Dixon v Puma
2017 NY Slip Op 30405(U)
January 27, 2017
Supreme Court, Kings County
Docket Number: 501004/2011
Judge: Gloria M. Dabiri

At an IAS Part 2 of the Supreme Court of the State of New York, held in and for the County of Kings, at the Courthouse, at Civic Center, Brooklyn, New York, on the 22nd day of December, 2016

PRESENT:

HON. GLORIA M. DABIRI,
Justice.

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LEE DIXON AND CEDRIC DIXON, AS THE ADMINISTRATORS OF THE ESTATE OF CAROLYN DIXON, DECEASED, LEE DIXON, INDIVIDUALLY, AND CEDRIC DIXON, INDIVIDUALLY,

DUPLICATE ORIGINAL

Plaintiffs,

- against -

Index No. 501004/11

JOSEPH PUMA, et al.,
Defendants.

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The following papers numbered 1 to 17 read herein:

	Papers Numbered
Notice of Motion/Order to Show Cause/ Petition/Cross Motion and Affidavits (Affirmations) Annexed	1 - 16
Opposing Affidavits (Affirmations)	
Reply Affidavits (Affirmations)	17
Affidavit in Further Support	
Other Papers	

Upon the foregoing papers defendants Alfio Carroccio, M.D. and Park Lenox Surgical, P.C., s/h/a/ Park Avenue Surgical (Park Lenox Surgical) (MS#11); Seth Keller, M.D. and Cardiovascular Associates of New York, P.C. (Cardiovascular Associates) (MS#13); Lenox Hill Hospital (Lenox Hill or the Hospital) (MS#14); and Joseph Puma, M.D. and Francisco Santoni-Rugio, M.D. (MS#15), seek an order, pursuant to CPLR 3212,

granting summary judgment in their favor and dismissing plaintiffs' complaint.[1]

Plaintiffs cross-move for an order, should any defendant be granted summary judgment in their favor, that any remaining defendant(s) be precluded from obtaining, or be deemed to have waived or forfeited, the limited liability benefits of CPLR Article 16 with respect to that party's acts or omissions and that this ruling constitute "law of the case" so as to preclude the application of CPLR 16 (MS#16). Plaintiffs do not oppose the motions of Dr. Keller, Cardiovascular Associates and Dr. Santori-Rugio.

Plaintiffs commenced this action on October 31, 2011 against Dr. Puma, Amerimed, Dr. Keller, Cardiovascular Associates, Dr. Santoni-Rugio, Manhattan Cardiac-Arrhythmia Associates, P.C., John Doe, and Lenox Hill to recover damages for medical malpractice, lack of informed consent and wrongful death. Plaintiffs also assert a claim for wrongful death. On December 22, 2011 plaintiffs commenced a similar action against Dr. Carroccio and Park Lenox Surgical. The two actions were consolidated by order of August 3, 2012.

BACKGROUND

In 2010 Carolyn Dixon, age 60, was referred by her internist to Dr. Puma, an interventional cardiologist, for a cardiovascular evaluation due to her history of exertional chest pain, shortness of breath, diabetes, hypertension, elevated lipids and smoking. On February 16, 2010 Ms. Dixon presented to Dr. Puma with complaints of chest pain. On

[1] A stipulation of discontinuance was executed with regard to Amerimed Physicians Group (motion sequence number 12) and filed with the court on November 2, 2015.

March 8, 2010 Ms. Dixon presented to the defendant Lenox Hill Hospital with complaints of chest pain and shortness of breath and was admitted to the hospital by Dr. Puma. She underwent a cardiac catheterization through her right femoral artery and an angioplasty of the right coronary artery – with placement of a drug eluting stent. The cardiac catheterization revealed coronary artery disease in her right coronary artery and left anterior descending and diagonal branch. Following this procedure Ms. Dixon's hematocrit (HCT) level was 36.4. She was discharged on March 9, 2010 with a plan for a subsequent angioplasty of the left anterior descending coronary artery, and was advised to follow up with Dr. Puma in 1-2 weeks.

On March 22, 2010 Ms. Dixon returned to the Hospital with complaints of mid-sternal chest pain radiating through her back, and right arm heaviness. At 2:05 p.m. Ms. Dixon's blood pressure was recorded at 175/85 mmHg. Dr. Yoram Amsalem, a cardiac fellow, under the supervision of Dr. Puma performed a repeat cardiac catheterization through Ms. Dixon's right femoral artery with angioplasty and stenting of the mid-anterior descending coronary artery. During this procedure the femoral sheath was placed through the same puncture site as was used during the first procedure. No significant event was reported, Ms. Dixon's vital signs were stable, her blood pressure was 170/79 and there appeared to be no evidence of a perforation. At the end of the procedure Dr. Puma started Ms. Dixon on aspirin and Plavix, and requested that Dr. Keller, a consulting physician, evaluate Ms. Dixon for sinus tachycardia. The medication sheet does not indicate that this medication was administered.

Ms. Dixon was transferred to a telemetry bed in the Progressive Care Unit (PCU). Dr. Puma was of the opinion that she was otherwise stable and ready for discharge should she remain hemodynamically stable and asymptomatic.

Some time later, a physician assistant (PA) informed Dr. Puma that Ms. Dixon had a hematoma in her right groin and had complained of pain and right lower quadrant discomfort. Dr. Puma ordered a CT scan with contrast, which was performed at 6:16 p.m., and revealed a large right sided retroperitoneal hematoma extending from the lower pole of the right kidney deep into the pelvis and compressing and displacing the bladder to the left. The radiologist suggested a repeat study with intravenous contrast to determine if there was extravasation (bleeding) if clinically indicated.[2] Anticoagulant medication was discontinued and Ms. Dixon receive IV fluids and packed red blood cells. Ms. Dixon remained in the PCU during the evening of March 22, 2010. It is alleged that directions were given that, should she become hemodynamically unstable, the vascular surgery department be notified.

At 5:30 a.m. on March 23, 2010, Ms. Dixon's hemoglobin and HCT levels were 9.5 and 28.8, respectively, and her blood pressure was 42/48. At 6:15 a.m. a nurse noted that Ms. Dixon was hypotensive, diaphoretic and weak following use of the restroom to void. At 6:47 a.m. Ms. Dixon's HCT level dropped to 27.1, she was placed in the Trendelenburg position, given IV fluids and her blood pressure rose to 79/50 by 8:00 a.m.[3] At 8:15 a.m. PA

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[2]These results were, according to the report, reported to PA Alexander Avdahenko.

[3] The nurses notes indicate that the overnight PA Betsy Cruz was notified. When deposed PA Dabissiere testified that, PA Cruz contacted Dr. Puma and he had ordered 1 unit of RBCS.

Marinique Dabissiere recorded Ms. Dixon's blood pressure as 95/45 and noted her complaints of right groin pain, pelvic pain, shortness of breath, lower abdominal tenderness with palpation and a positive hematoma. She reported that Ms. Dixon was hypotensive but asymptomatic. PA Dabissiere discussed Ms. Dixon's condition with Dr. Puma, including the possibility of repeating the CT scan with contrast and transferring Ms. Dixon to the CCU unit. Dr. Puma did not examine Ms. Dixon, but ordered continuation of the plan to transfuse one unit of packed red blood cells, monitor Ms. Dixon's vital signs, and obtain follow-up hemoglobin and HCT levels. At 12:00 p.m. Dr. Puma requested that Dr. Amsalem, a fellow, evaluate Dixon.[4] At 8:30 a.m. Ms. Dixon received a blood transfusion. It is alleged that PA Dabissiere remained in contact with Dr. Amsalem following his evaluation of Ms. Dixon. Dr. Amsalem agreed that vascular surgery should be consulted. Between 8:30 a.m. and 5:00 p.m. Ms. Dixon's blood pressure remained between 89/52 and 109/62, and her heart rate between 61 and 77. At 4:45 p.m. her hemoglobin and HCT levels dropped to 8.6 and 25.2.

At 5:25 p.m. on March 23, 2010, Dr. Puma evaluated Ms. Dixon. He noted that she was sitting up in bed, eating, spoke with him and appeared to be doing well. He reported that her blood pressure (140/160) and heart rate (87 bpm) were stable and that she may need more transfusions, but he saw no evidence of bleeding. Dr. Puma testified that he relied upon the information provided by the interventional PA regarding Ms. Dixon's clinical course throughout the day. He did not recall whether he personally reviewed the nursing notes or

[4] Dr. Puma testified that a CBC was not repeated at 12:00pm and there was no note showing that the fellow, Dr. Amsalem, evaluated Ms. Dixon. The next blood draw was at 2:45pm

record. He testified that he "updated" a vascular surgeon who was performing rounds at the same time as he was, on the status of Ms. Dixon. Dr. Puma believed that a vascular consult had already been performed based upon his initial order, though there was no vascular surgery note documenting a consult in the record. He planned to continue observation of Ms. Dixon's HCT levels, continue IV fluids and to discharge her the next morning if she was stable.

At approximately 6:30 p.m. on March 23, 2010, PA Dabissiere approached Dr. Carroccio, a vascular surgery attending, to request that he examine Ms. Dixon. Dr. Carroccio's note of April 14, 2010 states that Ms. Dixon suffered from a right retroperitoneal hematoma following the cardiac catheterization and had stable hemodynamics. He ordered an additional transfusion of two units of red blood cells with a plan for an angiogram if her condition deteriorated. At 8:00 p.m. on March 23, 2010, nursing notes indicate that Ms. Dixon had no complaints and that her vital signs were stable. Her blood pressure was 134/60, her respiratory rate was 18 and her red blood cells were infusing. Between 9:00 p.m. and 12:00 a.m. her blood pressure was between 102/58 and 174/89, her pulse was between 78 and 88, her respiratory rate was between 18 and 20 and her p02 was between 96 and 100%. At 10:00 p.m. on March 23, 2010, the first transfusion of packed red blood cells was completed and at 11:44 p.m. the second unit was started.

At 12:00 a.m. on March 24, 2010, Ms. Dixon's BP was 174/80 and the nurse's notes indicated that she was comfortable. At 12:45 a.m., a code was called because Ms. Dixon was

diaphoretic and her p02 was 88%. She was administered 3 liters of oxygen. A PA noted that her p02 level decreased to between 60 and 70. A cardiac fellow was present at approximately 12:57 a.m. and Ms. Dixon continued to deteriorate. Her pulse was between 60 and 70 and her HCT level was 13.8 at 2:03 a.m. A CCU fellow contacted Dr. Puma during the morning hours and informed him that Ms. Dixon was unresponsive. Unsuccessful resuscitation efforts were performed and Ms. Dixon was pronounced dead at 3:34 a.m. on March 24, 2010. The cause of death was found to be hemorrhagic complications of percutaneous coronary intervention for treatment of hypertensive and atherosclerotic cardiovascular disease.

SUMMARY JUDGMENT STANDARD

On a motion for summary judgment the party seeking judgment as a matter of law has the burden of tendering evidentiary proof in a form admissible at trial to show the absence of triable issues of fact (*Pizzo-Juliano v Southside Hosp.*, 129 AD3d 695, 696 [2015], citing *Alvarez v Prospect*, 68 NY2d 320, 324 [1986]; *Winegrad v New York Univ. Med. Ctr.*, 64 NY2d 851, 853 [1985]). In a medical malpractice action the defendant establishes prima facie entitlement to judgment as a matter of law by adducing expert opinion evidence that he/she did not deviate from the relevant standards of care, or that the patient was not injured thereby (*Berger v Hale*, 81 AD3d 766, 766 [2011]; *see also McKenzie v Clarke*, 77 AD3d 637, 638 [2010]; *Shahid v New York City Health & Hosps. Corp.*, 47 AD3d 798, 799 [2008]; *see Alvarez v Prospect Hosp.*, 68 NY2d 320, 324 [1986]). In this regard a defendant must

specifically address the allegations of medical malpractice contained in the plaintiffs' bill of particulars (*Lormel v Macura*, 113 AD3d 734, 735 [2014], citing *Wall v Flushing Hosp. Med. Ctr.*, 78 AD3d 1043, 1044-1045 [2010]; *Terranova v Finklea*, 45 AD3d 572, 572 [2007]). Expert opinion which is speculative or unsupported by any evidentiary foundation shall not be given any probative force (*Kracker v Spartan Chemical Co.*, 183 AD2d 810, 812 [1992], citing *Espinosa v A & S Welding & Boiler Repair*, 120 AD2d 435 [1986]; *Diaz v New York Downtown Hosp.*, 99 NY2d 542, 544 [2002]; *see Keevan v Rifkin*, 41 AD3d 661 [2007]; *Shields v Baktidy*, 11 AD3d 671 [2004]).

In opposition to the motion the plaintiff must submitted an affidavit or affirmation of an expert which is sufficient to raise a triable issue of fact as to whether the defendant departed from good and accepted medical practice (*see Adjetey v New York City Health & Hosps. Corp.*, 63 AD3d 865 [2009]; *Boutin v Bay Shore Family Health Ctr.*, 59 AD3d 368 [2009]). "'A plaintiff's evidence may be deemed legally sufficient even if [her] expert cannot quantify the extent to which the defendant's act or omission decreased the plaintiff's chance of a better outcome or increased [the] injury, as long as evidence is presented from which the jury may infer that the defendant's conduct diminished the plaintiff's chance of a better outcome or increased [the] injury'" (*Alicea v Ligouri*, 54 AD3d 784, 786 [2008]; *Flaherty v Fromberg*, 46 AD3d 743, 745 [2007]).

Summary judgment may not be awarded in a medical malpractice action where the parties adduce conflicting opinions of medical experts, creating a question of credibility

requiring resolution by a jury (*see Espinal v Jamaica Hosp. Med. Ctr.*, 71 AD3d 723 [2010]; *Dandrea v Hertz*, 23 AD3d 332 [2005]). Finally, on a motion for summary judgment, the court is required to draw all inferences against the moving party (*see e.g. Cerny v Williams*, 32 AD3d 881, 884 [2006]; *citing Erikson v J.I.B. Realty*, 12 AD3d 344, 345 [2004]; *Brandes v Incorporated Vil. of Lindenhurst*, 8 AD3d 315, 315 [2004]; *Hoovis v Winthrop Univ. Hosp.*, 268 AD2d 409 [2000]).

Dr. Puma's Motion for Summary Judgment

Plaintiffs allege that Dr. Puma departed from good and accepted standards of medical care by failing to timely and properly treat and monitor Ms. Dixon's retroperitoneal hematoma. Dr. Puma argues that his care was at all times within accepted standards of medical care and that there is no evidence that he caused or contributed to Ms. Dixon's death or alleged injuries. Dr. Puma relies upon the affirmation of Dr. Louai Razzouk, a physician board certified in internal medicine with a sub-certification in cardiovascular diseases and interventional cardiology. Dr. Razzouk opines that a retroperitoneal hematoma is a known and accepted complication of cardiac catheterization and can occur in the absence of negligence. Dr. Razzouk opines that the retroperitoneal hematoma that Ms. Dixon suffered was the result of inadequate hemeostasis and that the necessary anticoagulation given during the procedure was a contributing factor to her bleeding.

Dr. Razzouk notes that Dr. Puma evaluated Ms. Dixon following the procedure. Thereafter, he was informed that a CT scan had confirmed the diagnosis of retroperitoneal

hematoma. Ms. Dixon became hypotensive early in the morning of March 23, 2010, at a time when Dr. Puma was not present. When he was later notified of her condition, he spoke with PA Dabissiere, who was monitoring the patient, and learned that Ms. Dixon had stabilized. It was Dr. Puma's belief that Ms. Dixon remained stable. Dr. Puma evaluated Ms. Dixon at 5:25 p.m., after which he spoke with the vascular attending to ensure that she would be monitored overnight so that her hemoglobin and hematocrit levels remained stable. Dr. Razzouk opines that if Ms. Dixon had not remained stable, her blood pressure and hematocrit levels would have been much lower and would have decreased at a much more rapid rate. Thus, he concludes that the claim that Dr. Puma was negligent in failing to timely and properly address Ms. Dixon's hemoglobin and hematocrit levels is without merit. Dr. Razzouk asserts that Dr. Puma timely and appropriately ordered a vascular surgery consult and recommended that all anticoagulants be stopped and that packed red blood cells be administered. He concludes that Dr. Puma properly cared for Ms. Dixon by continuing to monitor her condition, and that a re-bleed, which Ms. Dixon suffered on the morning of March 24, 2011, was an unforeseeable complication that could not have been prevented by Dr. Puma.

Dr. Razzouk further opines that Dr. Puma cannot be held liable for any injury to Ms. Dixon caused during the times when he was not present and she was being monitored by hospital staff. Specifically, Dr. Razzouk notes that cardiac catheterization patients admitted to Lenox Hill had a PA assigned to them prior to the procedure. If the patient was then

admitted to the Hospital, that PA – employed by the hospital– would monitor the patient in the post intervention or telemetry unit and under the supervision of a non-invasive cardiology attending.

In opposition, plaintiffs argue that Dr. Razzouk does not establish a proper foundation for his opinions in that he fails to indicate how long he has practiced, where he was board certified and whether he is familiar with the standard of care in 2010. Plaintiffs argue that the opinions of Dr. Razzouk are conclusory and contradicted by Dr. Puma's deposition testimony that Ms. Dixon's death could have been prevented. Dr. Puma testified that Ms. Dixon's blood pressure readings on March 23, 2010 showed that she was hypotensive and hemodymanically unstable and that had he been aware of these readings, he most likely, would have called vascular surgery immediately and had her admitted to the ICU. Plaintiffs also contend that because Dr. Razzouk fails to refute the claims set forth in the bill of particulars, the motion should be denied.

In the alternative, plaintiffs' expert[5] argues that it is his/her opinion, with a reasonable degree of medical certainty, that beginning at 6 a.m. on March 23, 2010, – when Ms. Dixon had a blood pressure of 42/28 and complained of feeling weak, hot and diaphoretic, – Dr. Puma should have been notified. S/he further argues that an immediate vascular surgery consultation should have been obtained, at that point, to assess options for imaging such as a repeat CT scan with contrast, CT angiography or immediate surgery. The expert also

[5] The unredacted original of the affirmation of plaintiff's expert was provided to the court for *in camera* inspection (*Turi v Birk*, 118 AD3d 979, 980 [2014], quoting *Cerny*, 32 AD3d at 886).

opines that Ms. Dixon should have been placed in the CCU for monitoring with an arterial line, bladder catheter to measure urine output and continuous nursing attention, and that the failure to take these actions was a substantial factors in bringing about pain and suffering for Ms. Dixon. In addition, if the appropriate consultations had been timely and properly called for and performed, Ms. Dixon's retroperitoneal hemorrhage would have been surgically repaired. Plaintiffs contend that Dr. Puma departed from good and accepted care by failing to timely and properly treat and monitor Ms. Dixon's retroperitoneal hematoma, which could have prevented her death.

The plaintiffs' expert further opines that the defendants' expert's opinion that surgery was not indicated because Ms. Dixon was asymptomatic and her blood pressure had stabilized, is without merit because severe hypovolemia can cause the body to clamp down on the blood vessels, thereby, raising the patient's blood pressure. If blood loss is ongoing, the patient may suffer cardiovascular collapse and cardiac arrest, particularly where the cardiac status of the patient is fragile as it was here. The expert also opines that Ms. Dixon's bleeding temporarily stopped or slowed when her blood pressure rose due to hemeostasis and tamponade from an intact peritoneal surface. Further, the normalization of Ms. Dixon's blood pressure during the evening of March 23, 2010 created a window of time within which surgery could have been performed with reasonable safety. The expert concludes that the temporary hemeostasis and tamponade could not withstand the increased pressure and, predictably, the peritoneal surface ruptured, causing her to fatally bleed out into her

peritoneal cavity.

In addition, the expert opines that it was inappropriate to rely upon the normal blood pressure in view of the presence of a huge hematoma. On the morning of March 23, 2010 Ms. Dixon's profound hypotension represented a life threatening condition which required immediate medical attention. The lack of other subjective symptoms did not diminish the importance of this finding. The expert notes that between 6 a.m. and 5:30 p.m., when Dr. Puma examined Ms. Dixon, her blood pressure was critically low (between 42 and 89) particularly since her normal blood pressure was in the 140-160 range. Therefore, Dr. Puma's note that Ms. Dixon's blood pressure was stable is not supported by the reading taken during the day. Due to this blood pressure, the expert opines, Ms. Dixon was on the verge of shock and because she was bleeding, her condition was life threatening. The expert concludes that Dr. Puma's plan to continue IV fluid, monitor HCT, observe and discharge her in the morning if she was stable was inappropriate as she was in need of immediate surgery. The expert opines that this conclusion is further supported by the fact that at 4:45 p.m – just before Dr. Puma examined Ms. Dixon – her HCT was precipitously down to 25.2, indicating that there was an on-going, major life threatening pelvic hemorrhage which required immediate surgery.

Discussion

Dr. Razzouk, a physician board certified in internal medicine and certified in cardiovascular disease, is qualified to offer an expert opinion in this matter. "An expert is

qualified to proffer an opinion if he or she is 'possessed of the requisite skill, training, education, knowledge or experience from which it can be assumed that the information imparted or the opinion rendered is reliable '" (*Leicht v City of New York Dept. of Sanitation*, 131 AD3d 515, 516 [2015], quoting *Matott v Ward*, 48 NY2d 455, 459 [1979]). Dr. Razzouk's affirmation is sufficiently detailed to address the allegations against Dr. Puma made in plaintiff's Bill of Particulars.

Dr. Razzouk's opinions, however, are contradicted by Dr. Puma's deposition testimony and the hospital records. Specifically, Dr. Puma testified that he was not aware of Ms. Dixon's low blood pressure readings on March 23, 2010 and that if he had been, he would have ordered an immediate vascular consultation and transferred her to ICU. Thus, Dr. Puma fails to demonstrate the absence of triable issues of fact so as to entitle him to summary judgment dismissing the complaint (*see Callahan v Guneratne*, 78 AD3d 753, 754 [2010]; *see generally Faicco v Golub*, 91 AD3d 817, 818 [2012]).

Moreover, the affidavit offered by plaintiffs' expert raises issues of fact sufficient to warrant denial of Dr. Puma's motion (*see e.g. Contreras v Adeyemi*, 102 AD3d 720, 721 [2013]; *Shahid*, 47 AD3d at 799; *Shields*, 11 AD3d at 672), specifically with respect to whether Ms. Dixon's severe drop in blood pressure, – which was either discussed with Dr. Puma by the PA or apparent upon review of Ms. Dixon's medical chart, – required Dr. Puma to take immediate action, including transferring Ms. Dixon to the CCU, ordering a repeat CT scan with contrast and requesting an immediate vascular consult. Thus, plaintiffs raise

triable issues of fact as to whether Dr. Puma departed from the standard of care and whether such departure decreased Ms. Dixon's opportunity to obtain life-saving surgery.

Dr. Santori-Rugio's Motion for Summary Judgment

In support of his motion Dr. Santori-Rugio relies upon the affirmation of Dr. Louai Razzouk who asserts that Dr. Santori-Rugio never treated the plaintiff and, therefore, did not cause or contribute to her injury. Dr. Santori-Rugio submits an affidavit in which he avers that, upon his review of Ms. Dixon's chart pertaining to her March 22, 2010 admission, he found no handwritten entries or references by the hospital staff that he rendered treatment to Ms. Dixon. Further, he points out that by the time he was notified to provide a consultation Ms. Dixon had died. Based upon the absence of treatment, he argues that no physician-patient relationship existed between him and Ms. Dixon.

Discussion

Plaintiffs offer no submission or argument to rebut Dr. Santori-Rugio's *prima facie* showing that a claim for medical malpractice cannot be sustained against him (*Heller v Peekskill Community Hosp.*, 198 AD2d 265, 265 [2nd Dept 1993]; *Lee v New York*, 162 AD2d 34 [2nd Dept 1990][physician-patient relationship created when the professional services of a physician are rendered to and accepted by another person for the purposes of medical or surgical treatment]). Accordingly, Dr. Santori-Rugio's motion is granted.

Summary Judgment Motion of Dr. Carroccio

Plaintiffs allege that Dr. Carroccio departed from good and accepted care by failing to timely and properly treat and monitor Ms. Dixon's retroperitoneal hematoma.

In support of his motion Dr. Carroccio relies upon the affirmation of Dr. William D. Suggs, a board certified vascular surgeon, who opines with a reasonable degree of medical certainty that plaintiffs' claims against Dr. Carroccio have no merit. Specifically, Dr. Suggs opines when Dr. Carroccio saw Ms. Dixon she was stable and his recommendations to administer two blood transfusions and to order an angiogram should her condition deteriorated, was appropriate and consistent with good practice. At that time, her blood pressure was 115/70 and her pulse was in the 60s, both of which were within the normal range. Dr. Carroccio noted that Ms. Dixon's vital signs had been normal throughout the day, and that while her blood pressure and hematocrit readings were low, they would have been much lower and would have decreased at a rapid rate if she were bleeding. In addition, Dr. Puma had examined Ms. Dixon at 5:25 p.m. and noted that she had been doing well and that her blood pressure was normal. Thus, because Ms. Dixon's condition had not deteriorated and she was hemodynamically stable prior to his examination, Dr. Carroccio's recommendation for two more units of blood was appropriate.

Dr. Suggs opines that because Ms. Dixon was stable, there was no reason to recommend surgery as argued by plaintiffs. In fact, even if she were unstable, surgery would not have been within the standard recommendations. Instead, the standard of care for a

patient diagnosed with a retroperitoneal bleed is to monitor the patient. If the patient deteriorates, a contrast study should be performed and, depending on the results, surgery may be warranted. In addition, Ms. Dixon's complaints of groin pain had subsided prior to Dr. Carroccio's examination. Dr. Suggs, thus, concludes that because Ms. Dixon did not display any clinical symptoms of a continued bleed, conservative management was proper.

Dr. Suggs opines that Dr. Carroccio's failure to make entries in the patient's chart until April 14, 2010 did not delay any treatment, in that he orally communicated his instructions to the PA. The sign-out notes of PA Dabissiere demonstrate that Dr. Carroccio's recommendations were carried out. Dr. Suggs, thus, concludes that the care and treatment rendered to Ms. Dixon by Dr. Carroccio was not a proximate cause of Ms. Dixon's death.

In opposition plaintiffs first argue that Dr. Suggs does not demonstrate that he is qualified to render an opinion, in that he does not state how long he has practiced vascular surgery, whether he practiced in 2010 or what medical records he reviewed. Moreover, plaintiffs argue, Dr. Suggs' opinions are conclusory, speculative and do not refute plaintiffs' claims.

Plaintiffs also rely upon the affidavit of an expert who opines, with a reasonable degree of medical certainty, that Dr. Carroccio departed from good and accepted care by failing to recognize that Ms. Dixon had an ongoing pelvic hemorrhage which required immediate surgical correction. The expert opines that Dr. Carroccio's reliance upon the CT scan taken on March 22, 2010 was inappropriate, in that the scan shows a massive hematoma

within six hours of a major repeat right femoral stick[6], in a patient who had received heparin during the procedure. In addition, plaintiffs' expert asserts that Dr. Carroccio should have recognized the recommendation of the radiologist to obtain a repeat CT scan with contrast, Ms. Dixon should have been admitted to the CCU and he should have recommended immediate surgery or an immediate CT scan as the radiologist suspected an ongoing bleed. The expert concludes that Dr. Carroccio's acts and omissions were substantial factor in bringing about Ms. Dixon's suffering and death.

Discussion

Dr. Suggs has established his qualifications as an expert. Dr. Suggs avers that he is a board certified vascular surgeon and was recertified in 2002 and 2012. He completed a residency in General Surgery at George Washington University Medical Center and a fellowship at Emory University School of Medicine in 1990. He is currently the Director of Vascular Services at White Plains Hospital and an Attending in Surgery at the Montefiore Medical Center. Dr. Suggs discusses Ms. Dixon's medical history in sufficient detail so as to demonstrate that he is familiar Ms. Dixon's medical records and the care that the defendants provided.

Dr. Suggs opines that although Ms. Dixon's blood pressure and hematocrit readings were low, they were within normal range, indicating that there was no bleeding throughout the day. He opines that surgery would not have been recommended for a patient in Ms.

[6] The femoral stick was referred to as "high," meaning in an area where manual compression could not be effective.

Dixon's condition, as the standard of care was to continue to monitor her because she appeared to be stable and was not complaining of pain. Dr. Suggs asserts that the failure of Dr. Carroccio to make contemporaneous notes did not delay any of Ms. Dixon's treatment in that he orally conveyed his instructions to PA Dabissiere. PA Dabissiere testified that his instructions were carried out, a conclusion that is supported by her sign out notes. Thus, Dr. Carroccio establishes his prima facie entitlement to judgment in by demonstrating that in his care and treatment of Ms. Dixon he did not depart from accepted practices (*see Shectman v Wilson*, 68 AD3d 848, 849 [2009]).

However, the affidavit of plaintiffs' expert is sufficient to raise a triable issue of fact with regard to whether Dr. Carroccio conformed with accepted practice. Here, plaintiff's expert contends that findings on the CT scan should have caused Dr. Carroccio concern and lead him to perform a further scan with contrast, or a CT-angiogram, which would have clearly shown the need for surgery. In addition, according to plaintiff's expert, Dr. Carroccio had the ability to admit Ms. Dixon to the CCU for closer monitoring or to recommend immediate surgical intervention, and the failure to do so contributed to her ongoing bleed.

While a consulting physician who examines a plaintiff on one occasion may not have a continuing duty to diagnose or supervise treatment (*see Arias v Flushing Hosp. Med. Ctr.*, 300 AD2d 610 [2002]; *Kleinert v Begum*, 144 AD2d 645 [1988]), here, plaintiffs raise issues of fact as to whether the claimed departures by Dr. Carroccio during his evaluation of Ms. Dixon require the denial of summary judgment (*Contreras v Adeyemi*, 102 AD3d 720, 721-

722 [2nd Dept 2013]; *Shahid*, 47 AD3d at 799; *Shields*, 11 AD3d at 672).

Park Lenox Surgical's Motion for Summary Judgment

In support of its motion Park Lenox Surgical, P.C., s/h/a Park Avenue Surgical, argues that it is entitled to summary judgment due to plaintiffs' failure to designate a representative of its facility to be deposed as directed by the court's March 7, 2014 order (Dabiri, J.).

In opposition, plaintiffs argue that Park Lenox Surgical offers no evidentiary support for its demand for summary judgment, nor does the affirmation of Dr. Suggs in support of its motion address its claimed entitlement to summary judgment.

Having failed to eliminate all triable issues of fact as to whether Park Lenox Surgical departed from standards of good and accepted care or as to whether any departure was a proximate cause of injury to Ms. Dixon, summary judgment is denied (*Contreras v Adeyemi*, 102 AD3d at 721-722; *see Stukas v Streiter*, 83 AD3d 18 [2011]).

Lenox Hill's Motion for Summary Judgment

Plaintiffs claim that Lenox Hill Hospital, by its employees, failed to properly treat and monitor Ms. Dixon's retroperitoneal hematoma, to timely recognize complications which were evidenced by continued bleeding, to inform attending physicians and/or residents of Ms. Dixon's vital signs and lab values, to act independently, to perform an angiogram, to transfer Ms. Dixon to the ICU, to call in appropriate consultants, including vascular surgery, and to perform surgery to stop the bleeding. In addition, plaintiffs contend that Lenox Hill departed by failing to create, and implement, appropriate post-procedure management policies for

patients undergoing cardiac catheterization.

In support of its motion for summary judgment, Lenox Hill relies upon the affidavit of Edward Katz, a physician board-certified in Internal Medicine, Cardiovascular Disease and Adult Comprehensive Echocardiography. Dr. Katz opines that during Ms. Dixon's post-catheterization admission her private cardiologist, Dr. Puma, was solely responsible for all assessment and management decisions related to Ms. Dixon's treatment.[7] He avers that the Lenox Hill medical staff kept all attendings, including Dr. Puma, fully informed of Ms. Dixon's condition and carried out the directives of the attending doctors, without exercising any independent medical judgment. Nor were any of the attending physicians' orders clearly contraindicated, so as to require Lenox Hill staff to unilaterally depart from the physician's treatment plan.

Dr. Katz further notes that after Dr. Puma and Dr. Carroccio examined Ms. Dixon on March 23, 2010, they both concluded that her retroperitoneal hematoma and she were stable, and that additional imaging or a transfer to the ICU were not indicated. Dr. Carroccio recommend that Ms. Dixon receive an additional two units of packed red blood cells and this order was carried out as were orders that follow up exams be made, that her vitals be monitored, and that an angiogram be performed if her condition deteriorated. Thereafter, further physician notification was not warranted as Ms. Dixon was without complaints and

[7] Dr. Katz relies upon the deposition testimony of PA Dabissiere wherein she testified that during her interaction with Ms. Dixon she was supervised by Dr. Puma and the deposition testimony of Dr. Puma where in he stated that he was the supervising physician for the catheterization procedure.

her vital signs were stable until 11:45 p.m. when she became diaphoretic. Dr. Katz concludes that Lenox Hill staff did not exercise any independent judgment in their treatment of Ms. Dixon which caused or contributed to her alleged injuries.

In opposition, plaintiffs argue that Lenox Hill fails to establish that medical staff who rendered care to Ms. Dixon were not employed by, and were not under the control of, the Hospital. They point out that PA Dabissiere testified, when deposed, that both she and Dr. Amsalem were employees of the Hospital. Nor is evidence offered that Dr. Puma and Dr. Carroccio were not employed by Lenox Hill. Plaintiffs argue that Lenox Hill is vicariously liable for the medical malpractice of its staff.

Plaintiffs' expert notes that while Dr. Amsalem was asked to evaluate Ms. Dixon, there is no documentation regarding such an evaluation. The expert opines, with a reasonable degree of medical certainty, that Dr. Amsalem departed from standards of good care by failing to immediately order a vascular surgery consult to evaluate the options of imaging such as CT scans with contrast and/or CT angiogram, surgery or a transfer the CCU. The expert contends that the failure of Dr. Amsalem, the physicians assistants and the nursing staff, to properly communicate their findings to Dr. Puma was a departure from accepted standards of care and were substantial factors in bringing about pain, suffering and the death of Ms. Dixon. In this regard, the expert opines that had these communications been made, the appropriate consultation with a vascular surgeon would have occurred and Ms. Dixon would have undergone surgery to repair her retroperitoneal hematoma. Plaintiffs point

to the deposition testimony of Dr. Puma that had he been notified, during the morning of March 23, 2010, of Ms. Dixon's blood pressure and complaints, he would have immediately called a vascular surgeon and admitted Ms. Dixon to the CCU.

Plaintiffs also argue that it appears to have been Lenox Hill's policy that once an interventional cardiologist performs a cardiac catheterization, the patient would then be followed by PAs and non-interventional cardiologist. However, Dr. Puma testified that he did not believe that he had any responsibility to follow Ms. Dixon after the procedure and the resulting retroperitoneal hematoma, based upon this hospital policy. Rather, he indicated that he believed that he had an ethical obligation to do so. Plaintiffs' expert concludes, that it was a departure from good and accepted practice to create a policy which absolved attending physicians of their responsibility to follow a patient post-procedure when a complication occurs, and then failing to oversee the appropriate implementation of such policy.

Plaintiffs' expert argues that while it appears that Dr. Joseph Rancanelli was the non-interventional cardiologist assigned was to manage and supervise Ms. Dixon's post-procedure care, it does not appear that he treated or saw her. Instead, her care was managed by PAs who had no actual supervision. The expert concludes that the lack of appropriate attention from an attending physician to coordinate her care, to communicate with her private physician and to order the necessary consultations, were substantial factors in bringing about negligent care and treatment and was a proximate cause of injury to Ms. Dixon.

Discussion

"Generally . . . , a hospital may not be held vicariously liable for the negligence of a private attending physician chosen by the patient (*see Tomeo v Beccia*, 127 AD3d 1071, 1073 [2015]) [, so] long as the resident physicians and nurses employed by the hospital have merely carried out that private attending physician's orders, a hospital may not be held vicariously liable for resulting injuries (*see Seiden v Sonstein*, 127 AD3d 1158, 1160, [2015])" *(Doria v Benisch*, 130 AD3d 777, 777-778 [2015]). However, a hospital may be held liable when its staff follows a private attending's orders despite knowing 'that the doctor's orders are so clearly contraindicated by normal practice that ordinary prudence requires inquiry into the correctness of the orders' (*Toth v Community Hosp. at Glen Cove*, 22 NY2d 255, 265 n 3 [1968]; *see France v Packy*, 121 AD3d 836, 837 [2014]; *see generally Fiorentino v Wenger*, 19 NY2d 407, 414-417 [1967]) and when its employees have committed independent acts of negligence (*see Tomeo v Beccia*, 127 AD3d at 1073). A hospital also may be held liable for the negligence of a private, nonemployee physician on a theory of ostensible or apparent agency (*see Sampson v Contillo*, 55 AD3d 588, 590 [2008]; *see generally Hill v St. Clare's Hosp.*, 67 NY2d 72, 80-81 [1986])" (*Doria v Benisch*, 130 AD3d 777, 777-778 [2015]; *accord Quezada v O'Reilly-Green*, 24 AD3d 744, 746 [2005], *lv denied* 7 NY3d 703 [2013] [generally, a hospital cannot be held vicariously liable for the malpractice of a private attending physician who is not its employee]; *see generally Seiden*, 127 AD3d at 1160-1161; *Sampson*, 55 AD3d at 590-591).

In applying these principles, it must be recognized that "[t]he fact that the doctor also happened to be affiliated with the hospital, but not employed by the hospital, is not alone sufficient to impute the doctor's conduct . . . to the hospital" (*Ruane v Niagara Falls Memorial Medical Center*, 60 NY2d 908, 909 [1983]; *accord Urgovitch v Mt. Sinai Med. Ctr.*, 245 AD2d 53, 54 [1997]). Similarly, "an individual practitioner's affiliation with a hospital is insufficient to create a 'relevant relationship' between the two" (*Allende v New York City Health & Hosps. Corp.*, 90 NY2d 333, 340 [1997], citing *Meath v Mishrick*, 68 NY2d 992, 994).

Here, Ms. Dixon was admitted to Lenox Hill following her second catheterization procedure which was performed under the supervision of Dr. Puma. Thereafter, she was treated by hospital personnel, who it is alleged, failed to keep Dr. Puma apprised of Ms. Dixon's condition. While Lenox Hill has adequately demonstrated that there are no factual or legal grounds to hold it vicariously liabile for the conduct of Dr. Puma, Ms. Dixon's private physician,[8] (*Doria v Benisch*, 130 AD3d 777, 777-778 [2015]; *Dragotta v Southampton Hosp.*, 39 AD3d 697, 698 [2007]; *Mduba v Benedictine Hosp.*, 52 AD2d 450 [1976]), "concurrent liability [may] be imposed where, inter alia, a hospital's [employee commits] independent acts of negligence" (*Rosenstack v Wong*, 106 AD3d 804, 805 [2nd Dept 2013]).

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[8] The record demonstrates that Dr. Puma was not an employee of Lenox Hill but rather employed by Lenox Hill Interventional Cardiac and Vascular Services, P.C., which provided cardiovascular services to Lenox Hill. Plaintiff supplies no evidence to contradict this showing.

The plaintiffs' submissions raise triable issues of fact as to whether Lenox Hill, through its staff and attendings,[9] departed from the accepted standard of care by failing to properly communicate Ms. Dixon's condition to the appropriate personnel, resulting in a lack of coordination of care and ultimately a failure to timely treat Ms. Dixon's retroperitoneal hemorrhage (see *Rosenstack v Wong*, 106 AD3d 804, 805-806 [2013]). In this regard, the plaintiff's expert opines that Ms. Dixon was being cared for by PA Dabissiere, without the supervision of a physician, and that this was a departure from accepted standards of care. There are inconsistencies in the record as to which attending was responsible for supervising the hospital-employed PAs. The expert points out that although Dr. Rancanelli was charged with supervising PA Dabissiere, it appears that he was not present in the Hospital and did not evaluate or treat Ms. Dixon (*Doe v Guthrie Clinic, Ltd.*, 22 NY3d 480, 485 [2014] [medical corporation may face liable for failing to establish adequate policies and procedures or to train employees to properly discharge their duties under such policies and procedures]). In addition, questions of fact remain as to whether Lenox Hill's post-catheterization procedure was improperly implemented, resulting in the negligent care and treatment of Ms. Dixon.

[9]The testimony of PA Dabissiere and Dr. Carroccio establish that they, as well as Dr. Amsalem, were employees of Lenox Hill. Lenox Hill submits no evidence to establish that these individuals were not acting as its agent or employee in providing care to Ms. Dixon (*Contreras*, 102 AD3d 720, 722-723 [2013]; *see Sampson*, 55 AD3d at 589-590; *Ann Mary J. v City of New York, Health & Hosps. Corp.*, 204 AD2d 690, 691-692 [1994]).

Dr. Keller and Cardiovascular Associates of New York, P.C.'s

Motion for Summary Judgment

In support of their motion for summary judgment Dr. Keller and Cardiovascular Associates of New York, P.C. supply the affirmation of Philip M. Gelber, M.D., a physician board certified in internal medicine and cardiovascular disease. Dr. Gelber opines that Dr. Keller's treatment comported with accepted medical practice and that he did not perform any procedure which would have required him to first obtain Ms. Dixon's informed consent. In this regard Dr. Gelber contends that Dr. Keller's treatment of Ms. Dixon on March 22, 2010, which followed her second catheterization, was limited to a cardiac electrophysiology consultation for palpitations.[10] He contends that, as a specialist, Dr. Keller's care was limited to the treatment of arrhythmia disorders. Dr. Gelber contends that the decision to hold off on an invasive electrophysiology (EP) workup and to treat Ms. Dixon's rapid heart rate with beta-blockers, was appropriate in view of the information available at that time. Dr. Gelber points out that there was no evidence that arrhythmia and sinus tachycardia were a primary cardiology issue, a CT scan had not been conducted and Dr. Keller had not been made aware of a diagnosis of retroperitoneal hematoma.[11] Dr. Keller testified that when he treated Ms.

[10] Dr. Puma's note of March 22, 2010 reads in part: "[c]onsult Dr. S. Keller Re [sinus tachycardia]/LBB." Sinus tachycardia is explained by Dr. Keller at his deposition as a condition "where the normal pacemaker of the heart beats at a faster than normal rate."

[11] Dr. Keller testified that the function of a beta-blocker is to slow the beating of the heart and that if a patient was having a bleed and low blood pressure "then the beta-blockers should not be used." Dr. Keller also maintains that had Ms. Dixon been diagnosed with an intraabdominal bleed he would have documented such in his consultation note and would not have recommended continuation of beta-blockers. The CAT scan was performed at 6:16 P.M. The record is unclear on the time of Dr. Keller's consultation.

Dixon he did so as an employee of Cardiovascular Associates of New York, P.C.

The defendants demonstrate, *prima facie*, that they did not depart from accepted standards of care (*DiGeronimo v Fuchs,* 101 AD3d 933, 936 [2012]). The plaintiffs submit no opposition to this motion (*Koster v Davenport,* 142 AD3d 966 [2016]; *see Gillespie v NY Hosp. Queens*, 96 AD3d 901 [2012]).

LACK OF INFORMED CONSENT

In support of their demand for summary judgment dismissing plaintiffs' lack of informed consent claim, Dr. Carroccio and Park Lenox Surgical assert that this claim is predicated upon a failure to properly diagnose and treat Ms. Dixon's ongoing hemorrhage and that, therefore, her claim is not one for lack of informed consent. Dr. Puma argues that Ms. Dixon was fully informed about the procedure she was undergoing, along with its associated risks, and signed a consent form so indicating. Lenox Hill argues that responsibility for obtaining informed consent rests with the private attending, rather than with the Hospital.

The medical records contain a form signed by Ms. Dixon consenting to a cardiac catheterization performed on March 22, 2010. The records also contain the following note, signed by Dr. Puma:

> Risks & benefits of procedure and alternative therapy have been explained to the patient including but not limited to: allergic reaction, bleeding, infection, arrhythmia, renal and vascular compromise, limb damage, MI, CVA, emergent CABG and death. Informed consent obtained and in chart.

Dr. Razzouk opines that Dr. Puma advised Ms. Dixon of the risks of the procedure – as set forth in the above note – and obtained a valid and informed consent. He avers also that a patient in Ms. Dixon's position would have understood the risks of the procedure and consented to it.

With regard to the cardiac catheterization procedure, while the record indicates that plaintiff signed an informed consent form, the form is generic in nature and fails to set forth what alternatives to the proposed procedure, if any, were discussed with Ms. Dixon (*Walker v St. Vincent Catholic Med. Ctrs.*, 114 AD3d 669, 670-671 [2014]; *Rezvani v Somnay*, 65 AD3d 537, 538 [2009]). Defendant's expert makes no mention of whether Ms. Dixon was advised of alternatives and, moreover, fails to aver that the consent form complied with the prevailing standard applicable to reasonable practitioners performing the same kind of procedure (*Walker v St. Vincent Catholic Med. Ctrs.*, 114 AD3d at 670-671). Since Dr. Puma fails to establish his prima facie entitlement to judgment as a matter of law, summary judgment dismissing the cause of action alleging lack of informed consent is denied, regardless of the sufficiency of the plaintiff's opposition papers (*Whitnum v Plastic & Reconstructive Surgery, P.C.*, 142 AD3d 495, 498-499 [2016]).

As to plaintiffs' remaining allegations, it is noted that "[a]n element of a cause of action based upon lack of informed consent is 'some unconsented-to affirmative violation of the plaintiff's physical integrity' (Hecht v Kaplan, 221 AD2d 100, 103, 645 NYS2d 51 [1996]). . . . Lack of informed consent does not apply where, as here, injuries allegedly

resulted from a failure to undertake a procedure or a postponing of a procedure (*see Ellis v Eng*, 70 AD3d 887, 892 [2nd Dept 2010]). Stated differently, "[a] failure to diagnose cannot be the basis of a cause of action for lack of informed consent unless associated with a diagnostic procedure that involve[s] invasion or disruption of the integrity of the body" (*Janeczko v Russell*, 46 AD3d 324, 325 [2007] [internal citations omitted]). Accordingly, plaintiffs' allegations that defendants failed to evaluate the seriousness of Ms. Dixon's condition, with the result that affirmative treatment was not sought in a timely manner, does not state a cause of action for lack of informed consent (*Schel v Roth*, 242 AD2d 697, 698 [1997]). Similarly, plaintiffs' claim that defendants failed to recommend surgery, at a time when more beneficial results could have been obtained, fails to state a cause of action based on lack of informed consent (*Campea v Mitra*, 267 AD2d 190, 191 [1999]). Accordingly, it is

ORDERED, that the motions for summary judgment by Dr. Keller and Cardiovascular Associates (MS#13) and Dr. Santori-Rugio (MS#15) are granted to the extent that all claims against Dr. Keller, Cardiovascular Associates, and Dr. Santori-Rugio are dismissed and such parties are severed from the action; and it is further

ORDERED, that the motions of Dr. Carroccio and Park Lennox Surgical (MS#11), Lenox Hill (MS#14), and Joseph Puma (MS#15) are granted to the extent that plaintiffs' cause of action as premised upon lack of informed consent is dismissed. The remaining claims shall be severed and shall continue; and it is further

ORDERED, that plaintiffs' cross-motion (MS#16) is granted to the extent that the limited liability benefits under CPLR Article 16 cannot be applied to Seth Keller, Cardiovascular Associates of New York, P.C. and Franscisco Santoni-Rugio as such parties have been awarded summary judgment in their favor (*Hendrickson v Philbor Motors, Inc.*, 102 AD3d 251, 255 [2012]); and it is further

ORDERED, that the caption is amended to read as follows:

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Lee Dixon and Cedric Dixon, as the administrators of the Estate of Carolyn Dixon, Deceased, Lee Dixon, Individually, and Cedric Dixon, Individually,

Plaintiffs,

- against -

Joseph Puma, Manhattan Cardiac-Arrhythmia Associates, PC, "John Doe", The Vascular Surgery Attending Physician that wrote a Progress Note on April 15, 2010 at 10:33AM, Lenox Hill Hospital, Alfio Carroccio, and Park Lennox Surgical,

Defendants.

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The foregoing constitutes the order and decision of this court.

ENTER,

DATED: January 27, 2017

J. S. C.
HON. GLORIA M. DABIRI
J.S.C.