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SHORT FORM ORDER

INDEX No. 11-9907
CAL No. 14-00717MM

SUPREME COURT - STATE OF NEW YORK
I.A.S. PART 6 - SUFFOLK COUNTY

PRESENT:

Hon. RALPH T. GAZZILLO
Acting Justice of the Supreme Court

MOTION DATE 9-8-14 (#007)
MOTION DATE 9-24-14 (#008)
MOTION DATE 10-9-14 (#009)
ADJ. DATE 10-9-14
Mot. Seq. # 007 - MG
008 - MG
009 - MG

ALBERTA MORETT, as proposed Executrix of the Estate of BENJAMIN MORETT, Deceased,

Plaintiff,

- against -

LAWRENCE MERMELSTEIN, M.D., DORIS TAMAI, M.D., ALYSSA BROOKMEYER, M.D., SUFFOLK ANESTHESIOLOGY ASSOCIATES, P.C. and ST. CATHERINE OF SIENNA MEDICAL CENTER,

Defendant.

SULLIVAN PAPAIN BLOCK MCGRATH & CANNAVO, P.C.
Attorney for Plaintiff
120 Broadway
New York, New York 10271

KELLER, O'REILLY & WATSON, P.C.
Attorney for Defendant Mermelstein, M.D.
242 Crossways Park West
Woodbury, New York 11797

KERLEY, WALSH, MATERA and CINQUEMANI, P.C.
Attorney for Defendants Tamai, M.D., Suffolk Anesthesiology
2174 Jackson Avenue
Seaford, New York 11783

ROGAK & GIBBONS, LLP
Attorney for Defendant Brookmeyer, CRNA
50 Charles Lindbergh Boulevard, Suite 320
Uniondale, New York 11553

BARTLETT, MCDONOUGH, & MONAGHAN
Attorney for Defendant St. Catherine of Siena
670 Main Street
Islip, New York 11751

Upon the following papers numbered 1 to 59 read on these motions for summary judgment; Notice of Motion/ Order to Show Cause and supporting papers (007) 1-17; (008) 18- 32; (009) 33-59; Notice of Cross Motion and supporting papers ___; 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 defendant Alyssa Brookmeyer CRNA pursuant to CPLR 3212 for summary judgment dismissing the complaint as asserted against her is granted; and it is further

ORDERED that motion (008) by defendant Doris Tamai, D.O. s/h/a Doris Tamai, M.D., pursuant to CPLR 3212 for summary judgment dismissing the complaint as asserted against her is granted; and it is further

ORDERED that motion (009) by defendant Laurence Mermelstein, M.D. s/h/a Lawrence Mermelstein, M.D. pursuant to CPLR 3212 for summary judgment dismissing the complaint as asserted against him is granted.

In this medical malpractice action, Alberta Morett, as executrix of the estate of decedent, Benjamin Morett, seeks damages for the alleged injuries suffered by decedent premised upon the alleged negligent departures from good and accepted standards of care and treatment by the defendants; lack of informed consent; and pecuniary damages for loss of services, income, and support. On or about May 18, 2009, decedent Benjamin Morett, then 71 years of age, came under the care of the defendants at St. Catherine of Siena Medical Center for surgery for degenerative disc disease and spinal stenosis. Surgery consisted of L4-5 and L5-S1 posterolateral lumbar intertransverse fusion, with allograft prosthetic mesh disc spacers at L4-5, and posterior segmental instrumentation with pedicle screw instrumentation from L4 to S1, for treatment of back pain.

It is alleged, inter alia, that defendants failed to properly monitor and treat the decedent, allowing him to become hypotensive and hypoxic, negligently medicating him with Fentanyl, and permitting him to become over-medicated, resulting in shock, acute kidney failure, respiratory failure, and death. The surgery was performed by Laurence Mermelstein, M.D. Dr. Robert Fundacaro was the anesthesiologist assisted by Alyssa Brookmeyer, CRNA. The decedent was administered Versed, Fentanyl, Propofol, Lidocaine, and Desflourane. Rocuronium was used prior to intubation to temporarily paralyze the decedent. Postoperatively, the decedent was placed on Fentanyl via PCA (patient controlled analgesia) pump for pain management. Hypotension, lethargy, and cold extremities were noted in the early morning hours of May 20, 2009. The decedent was transferred to ICU with a critically low potassium level of 6.6, acidosis (7.1), and elevated liver and kidney function values. Coagulation studies revealed thrombocytopenia, and cardiac enzymes demonstrated heart damage. The decedent was placed on dialysis and intubated, then transferred to North Shore University Hospital, where he died on May 21, 2009.

In support of motion (007), defendant Alyssa Brookmeyer CRNA submitted, inter alia, an attorney's affirmation; copies of the summons and complaint, defendants' answers, and plaintiff's verified bill of particulars; unsigned but certified transcripts of the examinations before trial of Alyssa Brookmeyer and Robert Fundacaro, M.D. which are considered (*see* ***Zalot v Zieba***, 81 AD3d 935, 917 NYS2d 285 [2d Dept 2011]; ***Ashif v Won Ok Lee***, 57 AD3d 700, 868 NYS2d 906 [2d Dept 2008]); the

signed and certified transcript of Laurence Mermelstein, M.D.; stipulation of discontinuance as to defendant Brookmeyer, signed by plaintiff and counsel for Brookmeyer; certified copy of the medical record of St. Catherine of Siena Medical Center; autopsy report dated October 16, 2009; stipulation consolidating this action with the action #2 which is signed only by counsel for defendant Brookmeyer; and the affirmation of Steven B. Cagen, M.D.

In support of motion (008) Doris Tamai, D.O. submitted, inter alia, an attorney's affirmation; affidavit of Doris Tamai, D.O.; copies of the summons and complaint, defendants' answers, and plaintiff's verified bill of particulars; stipulation of discontinuance as to defendant Tamai signed only by plaintiff; and a certified copy of the medical record of St. Catherine of Siena Medical Center.

In support of motion (009) Laurence Mermelstein, M.D. submitted, inter alia, attorney's affirmation; copies of the summons and complaint, defendants' answers, and plaintiff's verified bill of particulars and supplemental bill of particulars; unsigned and certified transcripts of the examinations before trial of Alberta Morett, Alyssa Brookmeyer, and Robert Fondacaro which are considered (*see* ***Zalot v Zieba***, *supra*); the signed and certified transcript of Laurence Mermelstein, M.D., nonparty Alison Perry, non-party Ellen Beldy; the unsigned transcripts of non-party witnesses Carmela DiCarlo, Linda Chernoff, M.D., Ramman Irishman, and Desiree Johnson, which are not in admissible form, are not accompanied by an affidavit or proof of service pursuant to CPLR 3116, and are not considered (*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]); uncertified medical records; autopsy report dated October 16, 2009; stipulation consolidating this action with the action #2 which is signed only by counsel for defendant Mermelstein; stipulation of discontinuance for defendant Mermelstein signed by counsel for the plaintiff and defendants Mermelstein and Brookmeyer; and the affirmation of Alfred F. Faust, M.D.

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. To establish liability of a physician for medical malpractice, plaintiff must prove that the physician deviated or departed from accepted community standards of practice, and that such departure was a proximate cause of the plaintiff's injuries (***Fink v DeAngelis***, 117 AD3d 894, 986 NYS2d 212 [2d Dept 2014] *quoting* ***DeGeronimo v Fuchs***, 101 AD3d 933, 936, 957 NYS2d 167 [2d Dept 2012, *quoting* ***Stukas v Streiter***, 83 Ad3d 18, 23, 918 NYS2d 176 [2d Dept 2011].) " Accordingly, '[a] physician moving for summary judgment dismissing a complaint alleging medical malpractice must establish, prima facie, either that there was no departure or that any departure was not a proximate cause of the plaintiff's injuries'" (***Fink v DeAngelix***, 117 AD3d 894, *supra*, *quoting* ***Gillespie v New York Hosp. Queens***, 96 AD3d 901, 902, 947 NYS2d 148 [2d Dept 2012]). "Once a defendant physician has made such a showing, the burden shifts to the plaintiff to demonstrate the existence of a triable issue of fact, but only as to the elements on which the defendant met the prima facie burden" (***Matos v Khan***, 119 AD3d 909, 2014 WL 3732819 [2d Dept 2014]; *see* ***Stukas v Streiter***, 83 AD3d 18 at 30, *supra*). "Summary judgment is not appropriate in a medical malpractice action where the parties adduce conflicting medical expert opinions (***Fink v DeAngelis,*** 117 AD3d 894, *supra*; ***Feinberg v Feit***, 23 AD3d 517, 519, 806 NYS2d 661 [2d Dept 2005]). as "such conflicting medical opinions will raise

credibility issues, which can only be resolved by a jury" (***Fink v DeAngelis***, 117 AD3d 894, *supra;* ***DeGeronimo v Fuchs***, 101 AD3d at 936, 957 NYS2d 167 [2d Dept 2012]).

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]).

"The affidavit of a defendant physician may be sufficient to establish a prima facie entitlement to summary judgment where the affidavit is detailed, specific and factual in nature and does not assert in simple conclusory form that the physician acted within the accepted standards of medical care" ***(Lau v Wan***, 93 AD3d 763, 940 NYS2d 662 [2d Dept 2012]; ***Micciola v Sacchi***, 36 AD3d 869, 828 NYS2d 572 [2d Dept 2007]; ***Toomey v Adirondack Surgical Assoc.***, 280 AD2d 754, 755, 720 NYS2d 229 [3d Dept 2001][citations omitted]; ***Winegrad v New York Univ. Med. Ctr.***, 64 NY2d 851, 853, 487 NYS2d 316 [1985]; ***Machac v Anderson***, 261 AD2d 811, 690 NYS2d 762 [3d Dept 1999]).

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]).

Laurence Mermelstein, M.D. testified to the extent that he is employed by Long Island Spine Specialists, in which he is a shareholder. He is an orthopedic surgeon specializing in spine surgery. He is licensed to practice medicine in New York and California and is board certified in orthopedic surgery. He first performed surgery on the decedent in June 2000. The decedent returned to his office on July 3, 2000, ten days after surgery, complaining of pain due to a fall. Thereafter, the decedent was followed by his office for various cervical sprains and other injuries and problems. In February 2009, the decedent presented with a one-year history of lower back pain. He was diagnosed with degenerative disc disease and facet syndrome, for which he was referred to Dr. Sanelli for a right radicular facet block at L4-5 and L5-S1. He experienced pain relief with the block, but returned March 12, 2009 with increasing pain. Dr. Mermelstein described the ongoing care and treatment, and stated that on April 13, 2009, the decedent returned with continued low back pain. They discussed the testing which had been performed and the proposed surgery to treat the back pain.

Dr. Mermelstein continued that the decedent was seen at his office on May 4, 2009, at which time the procedure was reviewed and consent forms signed. Medical clearance was obtained preoperatively. Dr. Mermelstein set forth the risks associated with the surgical procedure and general anesthesia. He described the surgery performed on the decedent, Benjamin Morett, at St. Catherine of Siena Medical Center, on May 18, 2009. Dr. Mermelstein stated that it is his custom and practice not to decide the anesthesia to be given to the patient for surgery, and that the anesthesiologist determined the

medications used for anesthesia for the decedent. After surgery, PCA (patient controlled analgesics) are ordered by the anesthesiologist. If there is oral medication prescribed after surgery, he or one of his partners routinely order it. He continued that PCA is administered via a machine/pump wherein the machine is set up to deliver the dosage and number of times per hour the patient can activate the machine, pursuant to the anesthesiologist's order. The anesthesiologist, whose name he could not read, wrote the PCA order for Fentanyl 10 mcg per ml, with a loading dose of 50 mcg and a PCA bolus of 30 mcg. Lockout interval for the PCA pump was 6 minutes with a one hour limit of 350 mcg. He had no say in the order. He added that the anesthesiologist is in charge of adjusting the PCA order as necessary. CRNA Brookmeyer was also present during surgery with regard to anesthesia administration.

Dr. Mermelstein stated that he saw the decedent on May 19, 2009 at 8:30 a.m. His note indicated the decedent had a stable night. He was sitting in a chair, was sleepy but arousable, and using the PCA. He was mobilized with physical therapy. Dr. Mermelstein wrote in his note to discontinue the PCA in the a.m. (the following morning). He ordered Morphine 4mg subq every 3 hours for severe pain. In reviewing the decedent's laboratory tests obtained that day, he noted the BUN was high at 42; creatinine at 2.7 was elevated. He stated that these values indicated decreased kidney function. He had no recollection of being notified of these values. On May 20, 2009, there was a house note written at 12:45 a.m. which indicated he was made aware that the decedent was observed to be "not looking good," clammy with respirations of 19, pulse of 82, and blood pressure of 80/50; SPO2 90%; alert to voice; somnolent; and pupils were constricted. The physician who reported to Dr. Mermelstein indicated in his note that the decedent had "lactic acidosis, ? hypoxic with hypotension, is sepsis" (sic). The care plan was described, and the decedent was transferred to ICU. The rapid response team was called and the decedent was administered Narcan intravenously to reverse the effects of narcotics. Dr. Mermelstein stated Fentynl is a narcotic. The decedent was more alert after the Narcan, but was lethargic and vomiting, and had decreased blood pressure and cold extremities. A 2:00 a.m. order on May 20, 2009 by Dr. Mermelstein was for Percocet 2 tabs by mouth every four hours for pain, and Morphine 4 mg IM as needed for severe pain, which, Dr. Mermelstein stated, was to be the pain management medication once the PCA was discontinued.

Dr. Mermelstein stated that he did not see the decedent after May 20, 2009 upon his transfer to ICU, but Karen Pagano, a physicians assistant, saw him in ICU. Dr. Noor took over the decedent's care in ICU. The decedent was transferred out of St. Catherine of Siena on May 20, 2009 at about 6:00 p.m. with a diagnosis of cardiomyopathy. He was receiving dialysis. Dr. Mermelstein did not have a good feeling for the exact cause of the decedent's kidney failure, elevated troponins, and eventual expiration. He had no opinion as to the decedent's cause of death. It was his opinion that the decedent did not receive too much Fentanyl, or that Fentanyl was the cause of his organ failure.

Dr. Mermelstein testified that he saw the decedent on May 20, 2009 at about 11:00 a.m. and noted, among other things, that the decedent's blood pressure improved, he was sedated and his neuro status was difficult to assess. Dialysis was to start. He reviewed the consultations. Lab studies revealed worsening renal failure based upon the BUN and creatine. Troponin level were increased, indicating possible (cardiac) muscle damage, so he was to be seen on a cardiology consult. Dr. Marmelstein referenced a consultation note dated May 20, 2009, by Dr. Ilamathi, who indicated "narcotic overdosing self administered culminating in shock." Dr. Noor, upon medical assessment, diagnosed renal failure.

Dr. Lee, the cardiologist, diagnosed respiratory failure, respiratory acidosis, renal failure status spinal surgery, and thrombocytopenia, for which his plan was to have ventilator support, treat the acidosis, blood pressure management, and dialysis.

Robert Fondacaro, M.D. testified to the extent that he is an anesthesiologist, employed by Suffolk Anesthesia Associates since 1990, and is a partner in the group. He is licensed in New York State and has an inactive California license. He is board certified in anesthesiology. He provides services at St. Catherine of Siena, and has a surgery center in the Bronx. He provides services in several doctors' offices in the local community. He never met Mr. Morett prior to his presentation to the operating room holding area on May 18, 2009. He testified as to what he did and what he discussed with the decedent at that time. He noted that the decedent's echocardiogram revealed an ejection fraction of 65 to 70 %, with 1+ pulmonary insufficiency. He stated that while the decedent may have been taking other medications preoperatively, such as Lexapro, the responses to anesthesia and the other medication are judged by assessing the patient's vital signs, heart rate, blood pressure, and, when they are awake, observing the sedative effects and vital signs. Monitoring urinary output measures the volume status, intravascular fluid volume, and the amount of pressure in the vessels. A drop in blood pressure can result in changes of volume flow and output.

Dr. Fondacaro testified that he prescribed Fentanyl by bolus dose of 50 mcg, intravenously, then by PCA, for 30 mcg every 6 minutes, over an hour. The decedent would have controlled how often he needed it, but was prevented by the pump from getting more than one dose every six minutes. The PCA has an automatic lock out at ten doses, for a maximum of ten doses in an hour. In twenty years of practice, he has never seen a Fentanyl buildup. Dr. Fondacaro testified that he ordered one of the lowest doses of Fentanyl for the decedent because of his age, and because he had been on Lexapro, a sedative. Respiratory depression, drop in oxygen saturation, increase in breathing rate, a slower heart beat, lower blood pressure, sedation, can lead to hypoxia (decreased delivery of oxygen to the tissues), which can affect the heart, kidneys, and liver, and could cause a heart attack.

Dr. Fondacaro testified that he wrote the initial orders for the PCA pump. Any of the anesthesiologists could have changed it without talking to him. An anesthesiologist is assigned to and sees a patient each day. There is a protocol in the orders, and the patient is monitored by the nurses. The protocol provides parameters for the administration of the medication, and the anesthesiologist is to be notified if the systolic blood pressure is less than 85, or a heart rate greater than 120 or less than 45, which could require that Fentanyl be stopped. On May 18, 2009, about 2:00 p.m., when he was relieved of the case, he wrote in his order to notify the anesthesiologist immediately for sedation scale greater or equal to 4, motor or sensory function greater or equal to 1, respiratory rate less than 10 per minute and/or BP as indicated below. He stated that Narcan is standardly used to antagonize the effects of Fentanyl. He testified that there was nothing in the decedent's condition which contraindicated the use of Fentanyl. A total of 500 mcg of Fentanyl was administered during surgery, over a four and one-half hour period.

Dr. Fondacaro stated that the decedent was still under the care of anesthesia while in the post-anesthesia care unit, however, Dr. Fondacaro stated he was not there. He believed Dr. Tamai wrote the PACU Fentanyl orders, with an initial order of 100 mcg by intravenous push, then, at 13:30, PCA Fentanyl 25 mcg every five minutes was ordered. Dr. Fondacaro testified that he did not see the

decedent at any time after 2 p.m. when he left the operating room, as another physician took over as anesthesiologist for the decedent. He noted that the decedent's vital signs were stable, and he was alert when taken to recovery. At 6:45 p.m., on the day of surgery, Dr. Raj Krishna, an anesthesiologist who was board certified in pain management, ordered Tylenol which was given at 6:45 p.m., and Xanax .5 mg every 12 hours, which was given at 10:00 p.m. Dr. Raj Krishna, at 5:00 a.m., on May 19, 2009, was contacted by one of the nurses requesting pain medication for the decedent, as his pain control was fair. Ambien 10 mg was ordered and administered. Linda Chernoff, an anesthesiologist employed by his group, was responsible for evaluating the decedent and his response to PCA the day after surgery on May 19, 2009. Dr. Chernoff went off duty at 4:00 p.m. on May 19, 2009. Dr. Fondacaro testified that he did not know who the on call anesthesiologist was at the hospital covering until the following morning. On May 20, 2009, Dr. Siok Chen, now retired, was responsible for evaluating the decedent and his response to PCA in the morning. He continued that the evaluation entails determination of the patient's level of comfort on the PCA, whether the dosage needs adjustment based on comfort and sedation levels, and assessment for over sedation. Dr. Fondacaro continued that nurses on the floor will call the anesthesiologist if there is a problem with the patient, or call a code if the patient is in dire straits.

Dr. Fondacaro testified that after Dr. Chen saw the decedent the second morning after surgery, she advised him the PCA had been stopped the day before by Dr. Chernoff because the decedent was having a problem and was in renal failure. She further advised him that the decedent was transferred to ICU. Dr. Michael Weiss was called in during the night to intubate the decedent. Morphine was administered. On May 21, 2009, Xanax was stopped. Dr. Fondacaro testified that Xanax is a sedative/anti-anxiety medication which has an additive effect with Fentanyl. Dr. Makrides, an anesthesiologist, told him the decedent was being transferred to North Shore University Hospital. He further indicated to Dr. Fondacaro that Dr. Lamonte, a renal specialist, had written a noted which stated the patient had been overdosed with Fentanyl, self-administered.

Linda Chernoff, M.D. testified to the extent that she is a physician licensed to practice medicine in New York State and is board certified in anesthesiology. At the time she saw the decedent, she was employed at Suffolk Anesthesia Associates with privileges at St. Catherine of Siena Medical Center. As a staff anesthesiologist, she can be assigned a room in the operating room, do rounds, go to the endo suite, or do other things. She was doing PCA rounds on May 19, 2009. She stated the PCA is a patient controlled anesthesia. Patients can request the pain pump, which is ordered and monitored by anesthesia. The decedent, she stated, was receiving Fentanyl, a narcotic to treat pain. The decedent's PCA dose of Fentanyl had a basal rate of zero, which meant it is not running with any medication unless the patient pushes the pump. The PCA dose was 30 mcgs (micrograms) which the decedent could push every six minutes. She added that the patient can push as often as he likes, but will only be dosed every six minutes. She stated that it is possible to overdose on Fentanyl or any medication. A Fentanyl overdose would be exhibited with sedation, the patient would be unresponsive, and have decreased respiratory and heart rates, and decreased blood pressure. Respiratory arrest could lead to cardiac arrest.

Dr. Chernoff stated that she wrote a note in the decedent's chart on May 19, 2009 at 8:30 a.m. indicating the decedent's vital signs were stable. He was complaining of difficulty sitting to eat, reaching the phone, and pushing the PCA, consistent with some pain. She instructed him how to push

the PCA button for relief, and determined that he did not push the button all that often. The current settings for the Fentanyl were to be continued. She did not recall seeing the decedent again after that. The nurses could call anesthesia for any problems such as continued pain, or side effects such as itching, or if the vital signs were not stable according to the PCA parameters. She set forth the parameters and stated that on May 19, 2009, the nurses were responsible for monitoring the decedent every four hours for respirations, sedation scale, pain scale, and vital signs. On May 19, 2009, between 6:00 a.m. and 10:00 a.m., the decedent made 109 PCA demands, however, only 19 boluses of 30 mcg each were delivered. At 2:00 p.m. when he was checked, the decedent had 317 demands, with 26 delivered. She stated that he was getting a dose that was therapeutic and safe, but she did not know if it relieved his pain. From 6:00 a.m. until 2:00 p.m., he received 780 mcg, which, based on parameters, was not a lot. At 5:00 p.m., there were zero demands and zero delivered. Four hours later, there was one demand and one delivery.

Dr. Chernoff testified that she was not made aware that the decedent was experiencing some confusion at times on May 19, 2009 at 1:30 a.m. On May 20, 2009, at 12:52 a.m., there was a notation that the rapid response team was called for the decedent, and Narcan was administered. She was not on duty at that time. It was her opinion that Fentanyl 750 mcg over an eight hour period would be under-sedation. She did not feel that on May 19, 2009 between 6:00 a.m. and 2:00 p.m., that the decedent was over sedated.

In motion (007), Alyssa Brookmeyer CRNA seeks an order dismissing the complaint as asserted against her. She testified to the extent that she has been a registered nurse anesthetist since 2007, and works with physician anesthesiologists for the administration of anesthesia. She was employed by Suffolk Anesthesia to work at St. Catherine of Siena from March to May 2009. She was also working at the same time for NAPA, North American Partners in Anesthesia, until May 2012. There was some overlap with Jacobi Medical Center for a year until December 2008. From April 1998 through October, 2007, she worked as a registered nurse at Winthrop University Hospital.

Brookmeyer testified that the physician determines which medications will be administered after a head-to-toe assessment of the patient, as well as medications the patient is taking, blood work including electrolytes and CBC. Risks of anesthesia are provided to patients. She stated that the decedent was advised generally of the risks, including blindness related to diabetes, blood pressure problems, or heart attack. She felt the decedent would do well. Prior to the administration of anesthesia, she determined what kind of monitoring was going to be done, as it dictates the type of anesthesia to be used as the monitoring may interfere with the anesthetic. Dosages may be adjusted to not exceed certain doses so it does not interfere with the monitoring. She described the protocol usually followed, and the types of medication provided. She stated that Dr. Fondacaro was the anesthesiologist for the decedent, and that she would have discussed the anesthesia plan with him. Once the patient goes under with intravenous medication, intubation is done. She would then manage the patient's airway. She testified that all the medications are titrated specifically for the patient. Lactated Ringers solution and cell saver blood was given to replace blood loss of 450 cc, and to maintain volume.

Nurse Brookmeyer testified that Fentanyl is a narcotic, a synthetic form of morphine, and was administered to the decedent during surgery in small boluses intravenously, and with induction. 100

mcgs were administered between 8:50 and 8:55. between 9:00 and 9:30, 25 mcgs at 11:05, 11:20, 12:10, 12:45, and 50 mcgs at 1:15 and 3:30, so that the decedent would not move during surgery and to maintain a baseline heart rate and blood pressure. It has an effect on the central nervous system and depresses everything, slowing down the heart rate and breathing, and lowering the blood pressure. Overdose would be demonstrated by anything from somnolence to death. Confusion may occur. Narcan will reverse the effects of Fentanyl, is typically fast acting, will cause the patient to experience pain pretty instantly, and the blood pressure and heart rate will increase. Versed was administered once at about 8:50 as an amnesic and anxiolytic, but she could not read the dosage. Decadron was administered at 9:15. She discussed the use of Rocuronium, an akinetic, to cease breathing by affecting the respiratory muscles, so that breathing can be done for the patient. Neosynephrine, she stated, is given shortly after induction to raise the blood pressure as the medications given lower the blood pressure. The Neosynephrine was given at 9:00, 9:30, and 1:00. Desflurane was given as an induction gas. Zofran was given as an antiemetic. Lidocaine was given to blunt the effects of the airway when intubation is done. Propofol 200 mg was administered at approximately 8:50 for induction (100 mg at 8:45), then maintained at 50 mcgs per kilo for the majority of the case from 9:00 a.m. until 14:15 p.m. She stated that it could lower the blood pressure, but did not really have an effect on the heart rate. At the end of the procedure, Lebetalol was given to lower the blood pressure which generally increases when the patient wakes up, however, it was administered by someone else who provided her with a break at 14:00 to 14:40. Anesthesia ended at 14:28.

Brookmeyer testified that the decedent's condition was optimized for the procedure, there were no contraindications to the anesthesia provided during surgery, including Fentanyl. She continued that Fentanyl is excreted through the liver, and that the decedent's liver function tests were good, nothing out of the ordinary that she could remember. If the liver were not working well, typically, the kidneys would pick up the slack. There was nothing to indicate that the decedent might have problems metabolizing Fentanyl. She stated that Dr. Tamai did not play any role in the decedent's care as Dr. Fondacaro was the anesthesiologist. Dr. Mermelstein was the surgeon, assisted by PA Ossipoff. Following surgery, the decedent was transferred to the recovery area, PACU, in stable coition. She no longer provided any care or treatment for the decedent upon transfer. Dr. Fondacaro made the decisions with regard to any postoperative pain control in PACU and afterwards. She never saw the decedent again after he left the operating room. She learned at some point from Dr. Fondacaro that the decedent was not doing well. She was surprised because the case was uneventful, he did well, and there were no intraoperative complications. When he awoke, it was without difficulty. He followed commands. A degree of lethargy was expected initially. She took no part in the patient controlled analgesics after surgery. May 18, 2009 was the only day she ever saw the decedent.

The affirmation of Dr. Steven B. Cagen has been submitted in support of Nurse Brookmeyer's application. Dr. Cagen affirms that he is licensed to practice medicine in New York State and is board certified in anesthesiology, internal medicine, nephrology, and critical care medicine. He set forth his education and training, as well as his current position as a practicing anesthesiologist. He indicated the records and materials which he reviewed. Dr. Cagen opined within a reasonable degree of medical certainty that the care and treatment rendered by CRNA Brookmeyer was in accordance with the good and accepted standards of care, and the care and treatment provided by her was not the proximate cause of the injuries and death of Mr. Morett on May 21, 2009.

Dr. Cagen set forth that the admission of Mr. Morett to St. Catherine of Siena Medical Center was on May 18, 2009, to the orthopedic service of Dr. Mermelstein, for the purpose of spinal surgery. Dr. Fundacaro was the anesthesiologist for the case, and Alyssa Brookmeyer, CRNA assisted in providing anesthesia care to the decedent under Dr. Fundacaro's supervision. They both evaluated the decedent preoperatively. Dr. Cagen set forth the anesthesia medications administered, and the care provided, stating that dosages were proper and appropriate for the decedent's age, stature, and vital signs. He was intubated without difficulty. Dr. Cagen noted that Fentanyl is a semi-synthetic narcotic utilized to alleviate pain as well as being used as an anesthetic. It is short acting and excreted by the liver. He set forth the dosages of Fentanyl administered to the decedent during surgery, for a total of 500 mcg over the course of approximately four and one-half hours.

Dr. Cagen continued that the decedent remained in stable condition throughout surgery. His vital signs, oxygenation, end tidal CO2, and urine output were acceptable. Extubation was uneventful with spontaneous breathing. He was awake and following commands. He went to PACU, where he appeared to be in stable condition. Pain management placed the decedent on a PCA pump to deliver Fentanyl into his system intravenously, initially as a bolus, and also when he pressed a button to trigger the machine to deliver the medication. The button on the machine was set to deliver a restricted amount of Fentanyl when pressed. CRNA Brookmeyer was not involved in the ordering of, or the monitoring of the PCA pump, or in ordering any medications for the decedent postoperatively.

Dr. Cagen stated that in the immediate postoperative period, the decedent was noted to be alert and oriented by 3, in no distress, and tolerating a liquid diet. It was not until two days after surgery, on the early morning of May 20, 2009, that the decedent was noted to have low blood pressure, lethargy, and cold extremities, and was transferred to ICU. Blood work drawn at 12:45 a.m. revealed critical values of 6.6, he was acidotic, his electrolytes were abnormal, and his liver function and kidney studies were elevated. Coagulation studies showed he was thrombocytopenic, and cardiac enzyme studies indicated he had heart damage. He was intubated, placed on dialysis, and seen by a kidney specialist and a cardiologist. Echocardiogram revealed global hypokinesis (lack of motion) in the left ventricle. He was transferred to North Shore University Hospital on May 20, 2009, and died on May 21, 2009. Dr. Cagen stated that the autopsy report certified by Dr. Wolodzko, set forth the cause of death as arteriosclerotic and hypertensive heart disease with acute myocardial infarction and hepatorenal failure.

In conclusion, Dr. Cagen opined that the amount of Fentanyl, and other medications used for analgesia and anesthesia, administered to the decedent intraoperatively were proper and were not a proximate cause of death of the plaintiff's decedent. He was not in any distress, was extubated without incident, awoke and responded. Had the medications caused untoward effects, it would have been apparent immediately, either during surgery or in the immediate postoperative period. He would have been unstable during the surgery, as evidenced by problematic vital signs, or he would not have been able to be easily extubated or remain extubated. There is no indicia of respiratory or cardiac distress in the operative report and postoperative care note.

Based upon the foregoing, CRNA Alyssa Brookmeyer has demonstrated prima facie that she did not depart from the standards of care in administering anesthesia care to the decedent and did not proximately cause the injuries or death of the decedent. The plaintiff has not opposed this motion and

has not raised factual issues to preclude summary judgment. It is noted that the plaintiff has signed a stipulation to discontinue the action as asserted against CRNA Brookmeyer. Although none of her co-defendants have signed the stipulation, they have not opposed her motion, they have not asserted a cross claim against her, and they have not presented expert opinion against her to preclude summary judgment. Therefore, the remaining co-defendants are precluded from asserting Article 16 benefits at the time of trial relative to CRNA Brookmeyer.

Accordingly, motion (007) is granted and the complaint asserted against CRNA Alyssa Brookmeyer is dismissed.

In motion (008), Doris Tamai, D.O. seeks an order dismissing the complaint as assert against her and has submitted an affidavit in support. Dr. Tamai avers that she is a physician licensed to practice medicine in New York State and is board certified in anesthesiology. She further averred that she reviewed the St. Catherine of Siena Medical Center record of Benjamin Morett concerning his admission of May 18, 2009, and determined that at no time did she treat or care for the decedent. She took no part in any decision making concerning his care, including the use and dosage of patient controlled analgesics, including Fentanyl. She continued that at no time did she have any conversations with any of the physicians or medical staff concerning the patient controlled analgesia rendered to the decedent during this admission. Dr. Tamai concluded by stating that she did write the post-anesthesia order for PACU and ASU, however, that order was only for Fentanyl to be administered in the recovery room and did not carry over after the decedent was discharged from the recovery room.

Based upon the foregoing, it is determined that defendant Doris Tamai, D.O. has demonstrated prima facie entitlement to summary judgment dismissing the complaint asserted against her. The plaintiff has not opposed this motion and has not raised a factual issue to preclude summary judgment from being granted to Dr. Tamai. It is noted that the plaintiff has signed a stipulation to discontinue the action as asserted against Doris Tamai, D.O. Although none of her co-defendants have signed the stipulation, they have not opposed her motion, they have not asserted a cross claim against her, and they have not presented expert opinion against her to preclude summary judgment. Therefore, the remaining co-defendants are precluded from asserting Article 16 benefits at the time of trial relative to Doris Tamai, D.O.

Accordingly, motion (008) is granted and the complaint as asserted defendant Doris Tamai, D.O. is dismissed.

In motion (009), Laurence Mermelstein, M.D. has submitted the affirmation of his expert, Alfred F. Faust, M.D. a physician licensed to practice medicine in New York State who is board certified in orthopedic surgery. He set forth the materials and records he reviewed, and indicated he maintains a practice in orthopedics.

Dr. Faust set forth the decedent's condition upon presentation to Dr. Mermelstein and the basis for the surgery performed on May 18, 2009. He described the surgery performed, and opined that it was performed within the standard of care, and done to minimize tissue disruption and blood loss. He continued that the anesthesiologist determined that general anesthesia would be administered, and

further determined the amounts and type of anesthesia given to the decedent. After surgery, he stated, the decedent was in stable condition. After surgery, the plaintiff was ordered postoperative pain medication, however, the anesthesiologist determined that PCA would be administered, and determined that Fentanyl would be used, as well as the dose the decedent was to receive. When Dr. Mermelstein saw the decedent on the morning of May 19, 2009, the decedent was stable, sitting up, and doing well with some pain. It was not until the early hours of May 20, 2009 that the decedent's condition began to change due to the development of respiratory distress requiring intubation.

Dr. Faust stated that the autopsy report of the Office of the Medical Examiner indicates that the decedent had severe triple vessel coronary arteriosclerosis, cardiomegaly from left ventricular hypertrophy, and an acute myocardial infarction. The decedent also had kidney arteriosclerosis. The cause for the decedent's death was arteriosclerotic and hypertensive heart disease. It is Dr. Faust's opinion that Dr. Mermelstein did not depart from good and accepted standards of care and practice. He continued that Dr. Mermelstein's care and treatment, and surgical procedure and technique, were at all times appropriate and did not cause or contribute to the decedent's injuries or death.

Based upon the foregoing, it is determined that Dr. Laurence Mermelstein, M.D. has demonstrated prima facie entitlement to summary judgment dismissing the complaint asserted against him. The plaintiff has not opposed this motion and has not raised a factual issue to preclude summary judgment from being granted to Dr. Mermelstein. It is noted that the plaintiff has signed a stipulation to discontinue the action as asserted against Dr. Mermelstein. Although none of the co-defendants have signed the stipulation, they have not opposed his motion, they have not asserted a cross claim against him, and they have not presented expert opinion against him to preclude summary judgment. Therefore, the remaining co-defendants are precluded from asserting Article 16 benefits at the time of trial relative to Laurence Mermelstein, M.D.

Accordingly, motion (008) is granted and the complaint as asserted defendant Laurence Mermelstein, M.D. is dismissed.

Dated: 12/9/14

A.J.S.C.

____ FINAL DISPOSITION __X__ NON-FINAL DISPOSITION