motion (010) by the plaintiff is granted and the remaining defendants are precluded from asserting the limited liability protection afforded by CPLR Article 16 for apportionment of liability or contribution against those defendants who have been granted summary judgment herein.

Dated: 3/25/12

THOMAS F. WHELAN, J.S.C.