MacLaren v Blyskal
2014 NY Slip Op 30391(U)
February 4, 2014
Sup Ct, Suffolk County
Docket Number: 08-35722
Judge: Denise F. Molia
Cases posted with a "30000" identifier, i.e., 2013 NY Slip Op 30001(U), are republished from various state and local government websites. These include the New York State Unified Court System's E-Courts Service, and the Bronx County Clerk's office.
This opinion is uncorrected and not selected for official publication.

[* 1]

SHORT FORM ORDER

COPY

INDEX No. 08-35722
CAL No. 12-02110MM

SUPREME COURT - STATE OF NEW YORK
I.A.S. PART 39 - SUFFOLK COUNTY

PRESENT:

Hon. DENISE F. MOLIA
Acting Justice of the Supreme Court

MOTION DATE 4-5-13 (007,008, 009)
MOTION DATE 4-19-13 (010)
MOTION DATE 9-6-13 (012)
ADJ. DATE 12-6-13
Mot. Seq. # 007 - MD # 008 - MD
009 - MD # 010 - MG # 012 - XMG

EDITH MacLAREN, as Executor of the Estate of JAMES L. MacLAREN, and EDITH V. MacLAREN, Individually,

Plaintiffs,

- against -

STANLEY E. BLYSKAL, M.D., ROBERT M. JAEGER, M.D., JAY B. STAMBLER, M.D., JAY B. STAMBLER, M.D., P.C., JOHN W. FRANCFORT, J.D., ELLEN G McCORMICK, M.D., GREAT SOUTH BAY SURGICAL ASSOCIATES AND VASCULAR LAB, LLP, JOHN MURATORI, M.D., ROSS, MACCONE & MURATORI, MDS, JANICE McCORMACK, M.D., SOUTH BAY CARDIOVASCULAR ASSOCIATES, P.C., SOUTHSIDE HOSPITAL and NORTH SHORE-LONG ISLAND JEWISH HEALTH SYSTEM,

Defendants.

DUFFY & DUFFY, PLLC
Attorney for Plaintiffs
1370 RXR Plaza, West Tower, 13th Floor
Uniondale, New York 11556

ANTHONY P. VARDARO, P.C.
Attorney for Defendants Blyskal, M.D., Jaeger, D.O. & Stambler, M.D. & P.C.
732 Smithtown Bypass, Suite 203
Smithtown, New York 11787

HELWIG, HENDERSON, RYAN & SPINOLA
Attorney for Defendants Drs McCormick an& Muratori, Ross, Maccone & Muratori, MDS, & Great South Surgical Associates
One Old Country Road, Suite 428
Carle Place, New York 11514

MARTIN CLEARWATER & BELL LLP
Attorney for Defendant Francfort, M.D.
90 Merrick Avenue, 6th Floor
East Meadow, New York 11554

PATRICK F. ADAMS, PLLC
Attorney for Defendants McCormack, M.D. & South Bay Cardiovascular
30 Vesey Street, Suite 1200
New York, New York 10007

SHAUB, AHMUTY, CITRIN & SPRATT, LLP
Attorney for Defendants Southside Hospital & North Shore-LI Jewish
1983 Marcus Avenue
Lake Success, New York 11042

RST

Upon the following papers numbered 1 to 85 read on these motions for summary judgment and to preclude; Notice of Motion/ Order to Show Cause and supporting papers (007) 1-17; (008) 18-32; (009) 33-47; (010) 48-56; Notice of Cross Motion and supporting papers (012) 57-67; Answering Affidavits and supporting papers 68-72; 73-74; 75-76; 77-78; Replying Affidavits and supporting papers 79-81; 82-83; 84-85; Other ; (~~and after hearing counsel in support and opposed to the motion~~) it is,

ORDERED that motion (007) by defendants, Southside Hospital and North Shore-Long Island Jewish Health System, pursuant to CPLR 3212 for summary judgment dismissing the complaint and any cross claims asserted against them is denied; and it is further

ORDERED that motion (008) by defendants, John Muratori, M.D. and Ross, Maccone & Muratori, MDS, pursuant to CPLR 3212 for summary judgment dismissing the complaint and any cross claims asserted against them is denied; and it is further

ORDERED that motion (009) by defendant, John W. Francfort, M.D., pursuant to CPLR 3212 for summary judgment dismissing the complaint as asserted against him, is denied; and it is further

ORDERED that motion (010) by defendant, Robert M. Jaeger, M.D., for an order granting leave to serve a late motion for summary judgment, and pursuant to CPLR 3212, for summary judgment, is granted and the complaint and any cross claims asserted against him are dismissed; and it is further

ORDERED that cross motion (012) by plaintiff to preclude defendants from asserting the benefits conferred by Article 16 and 14 as to any co-defendant to whom summary judgment has been granted, is granted.

In this medical malpractice action, causes of action premised upon the alleged negligent departures from the good and accepted standards of care during the defendants' care and treatment of the plaintiff's decedent, James MacLaren; wrongful death of the decedent; lack of informed consent; and a derivative claim on behalf of decedent's wife, Edith MacLaren, have been asserted. It is asserted that on March 27, 2007, the decedent was seen and treated by the defendant Stanley Blyskal, M.D. He was taken by ambulance and admitted to Southside Hospital on March 28, 2007 for gastrointestinal bleeding. Surgery, consisting of a right hemicolectomy, was performed by defendant Dr. John Francfort on March 28, 2007, after which time, the decedent developed signs and symptoms of shock, alleged by plaintiff to have been caused by internal bleeding and/or sepsis that went undiagnosed and untreated, resulting in the death of James MacLaren on April 3, 2007. It is alleged that the defendants failed to heed the readily apparent signs and symptoms of shock following surgery, failed to timely and appropriately interpret decedent's laboratory values and abnormal findings on a CT scan, and failed to timely and appropriately diagnose and treat the decedent, causing him pain and suffering, resulting in his death.

The proponent of a summary judgment motion must make a prima facie showing of entitlement to judgment as a matter of law, tendering sufficient evidence to eliminate any material issues of fact from the case. To grant summary judgment it must clearly appear that no material and triable issue of fact is presented (***Friends of Animals v Associated Fur Mfrs.,***). The movant has the initial burden of proving entitlement to summary judgment (***Winegrad v N.Y.U. Medical Center***, 64 NY2d 851, 487 NYS2d 316 [1985]). Failure to make such a showing requires denial of the motion, regardless of the sufficiency of the opposing papers (***Winegrad v N.Y.U. Medical Center***, *supra*). Once such proof has been offered, the burden then shifts to the opposing party, who, in order to defeat the motion for summary judgment, must proffer evidence in admissible form...and must "show facts sufficient to require a trial of any issue of fact" (CPLR 3212[b]; ***Zuckerman v City of New York***, 49 NY2d 557, 427 NYS2d 595 [1980]). The opposing party must present facts sufficient to require a trial of any issue of fact by producing evidentiary proof in admissible form (***Joseph P. Day Realty***

Corp. v Aeroxon Prods., 148 AD2d 499, 538 NYS2d 843 [2d Dept 1979]) and must assemble, lay bare and reveal his proof in order to establish that the matters set forth in his pleadings are real and capable of being established (***Castro v Liberty Bus Co.***, 79 AD2d 1014, 435 NYS2d 340 [2d Dept 1981]).

Transcripts of examination before trial which are neither signed nor certified, and unaccompanied by proof of service pursuant to CPLR 3116 are inadmissible (*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]). Unsigned but certified transcripts of the examination before trial submitted by the moving party are considered as being adopted as accurate by the moving defendant (*see* ***Zalot v Zieba***, 81 AD3d 935, 917 NYS2d 285 [2d Dept 2011]). Unsigned but certified transcripts of the examinations of the parties may be considered where there is no objection (*see* ***Zalot v Zieba***, 81 AD3d 935, 917 NYS2d 285 [2d Dept 2011]).

In support of motion (007), defendants Southside Hospital and North Shore-Long Island Jewish Health System submitted, inter alia, an attorney's affirmation; a copy of the summons and complaint, answers served by defendants McCormack, South Bay Cardiovascular Associates, Francfort, Great South Surgical Associates and Vascular Lab, Muratori, Maccone & Muratori, Blyskal, Jaeger, and Stambler, plaintiff's verified bill of particulars as to Southside Hospital, North Shore-Long Island Jewish Health System, Blyskal, Jaeger, Stambler, Francfort, McCormick, McCormack, Great South Bay Surgical Associates and Vascular Lab, Muratori, Ross Maccone & Muratori, South Bay Cardiovascular, amended verified bill of particulars as to Southside Hospital, North Shore Long Island Jewish Health System, McCormack, and South Bay Cardiovascular Associates, supplemental bill of particulars as to Blyskal, Jaeger, Scrambler, Francfort, McCormack, McCormick, Great South Bay Surgical Associates and Vascular Lab, Muratori, Ross Maccone & Muratori, South Bay Cardiovascular Associates, Southside Hospital and North Shore-Long Island Jewish Health System; unsigned but certified transcripts of Edith McLaren, Stanley Blyskal, Jay Stambler, M.D., Ellen McCormick, M.D.; certified copy of the Southside Hospital record; uncertified record of Stanley Blyskal, M.D., affirmations of Gregory Mazarin, M.D. and Milton L. Levine, M.D.

Motion (008), by John Muratori, M.D., and Ross Maccone & Muratori, M.D.s, is supported with, inter alia, an attorney's affirmation; expert affirmation of Robert Fuentes, M.D.; summons and complaint, answers served by John Muratori, M.D., Ross Maccone & Muratori, and Great South Surgical Associates and Vascular Lab, Ellen C. McCormick, Jay Stambler, Stanley Blyskal, Robert Jaeger, Southside Hospital, North Shore-Long Island Jewish Health System, South Bay Cardiovascular Associates, Janice McCormack, John W. Francfort, plaintiff's bill of particulars and supplemental bills of particulars; certified records from Southside Hospital; unsigned and uncertified transcripts of the examinations before trial of Stanley Blyskal and Jay Stambler; and the unsigned but certified transcript of the examination before trial of Edith MacLaren.

Motion (009), by John Francfort, M.D., is supported with, inter alia, an attorney's affirmation; affidavit of John Francfort, M.D., affirmation of Henry S. Partridge, M.D.; copies of the summons and complaint, his answer, plaintiff's verified bill of particulars; certified copy of the Southside Hospital record; unsigned but certified transcripts of the examinations before trial of Edith MacLaren, Stanley Blyskal and Ellen McCormick; and the signed and certified copy of the transcript of the examination before trial of Jay Stambler.

Motion (010) by Robert Jaeger, M.D. is supported with, inter alia, an attorney's affirmation; the affidavit of Robert Jaeger; copies of the summons and complaint, his answer, and plaintiff's verified bill of particulars; and an uncertified copy of the Southside Hospital record.

Motion (012) by Edith MacLaren is supported with, inter alia, an attorney's affirmation; a redacted copy of plaintiff's expert affirmation[1]; certain laboratory reports; patient critical care flow sheets, assessments, and CT report of May 31, 2007.

Edith MacLaren testified to the extent that James MacLaren was her husband. His primary physician for about fifteen years was Dr. Stanley Blyskal, his urologist was Dr. Breccia, his dermatologist was Dr. Basu, his surgeons were Dr. Simon and Dr. Romanelli, and ENT was Dr. Sullivan. At some point, Dr. Blyskal had referred her husband to Dr. Stambler who performed a colonoscopy at Southside Hospital "for a sac" which broke, and hemorrhoids. Then, on March 27, 2007, in the morning, her husband experienced rectal bleeding and an appointment was scheduled with Dr. Blyskal at about 5:20-5:40 p.m. He had two more episodes of rectal bleeding that morning, so she contacted Dr. Blyskal's office to see if her husband could be seen sooner, however, Dr. Blyskal told her she could take her husband to the emergency room. She then took him to the emergency room at Southside Hospital at about 11:30 a.m. or 12:00 noon. By 3:00 p.m., he had not been seen by a physician at the emergency room, only the triage nurse, so he left the hospital to keep his appointment with Dr. Blyskal. He was seen by Dr. Blyskal who recommended that her husband see Dr. Stambler for a colonoscopy, but Dr. Stambler was not available that day. She was upset with Southside Hospital emergency room because he waited a long time, her husband was 76 and bleeding, she had to bring him back and his condition worsened.

Mrs. MacLaren continued that at home that evening, her husband experienced heavy rectal bleeding, so she called the fire department and had him taken by ambulance to Southside Hospital emergency room. He was pale, dizzy, unsteady, and uncomfortable. After he was seen, Dr. Auerbach told him that his "blood was getting dangerously low" so he opted to transfuse her husband. The transfusions were started in the emergency room, and he was them admitted to the hospital. She left the hospital at 5:00 a.m. on March 28, 2007, and when she returned at 11:00 a.m., her husband was in ICU because he began to bleed heavily. Dr. Stambler had seen her husband before she arrived. When she spoke with Dr. Stambler, he advised he was going to perform a colonoscopy, but had a nuclear scan done around 4:00 or 5:00 p.m. Dr. Frankfort was called in and her husband was taken to surgery about 6:00 p.m. Dr. Francfort advised her that he removed a part of the colon and attached the remaining part, and that it would take him approximately three months for her husband to get back to the golf course. Edith MacLaren testified that a nurse suggested that Dr. Muratori see her husband because there weren't many physicians around that week. Her husband began to bleed again and had a CT scan done. He was seen by a renal doctor, and a heart doctor by the name of McCormack, and a surgeon by the name of McCormick who told her that her husband would be ok. She discussed some other events concerning her husband, and then stated that he died about 1:00 or 2:00 a.m. on April 3, 2007.

Dr. Stanley Blyskal testified to the extent that Mr. MacLaren was a patient of his office group whom he would typically see. He described Mr. MacLaren as being a delightful gentleman, easy to care for in that he followed instructions, very pleasant, and a congenial person. Mr. MacLaren had a history of a carotid artery atheroma and a small stroke in 2004, so he placed the decedent on Aspirin 81 mg daily. He also had an episode of diverticulitis. He believed those conditions had minor impact on his life expectancy. He testified that he did not see the decedent during his hospital admission to Southside Hospital on March 27, 2007 until his death on April 3, 2007, as he was not on hospital rounds at the time, but Dr. Stambler was. He and Dr. Stambler are

---

[1]An unredacted copy of plaintiff's expert affirmation has been provided to this court and returned to counsel for plaintiff (***Marano v Mercy Hospital,*** 241 AD2d 48, 670 NYS2d 570 [2d Dept 1998]). The Court has conducted an in-camera inspection of the original unredacted affirmation and finds it to be identical in every way to the redacted affirmation in plaintiff's opposition papers with the exception of the redacted expert's names.

associates who rent space in the same facility, but they are not partners. He stated that Dr. Jaeger had an office in the same facility he did. Both Dr. Jaeger and Dr. Stambler, as well as Dr. Rigerro and Dr. Ladinsky, would see his patients if he was unavailable, and he would do likewise for their patients. One single office record was maintained for a patient. Billing was done separately. If his patient was admitted to the hospital, and the other physicians were rounding, they may not necessarily communicate with him about the care and treatment of the patient on a daily basis, but would do so on a discretionary basis. At the end of the hospitalization, a copy of the patient's discharge summary is placed in the office record.

Dr. Blyskal testified that during the decedent's admission, no one from the hospital, and none of the covering physicians or any physician who treated the decedent, contacted him. He knew, however, that the decedent had been admitted because Dr. Stambler mentioned to him during the latter part of the decedent's hospitalization that he was admitted and was not doing well. He did not remember any specifics of the conversation, but he testified that he asked Dr. Stambler to keep him advised. They did not discuss treatment, however, he was advised by Dr. Stambler that the decedent was admitted for a bleeding episode overnight, his bleeding recurred, and he required surgery. Dr. Blyskal testified that Dr. Stambler told him after the decedent's death that he presumed the cause of death was sepsis. He noted that the discharge summary indicated that the cause of death was felt to be septic shock. He did not discuss with Dr. Stambler how the decedent developed sepsis in the hospital or why the decedent went into cardiac arrest.

Dr. Blyskal testified that he and his medical assistant saw the decedent in his office on March 27, 2007 for reported diarrhea, bright red blood, and lightheadedness. He had no past medical history for the same. He ordered a stat CBC to assess the degree of bleeding, which test was done in his office. The white count and differential were normal. The hemoglobin was 11.9 and hematocrit was 37.5. Red cell indices were normal and platelets were 131,000. He felt the hemoglobin and platelets were slightly diminished. Aspirin was discontinued and he was prescribed Cipro, an antibiotic due to his past history of diverticulitis. He continued that occasionally, an early infection can trigger bleeding in patients with diverticulosis. He also wanted Mr. MacLaren to see Dr. Stambler, a gastroenterologist, on an urgent visit the following morning.

Dr. Jay Stambler testified to the extent that he is a self-employed physician practicing in the area of internal medicine and gastroenterology. He first saw Mr. MacLaren on September 16, 1998 and performed a colonoscopy on him on September 25, 1998, at which time his impression was diverticulosis (pouching or pockets) scattered in many places of his colon (large intestine), including at the hepatic flexure, and that he had large internal and external hemorrhoids. Treatment of diverticulosis is with a high fiber diet if the patient is asymptomatic. He did not recommend any further colonoscopies, but did recommend rectal examinations or sigmoidoscopies every three to five years. He did not treat the decedent from September 25, 1998 until March 2007. He did not recall Dr. Blyskal contacting him on March 27, 2007 to see the decedent.

Dr. Stambler testified that he was not an employee of Southside Hospital. He was called in to see the decedent on a gastroenterology consult, and not because he was on rounds for the group. He then testified that in essence, he was called in to offer his opinion as a gastroenterologist, but at the same time, admitted him, or at least began the process as an internist as well. He saw the decedent on March 28, 2007 between 6:45 and 8:45 a.m. Upon obtaining a history and doing a physical exam, he learned that the decedent had 24 hours of painless rectal bleeding. Bowel sounds were positive. He reviewed the laboratory tests and EKG. His impression was likely that the decedent had a lower GI bleed secondary to diverticulosis, but in view of ASA (aspirin) daily and dark stool initially, he could not exclude upper source (ulcer). He felt that an endoscopy and colonoscopy were necessary and that he would do them the following day unless urgent endoscopy was needed for major active bleeding. He wanted to wait until the next day because, with a very recent bleed, there can be a period of time

when the blood count may continue to decline and an additional transfusion may be needed. Waiting also assists in making a more accurate diagnosis during the colonoscopy as an adequate bowel preparation can be done. No CT scan had been done. On March 28, 2007, Dr. Stambler ordered the H&H to be done every eight hours and to call him for a hemoglobin below 9 or a hematocrit below 27 %.

Dr. Stambler indicated that he ordered a nuclear bleed study on March 28, 2007 at approximately 1:00-2:00 p.m. to localize active bleeding as the decedent experienced renewed active bleeding associated with temporary hypotension. He was resuscitated and transferred to the ICU. He stated it was clear to him that surgical intervention would be necessary due to severe bleeding, and a colonoscopy no longer feasible. He then testified that the resuscitation took place at 9:00 a.m. and ended at 9:05 or 9:15. The rapid response team had responded. He was there part of the time when he was informed of the problem. After the decedent was resuscitated and before 2:00 p.m., he did not feel a need for surgical intervention because he believed that he should attempt to perform a colonoscopy using a less desirable but possibly helpful preparation of an enema within a couple hours once he was stabilized. However, the decedent continued to have heavy recurrent bleeding and required additional transfusions, so he felt that he was not stable enough for the colonoscopy. Thus, he ordered the bleeding scan as he felt they needed to move more quickly. The bleeding scan was completed at 3:20 p.m. He did not review the scan, but was provided the results and called Dr. Francfort, who came in to see the decedent and performed surgery. That evening, after surgery was completed at 19:55 hours, he spoke with Dr. Francfort.

Dr. Stambler did not see the decedent after the hemicolectomy surgery until March 29, 2007. No active bleeding was noted since surgery. He reviewed the blood work obtained. He testified that it was his intent to see the patient when his services might be necessary and keep abreast of the situation when he was around. While the decedent was a patient in ICU, he was seen by different doctors who performed different functions on different days. He next saw the decedent on March 30, 2007, but did not write a progress note or orders as there was "no real intervention that I needed to do." He recalled going into ICU and speaking with the decedent whom he described as "awake and in good spirits." Dr. Stambler was away on March 31 and April 1, 2007, and stated that he would have had a physician covering for him while he was away, likely Dr. Mitchell Weinstein. He did not believe Dr. Weinstein saw the decedent while he was gone.

Dr. Stambler testified that he saw the decedent on April 2, 2007, and noted that he had poor urine output, no active bleeding, and that he was awake and mildly confused. No bowel sounds were present. He noted there was a cardiology reconsult, a renal consult due to the poor urinary output and for assistance with fluid management, and consult with ID (infectious disease) to determine if the antibiotic the decedent was receiving was appropriate, if something else needed to be ordered, and for an opinion as to what was causing the decedent's fever. He had concerns there could be an infection within the decedent's abdomen which developed postoperatively, or that he had some postoperative occurrence that would lead to fever and some of the other changes he saw. He stated the decedent was seen by Dr. Nash for an infectious disease consult, and by, Dr. Barbato, the nephrologist on renal consult, on April 2, 2007. Dr. Janice McCormack, the cardiologist who saw the decedent preoperatively, saw the decedent that day on consult also. Dr. Stambler testified that fever, poor urine output, confusion, and hypotension are signs of sepsis. He did not have any concern on March 28, 2007, that the decedent was showing clinical signs of sepsis. Although he did not write a note on March 30, 2007, he did not have any concern that the decedent was showing signs of sepsis on that date either. On April 2, 2003, he became aware of the CT scan results from March 31, 2007. He remembered discussing with Dr. Ellen McCormick whether or not the decedent should have a surgical re-exploration, and that she did not feel re-exploration was needed at that time. He provided no further care and treatment for the decedent prior to the

decedent's passing in the early morning of April 3, 2007. He testified that based upon his review of the operative report, his impression was that the bleeding was caused by diverticulosis.

Dr. Stambler stated that he filled out the death certificate on April 3, 2007. Because he was the primary physician, he dictated the discharge summary on May 6, 2007. No autopsy was performed. Dr. Stambler testified that the immediate cause of death, as he saw it, was based on multiple body system failures, cardiac, respiratory, hemodynamic, urine and renal, as a consequence of bacterial septicemia. Generally, he stated, the blood and urine cultures all returned negative. He stated that he has no reason to doubt that the death certificate is correct. Because they did not culture live bacteria in the blood or urine does not exclude the diagnosis that bacterial products or toxins could have been the cause of the multi-organ system failure. Several days after the decedent's death, he met with Mrs. MacLaren and her two daughters in his office. He believed that he possibly gave them his thoughts as to what may have happened. He continued, that understanding that there was no autopsy, everything was speculation.

Ellen McCormick, M.D. testified to the extent that she is licensed to practice medicine and is board certified in general surgery and internal medicine. She is self-employed by her professional corporation, and has no employment relationship with Southside Hospital, North Shore Long Island Jewish Health Care System, or Great South Bay Surgical Associates. She stated that Great South Bay Surgical Associates is a financial account for individual doctors who have their corporate accounts and pay overhead into that account to pay their staff employees. Her P.C. does not have any employees. Her corporation bills the insurance company for patients she sees in the hospital. Dr. McCormick testified that one of her associates, Dr. John Francfort, had performed surgery on Mr. MacLaren on March 28, 2007. He then went on vacation and asked her to make rounds on Mr. MacLaren while he was away. She and Dr. Francfort have been working in the same office for 20+ years and each have their own individual P.C., and cover each other on weekends. Pursuant to the call schedule made up for all the doctors in the call group, consisting of doctors from her group (Gallagher, Francfort, Simon, Timmins, and herself) and three other doctors (Turoff, Finkelstein, and Doghany), she was responsible for making rounds at Southside Hospital on March 31, and April 1, 2007. If she was the covering on call physician and saw a patient on consult on the weekend, that would be her patient whom she would follow until hospitalization was complete. Because Dr. Francfort had not returned from vacation, she saw the decedent on April 2, 2007.

Dr. McCormick testified that she saw the decedent on March 31, 2007, at about before 11:00 a.m., and performed an examination targeting his lungs, heart, abdomen and wound. He had no fever, his abdomen was distended, he was afebrile, he had hypoactive bowel sounds, and his hemaglobin and hematocrit were stable for 24 hours. She discontinued the order to check his hemoglobin and hematocrit every six hours. She transferred him out of ICU as his condition was stable based upon his overall evaluation, vital signs, blood work, and physical condition. She later saw the decedent for a second time that day because the decedent passed bright red blood from his rectum. She did not personally check him for rectal bleeding when she saw him either time. His hemoglobin was 10 and she ordered that he be kept in the ICU. She had no communication with the decedent's medical doctors or the physician's assistants who saw the decedent prior to her visit. From March 31, 2007 through April 1, 2007, Dr. Doghany was on first call for her office. She was on second call, so if Dr. Doghany needed assistance, she would be called.

Dr. McCormick continued that she saw the decedent next on April 1, 2007. The physician's assistant had seen the decedent at 8:00 and 9:00 p.m. on March 31, 2007, and again at 3:00 a.m. on April 1, 2007. The decedent had SVT (supra ventricular tachycardia). A CT scan had been taken earlier, which she reviewed with the radiologist at about 11:00 a.m. on April 1, 2007. There were no anastomotic leaks or abscesses noted,

however, there were abdominal and pelvic ascites, which Dr. McCormick stated was perfectly normal after colon surgery. She continued that ascites could also be seen in patients with cirrhosis of the liver, cancer intra-abdominally, liver failure and heart failure. She saw no indication of his having any sort of pre-existing heart condition or kidney disease, or that he was suffering from heart failure on April 1, 2007. She noted on April 1, 2007, that the decedent had two bloody BMs yesterday, which she suspected was residual from prior GI bleed. She made no determination as to what was causing the SVT the night before, and she did not call for a cardiac consult. She was not aware of any issues of decreased urine output.

Dr. McCormick testified that she saw the decedent on April 2, 2007 between 9:00 and 11:00 a.m. She had been called by the critical care attending about 6:30 a.m. concerning the decedent's sluggish urine output during the night, and that Lasix and a bolus of fluid were given with not much result. He spiked a temperature to 103 (which she corrected was 101) and his blood pressure dropped. The critical care attending then placed a central line, performed cultures, and started antibiotics, Vancomycin and Primaxin. When she saw the decedent, she noted he was agitated, had sinus tachycardia, his abdomen was slightly distended, and he had hypoactive bowel sounds. She noted increased temperature, output, and blood pressure. She stated she ordered renal, infectious disease, and cardiology consults, however, later stated that Dr. Stambler ordered those consults. She noted the pH level of 7.42 to be within normal limits, and stated that he was not suffering from metabolic acidosis. Her impression was to rule out sepsis versus early ARDS (acute respiratory distress syndrome). She could not say that he had sepsis, but she was concerned about it. She did not feel that a repeat CT scan was necessary at that time. She thought the tachycardia could have been due to volume depletion. She did not consider doing an exploratory laparotomy at that point. She had no further contact with the decedent thereafter, no one called her, and she learned that he died when she made rounds the following day.

Dr. McCormick testified that sepsis usually means clinical infection, with fever and chills and an elevated white blood cell count. The ultimate progression of sepsis is to septic shock which causes the patient to become hemodynamically unstable, there is multi-organ failure where the liver, kidneys, and brain shuts down. Dr. McCormick stated that if a patient has decreased urine output, it would not be an indication as to whether or not there is a progression to multi-organ system failure. She stated that mottled skin is subjective and generally implies vasoconstriction of the blood vessels. She stated that confusion is not necessarily a sign and symptom of septic shock. She continued that shock by definition is that the patient has decreased blood pressure and can progress to multi-system failure. With septic shock, she stated, she would assume that the patient has a fever, either very elevated or very low white count, and that is it.

The requisite elements of proof in a medical malpractice action are (1) a deviation or departure from accepted practice, and (2) evidence that such departure was a proximate cause of injury or damage (***Holton v Sprain Brook Manor Nursing Home***, 253 AD2d 852, 678 NYS2d 503[2d Dept 1998], *app denied* 92 NY2d 818, 685 NYS2d 420). To prove a prima facie case of medical malpractice, a plaintiff must establish that defendant's negligence was a substantial factor in producing the alleged injury (*see* ***Derdiarian v Felix Contracting Corp.***, 51 NY2d 308, 434 NYS2d 166 [1980]; ***Prete v Rafla-Demetrious***, 221 AD2d 674, 638 NYS2d 700 [2d Dept 1996]). Except as to matters within the ordinary experience and knowledge of laymen, expert medical opinion is necessary to prove a deviation or departure from accepted standards of medical care and that such departure was a proximate cause of the plaintiff's injury (*see* ***Fiore v Galang***, 64 NY2d 999, 489 NYS2d 47 [1985]; ***Lyons v McCauley***, 252 AD2d 516, 517, 675 NYS2d 375 [2d Dept 1998], *app denied* 92 NY2d 814, 681 NYS2d 475; ***Bloom v City of New York***, 202 AD2d 465, 465, 609 NYS2d 45 [2d Dept 1994]).

"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" (***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, 812-813, 690 NYS2d 762 [3d Dept 1999]).

MOTION (007)

In motion (007), defendants Southside Hospital and North Shore-Long Island Jewish Health System seek summary judgment dismissing the complaint as asserted against them on the bases that the employees and staff at Southside Hospital did not depart from the applicable standards of care and did not cause, contribute to, or exacerbate decedent's claimed injuries, and that the staff and employees followed the orders of the decedent's private attending physicians.

Southside Hospital and North Shore-Long Island Jewish Health System (hospital defendants) submit the affirmations of Gregory Mazarin, M.D. and Milton L. Levine, M.D. in support of their motion for summary judgment. Dr. Mazarin set forth that he is licensed in New York and is board certified in emergency medicine. He set forth his education and training and work experience, as well as the records and materials which he reviewed concerning the care and treatment rendered by the hospital defendants to the plaintiff's decedent. He opined within a reasonable degree of medical certainty, that, in accordance with the appropriate standards of care from March 2007, through and including April 2007, Southside Hospital acted appropriately during the decedent's presentation at Southside emergency room as he was timely and properly triaged, and the hospital staff appropriately accepted the decedent's choice to see his primary care physician and leave. He continued that the hospital defendants acted in accordance with the standards of care during the decedent's admission to the hospital and did not proximately cause, contribute, or exacerbate the decedent's injuries or cause his death.

Dr. Mazarin stated that Dr. Stambler performed a colonoscopy on the decedent, on September 25, 1998 relating to rectal bleeding. On March 27, 2007, the decedent called Dr. Blyskal for an appointment, then went to Southside Hospital emergency department for complaints of rectal bleeding, diarrhea, and lightheadedness. He kept his appointment with Dr. Blyskal after waiting in the emergency room at Southside Hospital without being seen. Dr. Blyskal prescribed antibiotics to treat the possibility of early diverticulitis, and directed him to the emergency room should he have further bleeding. Dr. Mazarin stated that Dr. Stambler was involved in the decedent's care and treatment by admitting him, or at least beginning the process as an internist. Dr. Mazarin set forth a brief outline concerning the decedent's admission at Southside Hospital.

Dr. Mazarin stated that in March and April, 2007, Southside Hospital, within the standard of care, appropriately evaluated, monitored, documented, and communicated the decedent's condition to all individuals involved in his care during his admission. It was Dr. Stambler, as the decedent's private attending physician, who managed the decedent's care, ordered consults, and dictated decedent's treatment plan, including examinations, medications, procedures, and diagnostic studies. Dr. Mazarin stated that the role of Southside Hospital was limited to executing the orders of Dr. Stambler, which Southside did in accordance with the applicable standards of care as existed in March and April 2007. Dr. Mazarin stated that the hospital followed all directives and orders given by Dr. Stambler. All medications were timely and properly administered and documented, and communicated to the attending physician. All diagnostic tests were timely and properly performed, appropriately documented, and communicated to the attending physician. All consults were timely and properly performed, appropriately documented, and communicated. All significant changes in the decedent's complaints, signs, and symptoms, progress and treatment were appropriately documented and communicated to his attending physician.

Dr. Mazarin stated that he specifically disagreed with all of the allegations contained in the bills of particulars, including, but not limited to, the allegations that Southside Hospital was negligent in failing to exercise authority over individuals who treated decedent, failing to inform the attending physicians of the decedent's decreased urine output, hypotension, tachycardia and dehydration; failing to exercise authority over individuals who treated decedent; failing to instruct personnel regarding proper documentation; and failing to have properly trained nursing staff, ancillary staff, house staff, interns, medical residents, and personnel. Dr. Mazarin added that Dr. Stambler advised Mrs. MacLaren of her husband's condition and plan of treatment throughout his admission to the hospital, that she understood that Dr. Stambler arranged for Dr. Francfort to perform the exploratory laparotomy, and she consented to the surgery.

It is determined that Dr. Mazarin's affirmation is conclusory and lacks specifics to comport with his broad and general opinions. He does not set forth any of the standards of care which he affirms were complied with.

The hospital defendants also submitted the affirmation of Milton L. Levine, M.D. who affirmed that he is licensed to practice medicine in New York State and is board certified in internal medicine and gastroenterology. He did not set forth his current or past employment status. He set forth some of the materials and records reviewed, but did not include everything he reviewed. It is noted that except for paragraph one, and the number of years each expert practiced medicine, as set forth in paragraph 30, the affirmations submitted by Dr. Mazarin and Dr. Levine are identical in every way. Rather than repeat the identical opinions set forth by Dr. Levine, as they are set forth above with regard to Dr. Mazarin's affirmation, it is likewise determined that Dr. Levine's affirmation is conclusory and lacks specifics to comport with his broad and general opinions. He also does not set forth any of the standards of care which he affirms were complied with.

Based upon the foregoing, it is determined that defendants Southside Hospital and North Shore-Long Island Jewish Health System have not established prima facie entitlement to summary judgment dismissing the complaint asserted against them.

MOTION (008)

In motion (008), John Muratori, M.D. and Ross, Maccone & Muratori, MDS seek summary judgment dismissing the complaint on the basis that they did not depart from accepted practice of medical care and treatment, and none of their acts and/or omissions were a substantial factor in causing plaintiff's decedent's claimed injuries and death. They have submitted the expert affirmation of Robert Fuentes, M.D., a physician licensed to practice medicine in New York State who is board certified in internal medicine. He is currently a primary care physician in a multi-specialty internal medicine group. He did not set forth the materials and records which he reviewed. He set forth his opinions within a reasonable degree of medical certainty. It is Dr. Fuentes' opinion that the allegations against Dr. Muratori are without merit as he did not depart from the accepted standards of medical care and treatment, and none of his acts or omissions were a substantial factor in causing the decedent's injuries and death.

Dr. Fuentes set forth that it is claimed that the decedent suffered cardiac respiratory arrest, renal failure, paralytic ileus, chest pain, weakness, pain, tachycardia, sepsis, hypocalcemia, hemorrhage of the colon, vertigo, and death. Dr. Fuentes stated that Dr. Muratori saw the decedent on March 31 and April 1, 2007. He recited Dr. Muratori's notes entered into the decedent's hospital records. On March 31, 2007, Dr. Muratori noted, inter alia, that the decedent was doing "ok," with some abdominal pain and bright red rectal bleeding, and that he had decreased bowel sounds and anemia. The current treatment was to be continued. His note of April 1, 2007,

indicated, inter alia, that the decedent's CT scan of the abdomen/pelvis was positive for mild to moderate ascites and mild dilation of the small bowel. He ordered a "low dose of Lopressor and cardiac evaluation." Anemia was noted. Dr. Muratori ordered that the current treatment be continued.

Dr. Fuentes stated that Dr. Muratori ordered Lopressor to be administered intravenously, however, he does not set forth the indication for the same to be administered, what the decedent's blood pressure was, or parameters for its use. Dr. Fuentes continued that the two days that Dr. Muratori saw the decedent, he was being followed by surgery, cardiology, gastroenterology, pulmonology, nephrology, and infectious disease. Upon his review of the bill of particulars and the hospital chart, with attention to Dr. Muratori's notes, it is Dr. Fuentes' opinion within a reasonable degree of medical certainty that Dr. Muratori's care and treatment was within good and accepted medical practices.

It is determined that Dr. Fuentes' affirmation is conclusory and vague. He does not set forth the standard of care for those conditions, signs, and symptoms noted by Dr. Muratori, and he does not correlate the care and treatment based upon the decedent's clinical presentation. He does not indicate the basis for starting the decedent on Lopressor. He does not opine that any further workup, follow up, or evaluation was not required.

Based upon the foregoing, it is determined that Dr. Muratori, and Ross Maccone & Muratori, MDS have not established prima facie entitlement to summary judgment dismissing the complaint.

MOTION (009)

In Motion (009), defendant John W. Francfort, M.D. seeks summary judgment dismissing the complaint on the bases that the care and treatment he provided to the decedent at all times comported with good and accepted standards of care, and that he did not depart from the standard of care, or cause the decedent's alleged injuries or death.

Dr. Francfort set forth in his affidavit that he is licensed to practice medicine in New York State and is board certified in surgery and vascular surgery. He set forth that he reviewed the Southside Hospital medical record of James MacLaren from March 28, 2007, and the Great South Bay Surgical Associates' records. He indicated that Mr. MacLaren was seventy-six years of age and was taking aspirin. He came to the emergency department because of black and bloody stools. He presented earlier to the emergency department, but left to see Dr. Blyskal, his primary care physician. Dr. Blyskal performed a laboratory study which revealed that the decedent's hemoglobin was 11.9, and the normal level is between 14.0 and 18.0 g/dL. Thereafter, the decedent had 4 more bloody bowel movements, developed weakness and dizziness and was taken by ambulance back to Southside Hospital emergency room. Dr. Frankfort set forth the decedent's clinical presentation, and the admitting impression of acute gastrointestinal bleed, and indicated that two units of packed red blood cells were administered.

Dr. Francfort continued that Dr. Stambler performed a gastrology consult and planned an endoscopy and colonoscopy the following day. However, about 9:00 a.m. on March 28, 2007, the decedent began oozing blood from his rectum, became diaphoretic and lightheaded. He was noted to be clammy and cold, and passed out. The rapid response team addressed this situation. It was determined that the decedent had an acute gastrointestinal bleed and was hypotensive due to gastrointestinal blood loss. Dr. Francfort stated that it takes a loss of approximately 40% of a person's overall blood volume for a patient to evidence hypotension, or a systolic blood pressure below 90 mmHg. He set forth the decedent's care and treatment. Dr. Francfort stated that he spoke with Dr. Stambler who maintained his plan to perform an endoscopy/colonoscopy that day, if

indicated. He continued that thereafter, the internal medicine physician, who was not identified by Dr. Francfort, documented that the decedent still had profuse gastrointestinal bleeding and ordered the transfusion of two more units of packed red blood cells and two units of fresh frozen plasma. However, the patient remained hypotensive and Neo-Synephrine was ordered intravenously to increase his blood pressure. Dr. Francfort continued that at some point, Dr. Stambler ordered a stat nuclear gastrointestinal bleeding scan study which indicated active bleeding at the hepatic flexure of the right colon. There was more rectal bleeding, and more blood and frozen plasma were administered.

Dr. Francfort continued that he first saw the decedent at approximately 5:00 p.m. on March 28, 2007 on surgical consultation, after Dr. Stambler called him and they spoke about the patient who had hemorrhagic shock and lower gastrointestinal bleeding from the right colon. He anticipated that surgical intervention would be needed, and made preparations for the same, including ordering more blood. He indicated that he spoke with the decedent and his wife and daughter about the risks, benefits and alternatives associated with the procedure and noted this in his consultation. He set forth that which he would have told them. Upon performing a right hemicolectomy, he noted the presence of diverticulosis of the hepatic flexure of the right colon, and performed an anastomosis. He irrigated copiously to reduce the risk of infection and found no evidence of leakage or bleeding.

Dr. Francfort stated that postoperative, the decedent was hemodynamically stable. About 11:45 p.m., he spoke with one of the nurses caring for the decedent. He then saw him on March 29, 2007, and noted his observations. His hemoglobin was 10, but this was anticipated as with massive blood loss, it takes two to three days following the administration of large volumes of crystalloid fluids and blood transfusion products for the hemoglobin to equilibrate. He described the decedent's condition on March 30, 2007, and advised the family and decedent he was going on vacation. At that time, there was no evidence of signs of intestinal leakage or peritonitis, an inflammation of the peritoneum which can occur due to infection or sepsis in the abdomen, which would be evidenced by fever, severe abdominal pain, and leukocytosis. It was pre-arranged for Ellen McCormick to assume further surgical care of the decedent, whom he did not see or treat thereafter. Dr. Francfort added that the did not supervise any of the medical providers at Southside Hospital who rendered treatment to the decedent.

Dr. Francfort also submitted the affirmation of his expert, Henry S. Partridge, M.D., a physician licensed to practice medicine in New York State who is board certified in surgery. Dr. Partridge set forth the materials and records he reviewed. He set forth his opinions within a reasonable degree of medical certainty. It is Dr. Partridge's opinion that at all times, Dr. Francfort comported with good and accepted standards of surgical care, and that the medical care and treatment provided by him was not, and could not be a proximate cause of the injuries alleged to have been sustained by the decedent.

Dr. Partridge set forth the decedent's course during his admission at Southside Hospital, and Dr. Frankfort's care and treatment. He also reviewed Dr. Frankfort's affidavit submitted in support of his application. He reviewed Dr. Frankfort's surgery and findings, and care and treatment rendered to the decedent postoperatively. He set forth that the decedent began to experience rectal bleeding on March 31, 2007 at about 12:30 a.m. He was seen in the morning by Dr. McCormick who described the decedent as hemodynamically stable. Dr. Partridge stated that following abdominal surgery, it can take 48 to 72 hours before there is normal function of the bowel. He continued that the presence of some form of rectal bleeding following a colectomy for a massive bleed is not uncommon as any blood which remained in the colon distal to the resected area would be expelled from the rectum once bowel function returned. A CT scan ordered by P.A. Shannon revealed

ascites in the abdominal and pelvic areas and the possibility of partial or early bowel obstruction, with no evidence of leakage.

Dr. Partridge continued that on April 1, at about 3:00 a.m., the decedent's heart rate became unstable and irregular. A bowel movement was free of blood. On April 2, 2007, the decedent was becoming confused, his heart rate and blood pressure were unstable, and urine output decreased. P.A. Shanty noted the etiology of the hypotension was volume depletion and possibly sepsis with fever. Fluid resuscitation, pan cultures, and medications were ordered. Dr. McCormick saw the decedent on April 2, 2007, and noted the impression of sepsis versus early acute respiratory distress syndrome, without evidence of active bleeding. At 9:30 p.m., the decedent, as noted by the critical care P.A., exhibited septic shock, acute renal failure most likely caused by sepsis, and tachypnea most likely caused by metabolic acidosis. The decedent went into cardiac arrest about 3:07 a.m. on April 3, 2007, and expired at 3:38 a.m.

It is Dr. Partridge's opinion that, based upon the decedent's signs and symptoms upon presentation to Southside Hospital and the findings demonstrated in the gastrointestinal nuclear bleeding scan, that Mr. MacLaren was suffering from catastrophic gastrointestinal bleeding for which emergent life saving efforts were necessary. He stated that Dr. Francfort properly obtained consent from the patient prior to surgery and timely brought the patient to the operating room for a life saving right hemicolectomy. He further opined that Dr. Francfort used proper technique in exploring the decedent's abdomen, isolating and removing the bleeding area, and creating an anastomosis. Dr. Partridge opined that Dr. Francfort's postoperative care of the patient, including monitoring of his laboratory values, and ordering of testing and treatments all comported with good and accepted standards of surgical care.

Dr. Partridge continued that when Dr. Francfort last saw the decedent on March 30, 2007, he was afebrile, hemodynamically stable, conversant, free of severe distress, and free of any signs or symptoms of leakage, peritonitis, or sepsis. He also had a heart rate which was stable, his urine output was normal, and he did not exhibit signs of lactic acidosis, acute renal failure, paralytic ileus, hypovolemia, or dehydration. When Dr. Francfort transferred surgical care of the decedent to Dr. McCormick, a board certified surgeon, he had no further duty to render care or treatment to him, and did not, and could not have proximately caused the decedent's alleged injuries.

Based upon the foregoing, it is determined that Dr. Francfort has established prima facie entitlement to summary judgment dismissing the complaint as asserted against him.

In order to rebut a prima facie showing of entitlement to an order granting summary judgment, the opposing party in a medical malpractice action 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]). "Summary judgment is not appropriate in a medical malpractice action where the parties adduce conflicting medical expert opinions. Such credibility issues can only be resolved by a jury" (***Bengston v Wang,*** 41 AD3d 625, 839 NYS2d 159 [2d Dept 2007]).

Plaintiff submitted the redacted expert affirmation of a physician licensed to practice medicine who is board certified in surgery with extensive experience in performing hemicolectomy procedures and following patients post-operatively, in opposition to the motions for summary judgment submitted by defendants John W.

Francfort, M.D.; John Muratori, M.D.; Ross, Maccone & Muratori, MDS; Southside Hospital and North Shore Long Island Jewish Health System. Plaintiff's expert set forth the materials and records he reviewed, and offered his opinions within a reasonable degree of medical certainty. Plaintiff's surgical expert stated that the defendants have not set forth the standard of care that existed under the circumstances for the decedent, nor have they set forth the basis for their respective positions that they did not depart from the standard of care and did not proximately cause the injuries sustained by the decedent. He continued that the decedent exhibited signs and symptoms that required each of the moving parties to act, and that the failure of these providers to appropriately act were departures, which substantially contributed to the decedent's injuries.

Plaintiff's surgical expert noted that Dr. Stambler signed the decedent's death certificate, attesting that the cause of the decedent's death was "multi-organ failure due to bacterial septicemia," septic shock. Plaintiff's surgical expert set forth that the decedent demonstrated signs and symptoms of developing shock which were not timely and properly recognized, diagnosed, and/or treated. Each of the moving defendants, he continued, failed to act according to the standards of care in light of these findings, and these failures were departures from the standards of accepted care as they existed in 2007 for a patient such as the decedent. He continued that these departures were each substantial contributing factors in the decedent going on to suffer untreated shock, ultimately leading to his death. Had the defendants acted according to the standards of care, performed timely investigations in the diagnosis of shock, both hemorrhagic and septic, and identified the cause and provided appropriate treatment, the decedent would not have gone on to suffer death in the manner in which he did.

The plaintiff's expert stated that shock is a life threatening condition that occurs when the body is not getting enough blood flow, which can damage multiple organs and requires immediate treatment. The plaintiff's surgical expert defined the different types of shock, hypovolemic and septic, and further defined the four stages of shock, with typical signs of low blood pressure, rapid heart beat, and signs of poor end-organ perfusion or "decompensation/peripheral shut down" such as low urine output, confusion, or loss of consciousness. Hypovolemic shock is a result of inadequate blood volume from hemorrhage or loss of fluid from the circulation. Septic shock is caused by systemic infection resulting in vasodilation leading to hypotension or low blood pressure.

The plaintiff's expert described a right hemicolectomy as a surgical procedure in which the right side of the colon is removed, usually due to damage or disease, and the remaining portion of the colon is attached to the small intestines. The communication of the two portions, not previously attached, is an anastomosis. There can be an anastomotic leak which can lead to infection (sepsis) and potential internal bleeding. Thus, the standard of care in 2007 required than any physician or health care provider treating a patient during the post-operative period must be aware of the potential complications and take immediate action in the face of signs and symptoms representing such complications, and the failure to do so is a departure from the accepted standard of care. The plaintiff's surgical expert stated that the risk for these conditions occurring post-operatively is unquestionably increased in a patient who has the procedure as a result of diverticulitis or gastrointestinal bleeding, such as the decedent. The failure to timely diagnose and treat either shock, infection, or bleeding, is a substantial contributing factor in the death of a patient.

The plaintiff's surgical expert stated that on March 27, 2007, when the decedent experienced rectal bleeding, he called Dr. Blyskal, his primary care physician, who gave him an appointment for 5:20 p.m., but suggested that he go to the emergency room at Southside Hospital, which the decedent did. However, after waiting for four hours in the emergency room without being seen, the decedent went to his 5:20 p.m. appointment with Dr. Blyskal, who took blood tests and referred the decedent to Dr. Jay Stambler for a colonoscopy, which was not scheduled. That evening, the decedent experienced heavy rectal bleeding and

lightheadedness, and was taken by ambulance to the emergency department at Southside Hospital where he presented with significant low blood pressure. His hemoglobin was 10.2 and hematocrit 31.1. IV crystalloid fluid infusion was given, as was 2 units of packed red blood cells. Dr. Stambler performed a gastroenterology consultation between 6:45 and 8:45 a.m. on March 28, 2007, and recommended an endoscopy and colonoscopy for the following day. However, at about 9 a.m. on March 28, 2007, the decedent began to ooze large amounts of blood from his rectum, and he became diaphoretic and lightheaded, with his blood pressure dropping to 72/54. He was transfused another 2 units of packed red blood cells and transferred to the ICU. At 2:00 p.m., Dr. Stambler ordered an emergency gastrointestinal nuclear bleeding scan which revealed abnormal findings consistent with active gastrointestinal bleeding. At 5:00 p.m., Dr. Francfort saw the decedent for surgical consultation, and at 6:00 p.m., performed surgery wherein he removed the area of the right colon that was bleeding, and performed a side to side stapled anastomosis. He was transferred to PACU where he was administered an antibiotic, among other things. He was noted to be agitated, and had a rapid heart beat. Restraints were applied to his wrists. Arterial blood gases could not be obtained, so the physician's assistant obtained the same, revealing metabolic acidosis.

The plaintiff's expert continued to set forth the plaintiff's signs and symptoms, medications, and laboratory test results. By March 30, 2007, the plaintiff's hemoglobin had dropped to 6.7 and hematocrit to 19.7, which he described as significantly low and consistent with bleeding. The platelet count was low at 77. Dr. Francfort ordered transfusion of three units of packed red cells. By 8:00 a.m., the decedent had edema (swelling) of his feet. His abdominal wound was oozing serious drainage and his abdomen was softly distended with no bowel sounds and no flatus. Dr. Iroke examined the plaintiff and determined that the anemia was secondary to blood loss, and thrombocytopenia most probably secondary to blood loss/use, gastrointestinal bleed, and status post colectomy. He considered a hematology consult in view of the need for massive transfusions, but the consult was never performed. By March 31, 2007, the critical care/ICU note documented the decedent had diminished pedal pulses and a distended abdomen. His hemoglobin and hematocrit were 9.3 and 27.7, platelets 63, and red blood cells 3.10, were continually low and evidence of bleeding. Dr. Ellen McCormick noted the decedent's abdomen was distended with hypoactive bowel sounds. The nursing note at 12:30 p.m. indicated the decedent passed bright red blood from his rectum. Dr. Muratori wrote a medical attending note which documented that the decedent still had abdominal pain, bright red blood from the rectum, and decreased bowels sounds. At 7:45 p.m., P.A. Shannon was notified when the decedent passed a bright red bloody stool. An abdominal CT with contrast was conducted, revealing, inter alia, that the gall bladder was fluid filled, there was a small amount of abdominal ascites, mild dilation of the small bowel loops possibly due to an ileus or partial or early small bowel obstruction. The decedent was restless, and blood tests revealed abnormal values.

On April 1, 2007, at 3:00 a.m., a physician's assistant noted that the decedent's heart rate was in the 140s, unstable and irregular, for which treatment was administered. When Dr. McCormick saw the decedent later that day and noted that he had two more bloody stools, her impression was that the bloody stools were residual from the prior gastrointestinal bleed, so she continued the current treatment. Dr. Muratori saw the decedent and noted decreased bowel sounds. Dilaudid was given for abdominal pain. The decedent's urine output was decreasing so Lasix bolus was given. At 7:30 p.m., his abdomen was semi-firm, he had abdominal pain, and his temperature was 101. By 12:00 a.m. on April 2, 2007, he was restless with tachycardia in the 140s, temperature was 101.8, his systolic blood pressure was down to 85, and his respiratory rate increased to 25 with poor respiratory effort. His skin was mottled looking on the trunk and extremities, and he was becoming more confused. Thereafter, the decedent was seen by Dr. Stambler who noted that there was no active bleeding and that he was receiving intravenous antibiotics. There were no bowel sounds and the abdomen was mildly tender. He was started back on food by mouth. Dr. Stambler testified that he discussed surgical re-exploration

of the abdomen with Dr. McCormick, but the surgeon did not feel it was necessary. Dr. McCormick wanted to rule out sepsis versus early Adult Respiratory Distress Syndrome (ARDS).

The plaintiff's expert surgeon continued that by 9:30 p.m. on April 2, 2007, the decedents temperature was 102.2, blood pressure 84/40, heart rate 116, and that he had metabolic acidosis. The critical care physician's assistant's impression was septic shock, so an infectious disease consult was called and it was suggested that surgery follow the patient in the morning. On April 3, 2007, the decedent went into respiratory arrest, then cardiac arrest, and was pronounced dead at 3:28 a.m. The plaintiff's expert continued that an autopsy was not performed, so it is not possible to determine the exact cause of death. However, it is plaintiff's expert surgeon's opinion that shock from a bleed and/or infection was the cause of James MacLaren's death.

SOUTHSIDE HOSPITAL AND NORTH SHORE-LONG ISLAND JEWISH HEALTH SYSTEM

The plaintiff's expert stated that Southside Hospital is clearly responsible for the departures outlined with regard to Dr. Francfort and Dr. Muratori, and each of the physicians who saw the decedent, including Dr. Iroke, Dr. Gallagher, Dr. Wolberg, and Dr. McCormick, who should have acted upon the signs and symptoms presented by the decedent. Those signs and symptoms exhibited by the decedent could have been shock as a result of a significant bleed or significant infection, which the records clearly establish, required immediate action, whether it be calling in consults, or doing the workup themselves. The plaintiff's expert opined that the decedent presented with life-threatening signs and symptoms which these physicians failed to address, departing from the standard of care, substantially contributing to the decedent's injuries and death, and depriving the decedent of a substantial chance of a cure and/or better outcome. These factual issues and conflicting opinions by the defendants' and plaintiff's expert preclude summary judgment.

Although a hospital or other medical facility is liable for the negligence or malpractice of its employees, that rule does not apply when the treatment is provided by an independent physician, as when the physician is retained by the patient himself, unless the hospital knows that the patient is unaware of the dangers and novelty of the medical procedure proposed to be performed (***Birdell Hill v St. Clare's Hospital***, 67 NY2d 72, 499 NYS2d 904 [1986]). Here, there are additional factual issues concerning ostensible agency and Southside Hospital and North Shore-Long Island Jewish Health System with regard to the consulting physicians who were called in to see the decedent but were not retained by the plaintiff (*see* ***Mduba v Benedictine Hosp.***, 52 AD2d 450, 384 NYS2d 527 [3d 1976]).

Based upon the foregoing, even if the hospital defendants had established prima facie entitlement to summary judgment dismissing the complaint, it is determined that the plaintiff's expert has raised factual issues which preclude summary judgment from being granted to them.

Accordingly, motion (007) by Southside Hospital and North Shore-Long Island Jewish Health System is denied.

DR. JOHN FRANCFORT

With regard to Dr. John Francfort, it is the plaintiff's expert surgeon's opinion that Dr. Francfort departed from the standard of care in his post operative management and treatment of the decedent in failing to properly conduct an appropriate differential diagnosis in light of the signs and symptoms presented in a patient who had undergone intra-abdominal surgery. He continued that while Dr. Francfort did not see the decedent after March 30, 2007, when he did see the decedent, the decedent had signs and symptoms which required an

immediate work-up and treatment based upon the entire picture of the patient, with laboratory studies, evaluations by other medical providers, and diagnostic studies. The plaintiff's expert opined that the failure of Dr. Francfort to conduct an appropriate differential which included sepsis, intra-abdominal infection, internal bleeding, and anastomotic leak, and to affirmatively rule each of these conditions in or out, were departures from the standard of care.

The plaintiff's surgical expert continued that, contrary to the statements by Dr. Partridge and Dr. Francfort, the decedent was not clinically stable and had significant findings that required a proper work-up, such as hypotension on March 30, 2007. These findings should have raised a significant question as to whether there was an active bleed. An active bleed should have been affirmatively ruled out. While Dr. Francfort documented a blood pressure of 140/70, the flow sheet notes that his diastolic pressure was 43 at 7:03 a.m., and 48 at 8:00 a.m., accompanied with tachycardia. Although blood transfusions were administered which could increase the blood pressure, the diastolic pressure again dropped to 43 at 6:00 p.m., 7:00 p.m. and 7:51 p.m., however, the underlying cause was not investigated or determined. These findings demonstrate that the decedent was not hemodynamically stable, causing him to continue to deteriorate until his eventual death. Sepsis and/or internal bleeding should have been ruled out and should have been at the top of Dr. Francfort's differential diagnoses. Laboratory values were significant findings and abnormal, despite transfusions, requiring a work-up. Sigmoidoscopy should have been performed to determine if a bleeding source was missed or if there was a re-bleed. Plaintiff's surgical expert continued that Dr. Frankfort relied only on the total white blood cell count to determine that there was no evidence of infection. Laboratory blood test results significantly support a basis for the suspicion of infection as the granulocytes (neutrophils) were elevated and the lymphocytes were low. Had the proper differential diagnosis and diagnostic work up been made, and the signs and symptoms presented appreciated, and the laboratory values properly considered, the decedent would not have died from shock.

Based upon the conflicting opinions of Dr. Francfort, Dr. Francfort's expert, and plaintiff's expert, factual issues have been raised which preclude the granting of summary judgment to Dr. Francfort.

Accordingly, motion (009) by Dr. Francfort for summary judgment dismissing the complaint as asserted against him is denied.

DR. JOHN MURATORI AND ROSS, MACCONE & MURATORI, MDS

The plaintiff's expert stated that Dr. Fuentes, Dr. John Muratori's expert, merely stated that the care and treatment by Dr. Muratori was within good and accepted medical practices, and none of the acts or omissions of Dr. Muratori were a substantial factor in causing the patient's death. He stated that Dr. Fuentes did not mention the standard of care or any of the significant findings in the records, and that contrary to Dr. Fuente's blanket statements, the records reveal the decedent's condition required action by Dr. Muratori.

The plaintiff's expert stated that Dr. Muratori had all the information that Dr. Francfort had, and each of the departures by Dr. Francfort on March 30, 2007, and the consequences thereof, were also committed by Dr. Muratori. He continued that the standard of care required that Dr. Muratori review the course of the patient whom he had begun to treat, and to be aware of the laboratory studies, the findings on physical examination, such as low urinary output, and the blood pressure trending of the decedent. Once aware, he was required to consider the possibility that the decedent was suffering from the onset of shock and consider the possible causes for same, such as bleeding or infection. Dr. Muratori was required to timely and properly recognize that the decedent's blood pressure trending, laboratory values, and clinical picture were possibly being caused by the

onset of shock. An appropriate differential diagnosis should have been made, and should have included shock and an investigation into the potential causes of bleeding and infection should have been conducted. The plaintiff's expert opined that these departures from the accepted standard of care by Dr. Muratori were substantial contributing factors in causing the decedent's injury and death. Had Dr. Muratori timely and properly assessed, worked up and diagnosed the decedent, diagnostic studies, including a sigmoidoscopy, would have been ordered and performed, and the source of the decedent's shock syndrome would have been discovered. Such sources, he stated within a reasonable degree of medical certainty, were active bleeding and infection. The source of the bleeding would have been corrected, and the infection identified and treated with appropriate antibiotics, and the decedent would not have died from shock.

The plaintiff's expert continued that in addition to these departures, Dr. Muratori also departed from accepted standards of care in failing to timely and properly assess, work up, and recognize the causes for the blood pressure spikes, bright red bleeding from the rectum, very concerning oliguria, and abdominal pain on examination. These findings should have led to an immediate internal examination of the decedent. He stated that bright red blood is strongly suggestive of active bleeding and signifies that the bleeding is most typically coming from the colon. This bright red bleeding, along with abnormal laboratory results of low red blood cell count, low platelet, low hemoglobin, and low hematocrit, strongly suggested active bleeding, a potentially life threatening condition which required immediate investigation and intervention. By ordering that current treatment be continued, and by failing to determine the cause of the bleeding by ordering a sigmoidoscopy or other diagnostic studies, Dr. Muratori departed from the standards of care and substantially contributed to the decedent's injuries and death.

The plaintiff's expert continued that Dr. Muratori reviewed the results of the March 31, 2007 CT scan of the abdomen, which revealed, among other things, abdominal and pelvic ascites. Pelvic ascites, stated plaintiff's expert, is a significant finding, particularly in a patient with the clinical picture presented, as it meant that there was fluid in those regions. The fluid was not identified, but with decedent's signs and symptoms consistent with bleeding and/or intra-abdominal infection, it is imperative that the type and source of the fluid be established and corrected. Under the circumstances, bleeding and infection should have been considered, and the standard of care required that Dr. Muratori should have done a work up for the same. The plaintiff's expert stated that it was a departure from the standard of care to assume that the ascites were simply a by-product of surgery. The plaintiff's expert further noted that Dr. Fuentes, Dr. Muratori's expert, did not mention the CT scan findings. The plaintiff's expert continued that the failures of Dr. Muratori to conduct a work up regarding the ascites, call appropriate consultations, including infectious disease consult, and address the significant signs and symptoms presented by the decedent, were substantial contributing factors to the decedent's injuries and death.

Based upon the conflicting opinions of Dr. Muratori's expert and plaintiff's expert, factual issues have been raised which preclude summary judgment from being granted to Dr. Muratori and Ross, Maccone & Muratori, MDS.

Accordingly, motion (008) by to Dr. Muratori and Ross, Maccone & Muratori, MDS for summary judgment dismissing the complaint as asserted against them is denied.

MOTION (010)

In motion (010) defendant Robert M. Jaeger, M.D. seeks summary judgment dismissing the complaint as asserted against him on the bases that he did not render any care and treatment to the decedent although his name appears on the hospital/patient's name plate, and his signature does not appear anywhere on the record.

The note of issue was filed with this court on November 5, 2012, therefore, the last date on which a motion for summary judgment was permitted was March 5, 2013. Motion (010) was served on March 19, 2013, well after the 120 days. Counsel for Dr. Jaeger offers no excuse for the untimely submission of this motion except to state he mixed up the date. "Good cause" in CPLR 3212 (a) requires a showing of good cause for the delay in making the motion-a satisfactory explanation for the untimeliness-rather than simply permitting meritorious, non-prejudical filings, however tardy. No excuse at all, or a perfunctory excuse, cannot be "good cause" (*see* ***Brill v City of New York***, 2 NY3d 648, 781 NYS2d 261 [2004]; ***First Union Auto Finance, Inc.***, 16 AD3d 372, 791 NYS2d 596 [2d Dept 2005]; ***Tucci v Colell***, 26 Misc 3d 1234A, 907 NYS2d 441 [Sup Ct, Kings County 2010]). Here, counsel's excuse is perfunctory and does not demonstrate good cause as set forth in ***Parker v LIJMC-Satellite Dialysis Facility***, 92 AD3d 740, 939 NYS2d 96 [2d Dept 2012] or ***Grochowski v Rubins***, 81 AD3d 589, 916, NYS2d 171 [2d Dept 2011]. However, due to the basis for this motion which does not involve care and treatment of plaintiff's decedent, or an expert affirmation in support, but rather asserts that defendant Jaeger never treated the decedent, this court will permit this untimely motion which the plaintiff does not oppose.

It is noted that Dr. Jaeger's motion is supported by an affirmation instead of an affidavit in which he avers to the truth of his statements under the penalty of perjury (CPLR 2106). However, the affirmation is considered to be a technical error, and it is determined that defendant Jaeger has established prima facie entitlement to dismissal of the complaint as asserted against him on the basis that he did not render care and treatment to the decedent. No factual issues have been raised by any party to preclude summary judgment from being granted to him.

Accordingly, motion (010) is granted, and the complaint and any cross claims asserted against defendant Jaeger, are dismissed.

MOTION (012)

In motion (012), the plaintiff seeks an order precluding any remaining defendants, for whom summary judgment has not been granted, from seeking contribution pursuant to Article 14 and apportionment pursuant to Article 16 against those defendants to whom summary judgment has been granted. Since a summary judgment motion is the procedural equivalent of a trial, it follows therefrom that any defendant intending to obtain the limited liability benefits of CPLR Article 16 must adduce proof on point in admissible form (***Hendrickson v Philbor Motors, Inc.***,102 AD3d 251, 955 NYS2d 384 [2d Dept 2012]; ***Tapogna v Tan***, 2010 NY Slip Op 331818(U) [Sup Ct, Suffolk County]; ***Drooker v South Nassau Communities Hosp.***, 175 Misc2d 181, 669 NYS2d 169 [1988]). In support of preservation of the benefits afforded by Articles 14 and 16, no defendant has submitted a cross motion with notice of motion setting forth the relief requested, except plaintiff. No party has submitted an affirmation from his expert setting forth alleged departures by the co-defendant for whom summary has been granted as a basis for entitlement to preservation of Article 14 or 16 benefits. Accordingly,

no basis to preserve any benefits for contribution or limited liability pursuant to Article 16 has been demonstrated as a matter of law by any of the remaining defendants as against the released co-defendants in this action.

Accordingly, motion (012) is granted and the defendants remaining in this action are hereby precluded from asserting contribution or limited liability benefits conferred by Articles 14 or 16 as to any co-defendant to whom summary judgment has been granted.

Dated: 2-4-14

Hon. Denise F. Molia

A.J.S.C.

____ **FINAL DISPOSITION** __X__ **NON-FINAL DISPOSITION**