Leddy v Mount Sinai Med. Ctr.
2016 NY Slip Op 31257(U)
March 24, 2016
Supreme Court, New York County
Docket Number: 805164-2013
Judge: George J. Silver
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SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NEW YORK: PART 10

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KAREN LEDDY and MICHAEL PILSBURY,

Plaintiffs,

-against-

MOUNT SINAI MEDICAL CENTER, ROBERT ALDOROTY, M.D., ROBERT ALDOROTY, M.D., PhD, PLLC, JORDAN WICKER, M.D. and SIMON FITZGERALD, M.D.,

Defendants.

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Index No. 805164-2013

DECISION/ORDER

Motion Sequence 002

HON. GEORGE J. SILVER, J.S.C.

Recitation, as required by CPLR § 2219 [a], of the papers considered in the review of this motion:

Papers	Numbered
Notice of Amended Motion, Attorney Affirmation in Support & Collective Exhibits Annexed	1, 2, 3
Notice of Cross-Motion, Affirmation In Opposition to Motion and In Support of Cross-Motion & Collective Exhibits	4, 5, 6
Reply Affirmation and Collective Exhibits Annexed	7, 8

In this action for medical malpractice defendants Mount Sinai Medical Center (Mt. Sinai), Robert Aldoroty, M.D. (Aldoroty), Robert A. Aldoroty, M.D., PhD, PLLC, Jordan Wicker, M.D. (Wicker) and Simon Fitzgerald, M.D. (Fitzgerald) (collectively defendants) move pursuant to CPLR § 3212 for an order granting them summary judgment dismissing the complaint of plaintiffs Karen Leddy (Leddy) and Michael Pilsbury (collectively plaintiffs) on the grounds that there is no causal connection between the alleged malpractice and Leddy's cognitive and orthopedic injuries and that defendants did not depart from accepted standards of medical practice in connection with the care and treatment rendered to Leddy. Defendants also seek summary dismissal of Leddy's lack of informed consent claim. Alternatively, Fitzgerald and Wicker seek summary judgment dismissing the complaint against them on the ground that they were residents acting under the direct supervision Aldoroty and attending anesthesiologist Dr. Ronald Marn (Marn), respectively. Plaintiffs oppose the motion and cross-move for partial summary judgment on liability on the ground that Leddy would not have slid down and off the

operating table during her surgery in the absence of negligence or medical malpractice. The surgery, which consisted of a laparoscopic cholecystectomy, appendectomy, lysis of adhesions and open ventral hernia repair, was performed on November 26, 2012.

Aldoroty testified that during Leddy's surgery part of Leddy's body was no longer on the operating table and that it was not his intent to have a portion of Leddy's body come off the operating table at that time during the procedure. Specifically, Aldoroty testified that at a certain point during the surgical procedure Leddy's buttocks were no longer supported by the operating table because Leddy was seen to slide on the operating table a distance of 8 to 12 inches over a time period of 5 to 8 seconds. Aldoroty further testified that as the incident occurred Leddy was supported by a resident, Fitzgerald, who was positioned in between her legs and that Leddy's body was maintained at approximately the same level as the operating table. According to Aldoroty, prior to incident Leddy was in either a supine position on the operating table or a less reverse Trendelenberg position. Aldoroty requested the resident anesthesiologist, Wicker, to increase the angle of the reverse Trendelenberg position. Fitzgerald, who positioned in between Leddy's legs and holding a camera, then informed Aldoroty that Leddy was slipping. According to Aldoroty, Fitzgerald then braced Leddy and held her buttocks up. Aldoroty was not sure if Leddy buttocks had come off the operating table at that point. Aldoroty also grabbed Leddy's buttocks from above to assist Fitzgerald. Either immediately before or immediately after Fitzgerald said that Leddy was slipping Wicker said that Leddy's endotracheal tube had dislodged. According to Aldoroty, everyone in the operating room shared some responsibility for ensuring that the patient did not fall after the resident anesthesiologist was instructed to change the angle of the operating table. Aldororty also testified that Wicker, despite his status as a resident, had to ability say something to Aldoroty regarding the angle of the operating table to Aldoroty in the interest of protecting the patient. Aldoroty testified that the endotracheal tube was never out of Leddy's mouth but that it had just dislodged and that it was only dislodged for a short period of time. Aldoroty further testified that he held Leddy's buttocks for more than 10 seconds but less than 60 seconds which was long enough for him to determine that Fitzgerald was comfortable, to tell the anesthesiologist to level the operating table out and to then orchestrate the process of sliding Leddy up the operating table toward the head of the bed. Aldoroty testified that Fitzgerald held Leddy's buttocks for approximately 1 minute while the operating table was leveled and Leddy was slid back into position with her buttocks on the table. Leddy was under total general anesthesia at the time of the incident, which included a muscle relaxant. Aldoroty testified that Leddy did not slip far enough off the operating table to sustain any injury whatsoever and that he order intraoperative x-rays be taken after the incident out of an abundance of caution. Aldoroty claimed that the intraoperative x-rays, in his opinion, ruled out any internal injury to Leddy as a result of the slip and he continued with the surgery until it was completed. Aldoroty admitted that endotracheal tube dislodgement can cause hypoxia if the dislodgment is for a significant amount of time but denied that hypoxia was responsible for Leddy's short-term memory loss.

Wicker testified that Leddy slid down the operating table but did not fall off. When she was sliding, one of Leddy's arms was secured to an arm board and the other arm was tucked. Leddy's legs were in stirrups. According to Wicker, immediately before Leddy slid off the operating table Aldoroty was standing on the side of Leddy's abdomen. When the intraoperative

incident occurred Leddy was in the reverse Trendelenburg position with her head higher than her feet and her body at an angle of approximately 15 to 30 degrees. According to Wicker, Aldoroty was responsible for deciding Leddy's position during the surgery. Wicker was responsible for putting Leddy in the position requested by the surgeon and was responsible for evaluating pressure points so as to ensure that Leddy was not positioned in such a way that would cause nerve injury. Wicker testified that there was nothing in Leddy's history or anything regarding her size, weight and anatomy that put her at risk for the intraoperative incident. With respect to the intraoperative incident, Wicker testified that Aldoroty requested that Wicker increase the amount of reverse Trendelenberg so that Leddy would be a at a steeper angle with her head more above her feet. Wicker used a remote control that delivered reverse Trendelenberg positioning to the operating table in small increments in order to optimize the surgical view for Aldoroty. Wicker observed that the end tidal CO2 wave form was altered and that Leddy's endotracheal tube had moved. Leddy had slid down the operating table and Fitzgerald prevented Leddy from falling off the operating table and was holding Leddy, wedging her buttocks against the side of the operating table. Leddy was repositioned into supine and moved up the operating table and repositioned to where she was originally. When Wicker noted that the endotracheal tube had moved he alerted Aldoroty. According to Wicker, the endotracheal tube was placed in the correct position immediately after Leddy was returned to the supine position. Wicker testified that at no point was there a decrease in Leddy's oxygen saturation and the end tidal CO2 returned to normal. There were bilateral breath sounds, condensation in the endotracheal tube and bilateral chest rise. After the incident Wicker checked Leddy's head, neck and arms for injury while Aldoroty and a nurse checked Leddy's legs. Wicker testified that less than 10 seconds elapsed from the time he noted that part of Leddy's buttocks were off the operating table to the time he first noted any issue with the end tidal CO2, which is the partial pressure of carbon dioxide that is exhaled from a patient's lungs. According to Wicker, the endotracheal tube was not grossly removed from Leddy's trachea but, based upon his analysis of the end tidal CO2, the tube was not in optimal position. Wicker testified that Leddy's movement on the operating table caused the endotracheal tube to become dislodged and described the movement on the operating table and the dislodgment of the endotracheal tube as being a simultaneous event. Wicker also testified that Fitzgerald held Leddy for less than 10 seconds while Wicker put Leddy back into supine position. Wicker was unsure whether the end tidal CO2 actually disappeared or merely decreased but testified that 5 or 6 seconds elapsed between the disappearance or lowering of the end tidal CO2 until he was able to return Leddy to supine position and replace the endotracheal tube. The target end tidal COS for Leddy was anywhere from 30 to 45. The intraoperative incident occurred at 1:28 p.m. At 1:15 p.m. Leddy's end tidal CO2 level was between 25 and 30. At 12:40 or 12:45 p.m. the end tidal CO2 level was at its highest level prior to 2:00 p.m., at approximately 40 to 42. At 1:31 p.m, the end tidal CO2 level was 25 and it remained at 25 over the next 2 to 3 minutes. At 3:30 p.m the end tidal CO2 level was 35. Wicker testified that the fact that the end tidal CO2 was below 30 for a period of time was initially the result of the movement of the endotracheal tube but after Leddy was returned to supine and the surgery was stopped so x-rays could be taken Leddy's abdomen was no longer being insufflated with carbon dioxide. Wicker testified that it is common for end tidal CO2 to decrease as a result of the exogenous CO2, which is used to perform laparoscopy, no longer being placed into the abdomen.

Wicker also testified that dislodgment of the endotracheal tube could, in general, cause hypoxia. Wicker testified that the entire surgical team is responsible for ensuring patient safety.

In support of the motion, defendants submit an affirmation from Dr. Jill Fong, M.D. (Fong), a board certified anesthesiologist. According to Fong, Leddy was admitted to Mt. Sinai on November 26, 2012 for scheduled surgery by Aldoroty that included a laparoscopic (possible open) cholecystectomy, appendectomy and lyses of adhesions, and open ventral hernia repair with possible utilization of mesh. Leddy pre-surgery physical examination was, according to Fong, essentially normal. Fong contends that the selection of general anesthesia was appropriate for Leddy's surgery and that an attending anesthesiologist was present for induction, tracheal intubation, emergence from anesthesia, extubation and all critical events during Leddy's surgery. According to Fong, pre-operative measures were taken to appropriately position and secure Leddy, including placing Leddy's legs in Allen stirrups, padding and securing her right arm at her side and securing her left arm to a padded arm board. Leddy was repositioned and redraped with yellow fin stirrups and both arms on arm boards. The anesthesia start time was 11:07 a.m. and the surgery start time was 11:56 a.m. According to Fong, at 1:28 p.m.m there is an anesthesia note reflecting tha during a change of bed position Leddy's bottom shifted slightly off the bed. Fong contneds that the bed is frequently positioned intraoperatively to optimize the surgeon's view and that Aldoroty had requested that Leddy be placed in the reverse Trendelenburg for better surgical exposure. When Leddy's bottom shifted of the bed the anesthesia note reflects that end tidal CO2 disappeared and the endotracheal tube was partially out. According to Fong, Leddy was immediately repositioned back onto the bed and reintubated with slight advancement of the endotracheal tube. Fing contends that attending physician Marn confirmed the correct placement of the endotracehal tube with direct laryngoscopy. According to Fong, there was no oxygen desaturation during this period and bilateral breath sounds and positive end-tidal CO2 were noted after atraumatic reintubation. Hip and back x-rays were performed at 2:15 p.m. and noted to be negative at 4:52 p.m. by Aldoroty. The surgery was continued and completed at 6:49 p.m. with the anesthesia end time being 7:09 p.m. Leddy was transferred to the PACU from the operating room awake, talking and responsive.

Fong opines that the anesthesia care provided to Leddy during the November 26, 2012 surgery was within the standards of care. Fong contends that there are two appropriate and accepted choices of surgical position, supine or lithotomy. Fong claims that in either position slipping or sliding during surgery can and does occur, particularly during the angulation of the operating table that is necessary during the course of surgery. An intraoperative slip/slide, according to Fong, is not a departure from accepted standards of anesthesia care.

Fong further opines that at no point in time was Leddy's hemodynamic status affected as a result of the slip/slide and there is no evidence that Leddy experienced hypoxia. According to Fong, the physicians and staff in the operating room appropriately responded to the slip/slide and Leddy's oxygen saturation, blood pressure and pulse rate were always within normal limits. Oxygen saturation level (SpO2) reflects the amount of oxygen in a patient's blood. If SpO2 is low for a significant period of time hypoxia, or insufficient oxygen supply, can occur. According to Fong, the records clearly demonstrate that Leddy's SpO2 level was normal between 99-100 percent during the entire surgical procedure from 11:07 a.m. to 7:09 p.m. and at no time did Leddy experience insufficient oxygen supply during the surgery. Fong further claims that

Leddy's arterial blood pressure was always above 60, which is evidence that there was always enough pressure to circulate the blood.

Fong contends that while the SpO2, arterial pressure and pulse rate are indications of hemodynamic status, CO2 is a gauge of ventilation and helps determine if the endotracheal tube is in the proper position. According to Fong, CO2 is a safety precaution and a measure of how much carbon dioxide the patient is exhaling, not a gauge to determine if the patient is hypoxic. In this case, Leddy's end tidal CO2 was monitored in 2 minute increments and was recorded to be between 35 mmHg and 43 mmHG from 12:30 p.m. until 1:28 p.m. At 1:28 p.m. Leddy's end tidal CO2 decreased to about 25 mmHG and returned to 30 mmHG within approximately 30 minutes. Leddy's end tidal CO2 thereafter varied from about 30-45 mmHG for the remainder of the surgery. Fong claims that during the 30 minute period when the end tidal CO2 went from 25 mmHg to around 30 mmHG the end tidal CO2 varied but was never absent. According to Fong, the amount of time that the endotracheal tube was partially out and the end tidal CO2 disappeared was less than 2 minutes and the endotracheal tube was repositioned within less than 2 minutes. Fong claims that this brief recorded decrease of end tidal CO2 had no adverse impact on Leddy's level of oxygenation and hemodynamic stability.

Fong further opines that short-term memory loss in the immediate post-operative period occurs and is a known side effect of general anesthesia and resolves time. Fong argues that because Leddy did not consult with any specialists for her alleged memory loss and was found by non-party neurologist to have normal and intact memory and mental status two months after the surgery, the alleged departures of the performing and monitoring of Leddy's general anesthesia did not proximately cause any permanent injury, including hypoxia, cognitive deficit or memory loss.

On the issue of informed consent, Fong opines that Leddy gave adequate informed consent prior to surgery when she executed a consent for anesthesia form. This form, according to Fong, documents that the plan for primary anesthetic modality, procedures, medications for induction/maintenance/post-anesthesia care as well as relevant risks, benefits and alternatives were discussed with Leddy. Leddy signed the consent form and Fong claims that a patient when presented with the risks, benefits and alternatives of anesthesia would have agreed to go forward with the anesthesia plan presented to Leddy.

Fong also opines that Wicker and the other anesthesia residents were under the supervision and guidance of their attending physicians during Leddy's surgery.

Defendants also submit an affirmation from Dr. Jeffrey Richmond, M.D. (Richmond), a board certified orthopedic surgeon. According to Richmond, it was appropriate for Aldoroty to place Leddy in the lithotomy and reverse Trendelenberg positions during the course of the surgery to obtain appropriate surgical exposure. Richmond claims that surgeons have the operating table manipulated during surgery in order to obtain optimal exposure and opines that measures were taken to appropriately position and secure Leddy, including having Leddy's legs in Allen stirrups with wrapping of the legs and stirrups in Kerlix, with foam Kerlix wrapped around Leddy's right arm and her left arm on a padded arm board. Richmond further opines that the intraoperative slip/slide did not cause any orthopedic injury to Leddy. Richmond claims that the intraoperative x-rays taken on November 26, 2012 do not show any evidence of fracture or edema and opines that further imaging during Leddy's admission would not have provided any

additional information that would have changed Leddy's course of treatment. Richmond further contends that an MRI of Leddy's right hip taken on January 15, 2013 and a MRI hip anthrogram taken on February 25, 2013 show no evidence of edema and that the absence of edema is consistent with the fact that Leddy did not experience a traumatic intraoperative event on November 26, 2012 resulting in injury to her right hip/lower extremity. Richmond also contends that Leddy's post-operative films show no evidence of acute injury but instead depict chronic degenerative changes that take place as a result of years or wear and tear as well as anatomic abnormalities. Richmond opines that the September 23, 2013 surgery Leddy underwent to her right hip was not the result of anything that occurred during the November 26, 2012 surgery but was a result of Leddy's degenerative condition and anatomy. More specifically, Richmond claims that Leddy had a congential bump on her femoral head that caused femoroacetabular impingement (FAI) and that after time a labrum tear developed.

Finally, Richmond opines that, based upon the deposition testimony and his experience, Fitzgerald, as a surgical resident, was under supervision and guidance of Aldoroty at all times during Leddy's surgery and that Leddy was adequately informed prior to surgery of the risks, benefits and alternatives of the proposed surgery and that a patient presented with such risks, benefits and alternatives would have undergone the surgery.

In opposition to the motion and in support of the cross-motion plaintiffs submit an affidavit from Dr. Hervey S. Sicherman, M.D. (Sicherman), a board certified orthopedic surgeon licensed to practice medicine in New York and New Jersey. Sicherman opines that Fitzgerald's act of wedging Leddy's buttocks into the operating room table was a deviation from the standard of care which, according to Sicherman, requires tow or possibly more persons to hold the patient, but not against the operating table, until the operating table can be lowered to a 180 degree angle. Sicherman further contends that Aldoroty, Fitzgerald and Wicker were all negligent and/or departed from good and accepted medical practice when they allowed Leddy, who was under general anesthesia and unable to move voluntarily, to slide down and off the operating table. According to Sicherman, careful monitoring is required when the steepness of the operating table is being increased to ensure that the patient remains safe and does not slide down and off the operating table. Sicherman claims that a patient sliding off the operating table does not occur when the surgical team does what it is supposed to do.

Sicherman also opines that regardless of whether Leddy fell from the operating table and onto the floor or she was wedged against the operating table, either incident was the direct competent producing cause of Leddy's orthopedic injuries. Sicherman's opinion is based upon the intraoperative incident itself and Leddy not having experienced any orthopedic issues or complaints prior to the surgery. Sicherman disagrees with Richmond's contention that Leddy's injuries are degenerative in nature. Sicherman contends that Leddy's osteoarthritis and femoroacetabular impingement were caused by the intraoperative incident and that osteoarthritis is frequently diagnosed after a patient suffers a trauma. Sicherman further contends that femoroacetabular impingement, the improper impact between the femur and the acetabular, can be caused by trauma and that femoroacetabular impingement that is the result of congential causes is often realized and diagnosed in the teenage or early adult years when pain results after prolonged sitting or walking or after strenuous exercise. According to Sicherman, osteoarthritis is frequently diagnosed after a patient has suffered trauma and the fact that a patient suffered

from a degenerative condition or osteoarthritis after trauma does not indicate that the patient had that degenerative condition or osteoarthritis prior to the trauma.

Sicherman also contends that the fact that the radiographic imagining performed seven and eleven weeks after the incident did not reveal edema does not rule out an acute injury months earlier. Sicherman claims there would not be swelling for seven and eleven weeks after the trauma as swelling from an event like the intraoperative incident experienced by Leddy would go down after one or two weeks. According to Sicherman, there was no edema visualized because Mt. Sinai and Aldoroty failed to timely order appropriate radiographic testing or evaluations. Sicherman opines that Aldoroty departed from accepted standards of care when he failed to order radiographic films recommended by the radiology department after the intraoperative x-rays were taken and when he failed to order such testing given Leddy's repeated postoperative complaints of pain. Sicherman claims that if Aldoroty had ordered further radiographic imaging Leddy's labrum tear and bulging and herniated discs would have been diagnosed in November 2012. Sicherman also contends that Aldoroty and Mt. Sinai staff departed form accepted standards of care in failing to heed, work up and evaluate Leddy's postoperative complaints of pain in areas of the body not associated with abdominal surgery.

Plaintiffs also submit an affirmation from a board certified anesthesiologist, Dr. Weingarten (Weingarten). Weingarten opines that it was the standard and duty of care for everyone in the operating room to make sure that Leddy was safely positioned and secure so that she would not fall off the operating table when the angle of the operating table was being increased and that Aldoroty, Wicker and Fitzgerald were negligent and/or departed from the standard of care by failing to properly monitor Leddy and steepness of the operating table so as to make sure that she did not slide off the table.

Weingarten also contends that Wicker failed to timely and properly reintubate Leddy following the occurrence on the operating table, that the endotracheal tube was not properly placed for approximately 8 minutes and that Wicker failed to timely and properly monitor and treat cerebral intraoperative hypotension, thereby causing Leddy to sustain brain damage. Specifically, Weingarten contends that Wicker's testimony that Leddy's end tidal CO2 remained below 30 from 1:28 p.m. until approximately 1:36 p.m. indicates that there was a problem with the placement of the endotracheal tube and that regardless of whether the endotracheal tube was checked by an attending after the incident, the depressed readings confirm that the tube was not properly placed. Weingarten opines that the improper placement of the endotracheal tube for approximately 8 minutes can cause brain damage. Because Leddy was on general anesthesia and could not breath on her own the improper placement of the endotracheal tube resulted in Leddy not getting enough oxygen to her end organs. According to Weingarten, the brain is the most sensitive end organ and the first to be damaged when there is hypoperfusion. Weingarten claims that although it is impossible to tell from the anesthesia record how much the oxygen saturation dipped, the oxygen saturation levels are not demonstrative as to what was occurring in Leddy's brain. Rather, Weingarten claims because Leddy was in reverse Trendelenberg the circulation of blood to her head would be decreased due to gravity and as such, the head and brain would get less oxygenated blood than the inferior internal organs. Because the body gets greater circulation and oxygenation while the body is in reverse Trendelenberg position, and including for a period of at least 10 minutes after the body is returned to a flat position, the pulse oximeter on Leddy's

finger would also get greater circulation than her head. Thus, Weingarten claims that oxygen saturation is not an accurate assessment of the level of oxygenated blood flowing to Leddy's brain. According to Weingarten, the standard of care required administration of a ventilation mask until the endotracheal tube was properly placed.

Weingarten also contends that Leddy suffered cerebral intraoperative hypotension for approximately 12 minutes after the fall from the operating table. According to Weingarten, anesthetic medications lower a patient's blood pressure and it is the responsibility of the anesthesiologist in the operating room to monitor blood pressure and to make sure that it is at an acceptable level. When a patient is in reverse Trendelenberg position, the standard of care requires blood pressure readings to be maintained at 100mghg systolic over 70mmHg diastolic or higher. According to Weingarten, because blood pools and collects in a patent's lower body when the patient is in reverse Trendelenberg position, it takes time for blood pressure circulation to return to normal and, as such, cerebral blood pressure is 15-30 mmHg less than what is being registered from the probe on the patient's finger. The same is true, according to Weingarten, with respect to mean arterial pressure. Weingarten contends that Leddy's blood pressure for approximately 12 minutes after 1:28 p.m. was 70-80 mmHg systolic and 50 mmHg diastolic and that the blood pressure in her brain had to be much less. Weingarten claims that for this reason, the mean arterial pressure of 60 mmHg is not indicative of an acceptable intraoperative pressure because the cerebral blood pressure was much less than that, regardless of the systolic, diastolic or mean arterial pressure. Weingarten opines that when blood pressure drops the standard of care requires the administration of ephedrine, which raises blood pressure by constricting blood vessels, and that Wicker's failure to monitor Leddy's blood pressure and to administer additional does of ephedrine[1] were departures from good and accepted medical practice.

Plaintiffs also submit an affidavit from Kim Miller, Ph.D, (Miller) a neuro-psychologist and psychologist licensed to practice in New York State. Miller avers that she on May 30, June 6 and July 15, 2015 she performed a full and complete psychological work-up of Leddy. The work-up included the following testing: WAIS-IV, Wide Range Achievement test, Nelson Denny Comprehension, Delis-Kaplan Executive Function System, Roy-Osterreith Complex Figure and Beery-Buketencia test of visual Motor Integration. The tests were performed over approximately 10 hours of face-to-face contact with Leddy. According to Miller, the testing confirmed that Leddy had reduced IQ, memory, executive function skills, visual motor deficits, motor coordination skills and attention problems. Specifically, Miller claims Leddy has "scatter" which is when a patient gets more difficult questions correct but misses easy inquiries on testing such as intelligence subtests. Miller claims that "scatter" demonstrates that Leddy had a greater pre-morbidity ability that has now been impacted because of the events during the November 26, 2012 surgery. Miller opines that Leddy's neurologic impairments are of the type normally caused by a traumatic brain injury and not by natural aging. Miller also disagrees with defendants' claims that because Leddy was able to recall 3 items after 5 minutes and had normal attention and concentration abilities during a post -surgery neurological exam Leddy does not have neurologic deficits. Miller claims that the only way to come to the conclusion that Leddy is neurologically intact would be to ignore all of the complaints reported by her and her husband.

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[1] According to Weingarten, ephedrine had been administered at 1:00 p.m.

According to Miller, her comprehensive evaluation of Leddy confirms that Leddy has clear neurologic impairments that impact her on a daily basis which were caused by the hypoxia and lack of adequate oxygenated blood to Leddy's brain during the November 2012 surgery.

In reply, Fong contends that Weingarten's claim that Leddy's decreased end tidal CO2 levels from 1:28 p.m. through 1:36 p.m. is evidence that Leddy suffered hypoxia and brain damage is inaccurate. According to Fong, the level of end tidal CO2 provides physiologic information about ventilation, pulmonary blood flow, metabolism and carbon dioxide flow but does not indicate whether a patient is hypoxemic or hypoxic. Pulse oximetry measures oxygen saturation (SpO2) levels which are an indication of amount of oxygen in a patient's blood. A low SpO2 level may be indicative of hypoxemia and ultimately hypoxia if SpO2 levels are reduced for a significant period of time. Fong claims that Leddy's SpO2 levels always remained between 98% and 100% throughout the surgery, evidencing that at no time was Leddy hypoxemic. Fong further contends that the endotracheal tube was readjusted and Leddy did not suffer any type of injury as outlined by her arterial pressure pulse rate, mean arterial pressure and, most importantly, the oxygen saturation levels which remained between 98% ad 100%.

According to Fong, Weingarten's opinions are based on inaccurate and incorrect facts. Fong argues that Weingarten's claims that Wicker did not timely and properly reintubate Leddy, that the endotracheal tube was not properly placed for 8 minutes and that Leddy suffered cerebral intraoperative hypotension is not based on any facts contained in the medical chart or deposition testimony. Relying on the oxygen saturation levels of between 98% and 100%, Fong argues that Leddy's ventilation and respiratory gas exchange were adequate between 1:28 p.m. and 1:36 p.m. Fong also argues that Leddy was immediately reintubated after the incident, that because the reintubation took less than 2 minutes and that there was no disappearance of end tidal CO2 reflected in the anesthesia record because anesthesia recordings were made very 2 minutes. Finally, Fong argues that Leddy was returned to the supine position immediately at the time of the slip and remained in the supine position until at least 2:52 p.m. when the intraoperative x-ray results came back. Since Leddy was in the supine position, Fong claims there was more than enough blood pressure to push well-oxygenated blood up to Leddy's brain. Fong claims that when a patient like Leddy is returned to a 180 degree angle the body would almost immediately regulate circulation of blood flow to all parts of the body and argues that Weingarten's claim that Leddy's head and brain received less oxygenated blood for a period of 10 minutes after being returned from reverse Trendelhenberg to supine is not based on accepted standards of medical practice. According to Fong, if a patient is hypoxemic or hypoxic blood is shunted toward the patient's core and vital organs, including the heart and brain. Therefore, if Leddy was hypoxic, blood would have left Leddy's finger in order to move toward the brain. The fact that Leddy's SpO2 levels were normal, according to the pulse oximeter on her finger, shows there was no hypoxemia or hypoxia.

Richmond, in reply, contends that defendants took appropriate pre-operative and intra-operative measures with respect to the positioning and safety of Leddy and that Sicherman does not explain what measures defendants failed to take in order to conform to accepted standards of care. Richmond opines that it was appropriate to place Leddy in the lithotomy and reverse Trendelenberg positions during the surgery to obtain appropriate surgical exposure.

Richmond further contends that Fitzgerald was a training resident acting under the

supervision and guidance of Aldoroty and argues that it cannot be said that Fitzgerald's act of supporting Leddy's buttocks after they came off the operating room table was not within the standard of care. Richmond also contends that Sicherman's claim that Fitzgerald improperly "wedged" Leddy's body into the operating table while it was being placed back onto the table is based upon a fact not in evidence. Richmond also claims that a significant portion of the population has asymptomatic disc bulges and argues that the fact symptoms become symptomatic at a certain point in time does not infer that malpractice was the cause of the symptoms. Richmond also reiterates his contention that Leddy's femoroacetabular impingement, as shown on a February 25, 2013 MRI, pre-dated the alleged malpractice because because such an injury does not develop within a period of 3 months and that the absence of post-operative edema is proof that Leddy did not experience a traumatic intraoperative event resulting in injury to her right hip/lower extremity.

In an action premised upon medical malpractice, a defendant doctor establishes *prima facie* entitlement to summary judgment when he/she establishes that in treating the plaintiff there was no departure from good and accepted medical practice or that any departure was not the proximate cause of the injuries alleged (*Thurston v Interfaith Med. Ctr.*, 66 AD3d 999, 1001 [2d 2009]; *Myers v Ferrara*, 56 AD3d 78, 83 [2d 2008]; *Germaine v Yu*, 49 AD3d 685 [2d Dept 2008]; *Rebozo v Wilen*, 41 AD3d 457, 458 [2d Dept 2007]; *Williams v Sahay*, 12 AD3d 366, 368 [2d Dept 2004]).

With respect to opinion evidence, it is well settled that expert testimony must be based on facts in the record or personally known to the witness, and that an expert cannot reach a conclusion by assuming material facts not supported by record evidence (*Cassano v Hagstrom*, 5 NY2d 643, 646, 159 NE2d 348, 187 NYS2d 1 [1959]; *Gomez v New York City Hous. Auth.*, 217 AD2d 110, 117 [1st Dept 1995]; *Matter of Aetna Cas. & Sur. Co. v Barile*, 86 AD2d 362, 364-365 [1st Dept 1982]). Thus, a defendant in a medical malpractice action who, in support of a motion for summary judgment, submits conclusory medical affidavits or affirmations, fails to establish *prima facie* entitlement to summary judgment (*Winegrad v New York Univ. Med. Ctr.*, 64 NY2d 851, 853, 476 NE2d 642, 487 NYS2d 316 [1985]; *Cregan v Sachs*, 65 AD3d 101, 108 [1st Dept 2009]; *Wasserman v Carella*, 307 AD2d 225, 226 [1st Dept 2003]). Further, medical expert affidavits or affirmations, submitted by a defendant, which fail to address the essential factual allegations in the plaintiff's complaint or bill of particulars fail to establish prima facie entitlement to summary judgment as a matter of law (*Cregan*, 65 AD3d at 108; *Wasserman* 307 AD2d at 226).

Once the defendant meets her burden of establishing prima facie entitlement to summary judgment, it is incumbent on the plaintiff, if summary judgment is to be averted, to rebut the defendant's prima facie showing (*Alvarez v Prospect Hosp.*, 68 NY2d 320, 324, 501 NE2d 572, 508 NYS2d 923 [1986]). The plaintiff must rebut defendant's prima facie showing without "[g]eneral allegations of medical malpractice, merely conclusory and unsupported by competent evidence" (*id.* at 325). Specifically, to avert summary judgment, the plaintiff must demonstrate that the defendant did in fact commit malpractice and that the malpractice was the proximate cause of the plaintiff's injuries (*Coronel v New York City Health and Hosp. Corp.*, 47 AD3d 456 [1st Dept 2008]; (*Koeppel v Park*, 228 AD2d 288, 289 [1st Dept 1996]). In order to meet the required burden, the plaintiff must submit an affidavit from a medical doctor attesting that the

defendant departed from accepted medical practice and that the departure was the proximate cause of the injuries alleged (*Thurston* 66 AD3d at 1001; *Myers* 56 AD3d at 84; *Rebozo* 41 AD3d at 458).

The doctrine of *res ipsa loquitur* is available in a narrow category of factually simple medical malpractice cases requiring no expert to enable the jury to reasonably conclude that the accident would not happen without negligence (*Kambat v St. Francis Hosp.*, 89 NYS2d 489, 496, 678 NE2d 456, 655 NYS2d 844 [1997]). *Res ipsa loquitur* permits a fact finder to infer negligence from the circumstances of the occurrence (*Kambat*, 89 NY2d at 495). Application of the doctrine requires a plaintiff to satisfy the burden of proof with respect to three elements - first, that the injury-causing event be of a kind that ordinarily does not occur in the absence of negligence, second, that the injury was caused by agent or instrumentality within the exclusive control of the defendant and, third, that no act or negligence on the plaintiff's part contributed to the happening of the event. The second and third elements are easily established here. There is no question defendants were in exclusive control of the operating table and the remote control used to raise and lower it during the surgery and Leddy, as a result of being anesthetized at time of the occurrence, could not have contributed to the happening of the intraoperative event. Regarding the first element, that the injury-causing event be of a kind that ordinarily does not occur in the absence of negligence, the Court of Appeals has held that it is proper to allow the use of expert medical testimony to inform the jury's question on this element (*States v Lourdes Hosp.*, 100 NY2d 208, 210, 792 NE2d 151, 762 NYS2d 1 [2003]). Specifically, the Court of Appeals stated that "expert testimony may be properly used to help the jury 'bridge the gap' between its own common knowledge, which does not encompass the specialized knowledge and experience necessary to reach a conclusion that the occurrence would not normally take place in the absence of negligence, and the common knowledge of physicians, which does" (*id.* at 212). The Court of Appeals further noted that just as a fact finder should be allowed to hear from a plaintiff's expert in order to determine whether an injury would normally occur in the absence of negligence, a defendant must be given the opportunity to rebut the assertion with competent expert evidence to show, for example, that the injury is an inherent risk of the surgical procedure and not totally preventable in the exercise of ordinary care (*id.* at 214).

In *Thomas v New York Univ. Med. Ctr.*, 283 AD2d 316, 317 [2001], the Appellate Division, First Department granted a plaintiff in a negligence/medical malpractice action partial summary judgment on the issue of liability pursuant to *res ipsa loquitur* where the plaintiff was injured when, while anesthetized, the lower part of his body slid off the operating table during an operation. As a result of the fall, the plaintiff's head was pulled out of a head stabilizing device causing his head to be lacerated (*id.*). The First Department noted that there was an indication that the accident was a result of the operating table being titled at an extreme angle (*id.*). In granting the plaintiff summary judgment on the issue of liability, the First Department held "it can hardly be debated that anesthetized patients do not fall from operating tables in the absence of negligence" (*id.*).

While there is a dispute between the parties as whether Leddy fell from an operating table, with defendants contending that Leddy did not "fall" because her buttocks merely slid off the operating table but never came into contact with the operating room floor and plaintiffs arguing that Leddy fell because a portion of her body dropped from an elevated position on the

operating table to a lower position, the question of whether Leddy experienced an intraoperative fall, slide or slip is semantical and irrelevant for the purposes of summary judgment. What is undisputed is that Leddy's buttocks came off the operating table while Leddy was anesthetized and that Aldoroty did not intend to have any portion of Leddy's body off the operating table during the operation. Thus, it would appear that this court could find that defendants were negligent as a matter of law, in accordance with the First Department's holding in *Thomas*. However, because the Court of Appeals has expressly held that expert testimony is admissible to bridge the knowledge gap when applying the doctrine of *res ipsa loquitur* (*States*, 100 NY2d at 212) and defendants have proffered an expert opinion from an anesthesiologist that an anesthetized patient slipping or sliding on an operating table is not a departure from accepted medical standards, a fact finder must resolve the question of liability in this case. While Fong's opinion strains credulity, particularly in light of the silence from defendants' expert surgeon on the issue of whether Leddy's buttocks coming off the operating table was a departure from the standard of care and Aldoroty's testimony that such an occurrence is unusual and that he did not intend for it to happen during Leddy's operation, it is inappropriate for a court to resolve credibility issues on a motion for summary judgment (*see Martin v Citibank, N.A.*, 64 AD3d 744 [1st Dept 2009]). Moreover, plaintiffs have proffered expert opinions on the issue of liability that are in direct conflict with Fong's opinion (*Guctas v Pessolano*, 132 AD3d 632 [2d Dept 2015] [conflicting expert opinions raise credibility issues which are to be resolved by the factfinder]). Therefore, defendants are not entitled to summary dismissal of plaintiffs' complaint on the ground that they did not depart from accepted standards of medical care and plaintiffs are not entitled to partial summary judgment on the issue of liability pursuant to the *res ipsa loquitur* doctrine.

Defendants are also not entitled to summary dismissal of plaintiffs' complaint on the ground that Leddy's orthopedic and neurological injuries are not causally related to defendants' alleged acts of negligence and/or medical malpractice. Generally, "the opinion of a qualified expert that a plaintiff's injuries were caused by a deviation from relevant industry standards would preclude a grant of summary judgment in favor of the defendants" (*Diaz v New York Downtown Hosp.*, 99 NY2d 542, 544, 784 NE2d 68, 754 NYS2d 195 [2002]). To defeat summary judgment, the expert's opinion "must demonstrate 'the requisite nexus between the malpractice allegedly committed' and the harm suffered" (*Dallas-Stephenson v Waisman*, 39 AD3d 303, 307 [1st Dept 2007], *quoting Ferrara v South Shore Orthopedic Assoc.*, 178 AD2d 364, 366 [1st Dept 1991]). With respect to Leddy's claimed orthopedic injuries, the record presents conflicting expert opinions as to whether Leddy's injuries are degenerative in nature or were caused by Leddy's buttocks being improperly supported or "wedged" against the operating table by Fitzgerald.

Plaintiffs' submission raises triable issues of fact with respect to Leddy's alleged neurological injuries. Defendants' expert anesthesiologist contends that Leddy's hemodynamic status was not affected as a result of the slip/slide and there is no evidence that Leddy experienced hypoxia because Leddy's SpO2 level was normal between 99-100 percent during the entire surgical procedure and her arterial blood pressure remained above 60. Plaintiffs' expert argues that Leddy's oxygen saturation level is not demonstrative of what was occurring in Leddy's brain and the mean arterial pressure of 60 mmHg is not indicative of an acceptable

intraoperative cerebral blood pressure in the minutes immediately following the intropertive incident when Leddy's body was returned to supine position. Rather, plaintiffs' anesthesiologist argues that because Leddy had been in the reverse Trendelenberg position, the circulation of blood to her head was decreased due to gravity and, therefore, Leddy's cerebral blood pressure was 15-30 mmHg less than what was recorded on the probe on her finger and Leddy's head and brain were receiving less oxygenated blood than her inferior internal organs. Contrary to defendants' argument, plaintiffs' expert's opinion is nonconclusory and based on evidence in the record. Plaintiffs' expert's opinion merely presents a different interpretation of the medical evidence than the one offered by defendants' expert. Summary judgment is not appropriate in a medical malpractice action where the parties adduce conflicting medical expert opinions (*see Barbuto v Winthrop Univ. Hosp.*, 305 AD2d 623, 624 [2003]) and the experts' competing opinions on causation present an issue of fact for a jury to decide (*Carnovali v Sher*, 121 AD3d 552 [1st Dept 2014]).

Wicker and Fitzgerald are also not entitled to summary dismissal of the claims against them. Although a resident is shielded from liability when he or she follows the orders of an attending physician, unless those order are so clearly contraindicated by normal practice that ordinary prudence requires inquiry into their correctness (*see Filippone v St. Vincent's Hosp. & Med. Ctr.*, 253 AD2d 616 [1st Dept 1998]), both Wicker and Aldoroty testified that every staff member in the operating room was responsible for ensuring Leddy's safety. Moreover, plaintiffs' expert contends that Wicker, despite his status as a resident, was negligent and/or departed from accepted medical practice by increasing the angle of the operating table without properly monitoring Leddy to make sure that she would not slide down the table while plaintiffs' orthopedist contends Fitzgerald departed from accepted standards of medical care by wedging Leddy's buttocks into the side of the hard operating room table. Plaintiffs' orthopedist claims that the standard of care required two or possibly more persons from the operating room staff to hold Leddy, but not against the operating table, until the table could be returned to a supine position. Plaintiff's expert contends that even a resident would and should know that a patient's back and pelvis cannot be pressed into the operating table while it is being moved from reverse Trendelenberg to supine position.

Defendants are entitled to summary dismissal of Leddy's informed consent claim. To prevail on an informed consent claim, a plaintiff must establish, via expert medical evidence, that defendant failed to disclose material risks, benefits and alternatives to the medical procedure, that a reasonably prudent person in plaintiff's circumstances, having been so informed, would not have undergone such procedure, and that lack of informed consent was the proximate cause of her injuries (*Balzola v Giese*, 107 AD3d 587 [1st Dept 2013]). Plaintiffs' experts have not addressed defendants' *prima facie* showing that they disclosed all of the material risks, benefits and alternatives to the surgery and that a reasonably prudent person in Leddy's position would have undergone the surgery (*see Brady v Westchester County Healthcare Corp*, 78 AD3d 1097 [2d Dept 2010]).

In accordance with the foregoing, it is hereby

ORDERED that defendants' motion for summary judgment is granted to the extent that Leddy's informed consent claim is dismissed. Defendants' motion is otherwise denied; and it is further

ORDERED that plaintiffs' cross-motion for summary judgment is denied; and it is further

ORDERED that the parties are to appear for a pre-trial conference on June 8, 2016 at 2:30 p.m. in Part 10, room 422 of the courthouse located at 60 Centre Street, New York, New York 10007; and it is further

ORDERED that defendants are to serve a copy of this order with notice of entry upon plaintiffs within 20 days of entry.

George J. Silver, J.S.C.

Dated: 3/24/16
New York County

HON. GEORGE J. SILVER