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SHORT FORM ORDER

COPY

INDEX No. 08-42851
CAL. No. 16-01854MM

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

PRESENT:

Hon. THOMAS WHELAN
Justice of the Supreme Court

MOTION DATE 2-23-17 (005, 008)
MOTION DATE 3-6-17 (006, 007)
MOTION DATE 3-9-17 (009, 010, 011)
ADJ. DATE 4-24-17
Mot. Seq. # 005 - MotD # 009 - MotD
006 - MotD # 010 - MG
007 - MD # 011 - MG
008 - MG

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JACQUELINE V. ROBINSON, as Administratrix of the Estate of LATOSH R. KNIGHT-SCOTT a/k/a LATOSH RENEE KNIGHT-SCOTT,

Plaintiff,

- against -

GOOD SAMARITAN HOSPITAL, MICHELLE GEBHARD, M.D., MICHAEL R. MENDOLA, M.D., DAVID BRAUNSTEIN, M.D., JEFFREY LIEBERMAN, M.D., SHAHRAM D. SHAMEKH, M.D., ROBIN MACKOFF, M.D., WILLIAM SIERRA, M.D., SHAHRAM HORMOZI, M.D., RALPH BARBATO, M.D., GERRY RUBIN, M.D., and NARENDRA SINGH, M.D.,

Defendants.

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Upon the following papers numbered 1 to 253 read on these motions for summary judgment ; Notice of Motion/ Order to Show Cause and supporting papers 1- 111; 119-151; 154-179; 182-193;196 - 213; 216- 235; 238-251; Notice of Cross Motion and supporting papers ___; Answering Affidavits and supporting papers 112-116 ; Replying Affidavits and supporting papers 117- 118; 152-153; 180-181; 194-195; 214- 215; 236- 237; 252-253 Other __; (~~and after hearing counsel in support and opposed to the motion~~) it is,

ORDERED that the motion (seq. 005) of defendants William Sierra, PA, and Good Samaritan Hospital, the motion (seq. 006) of defendants Dr. Shahram Hormozi and Dr. Narendra Singh, the motion (seq. 007) of defendant Dr. Shahram Shamekh, the motion (seq. 008) of defendant Dr. Ralph Barbato, the motion (seq. 009) of Dr. Michelle Gebhard and Dr. Robin Mackoff, the motion (seq. 010) of Dr. David Braunstein and Dr. Jeffrey Lieberman, and the motion (seq. 011) of Dr. Gerry Rubin are consolidated for the purposes of this determination; and it is further

ORDERED that the motion of defendants William Sierra, PA, and Good Samaritan Hospital for summary judgment dismissing the complaint against them is granted to the extent set forth below, and is otherwise denied; and it is further

ORDERED that the motion of defendants Dr. Shahram Hormozi and Dr. Narendra Singh for summary judgment dismissing the complaint against them is granted to the extent set forth below, and is otherwise denied; and it is further

ORDERED that the motion of defendant Dr. Shahram Shamekh for summary judgment dismissing the complaint and any cross claims against him is denied; and it is further

ORDERED that the unopposed motion of defendant Dr. Ralph Barbato for summary judgment dismissing the complaint against him is granted; and it is further

ORDERED that the motion of defendants Dr. Michele Gebhard and Dr. Robin Mackoff is granted to the extent set forth below, and is otherwise denied; and it is further

ORDERED that the unopposed motion of defendants Dr. David Braunstein and Dr. Jeffrey Lieberman for summary judgment dismissing the complaint and any cross claims against them is granted; and it is further

ORDERED that the unopposed motion of defendant Dr. Gerry Rubin for summary judgment dismissing the complaint against him is granted.

Plaintiff, as administratrix of the estate of Latosh Knight-Scott, commenced this action to recover damages for personal injuries and wrongful death allegedly caused by defendants' medical malpractice. The complaint alleges that plaintiff's decedent was treated in the emergency department at Good Samaritan Hospital on January 1, 2008 and from January 2, 2008 through January 3, 2008. By the amended bill of particulars, plaintiff alleges that defendants failed to timely diagnose and treat decedent for septic shock and pneumonia, causing personal injuries and wrongful death. Plaintiff alleges that defendants were negligent, inter alia, in failing to order that decedent's vital signs be checked and recorded every fifteen minutes; in failing to order input and output charting; in failing to order boluses of fluids; in failing to transfer decedent to another hospital that had an available bed in the intensive care unit; and in failing to refer and consult with various specialists. Plaintiff further alleges that defendant Good Samaritan Hospital is vicariously liable for the conduct of the named defendants and for its hospital staff, including Dr. Adriane Collins, an infectious disease doctor, Lauren Maure and Brunilda

DeJesus, nursing assistants, Marilyn Nagtalon and nurses Colleen Martella, Erin Mortensen Shrieber, and Renata Flegar.

All of the defendants move for summary judgment dismissing the complaint and any cross claims against them. Plaintiff has submitted one set of opposition papers, which include an expert affidavit by Dr. Peter Marshall. The motions are numbered from sequence 005 through sequence 011, and will be addressed in their consecutive order.

Defendants Good Samaritan Hospital and William Sierra, PA, move for summary judgment dismissing the complaint on the grounds that William Sierra did not treat or see plaintiff's decedent at any time, and that the treatment rendered did not depart from accepted medical care and was not a proximate cause of decedent's injuries or death. In support of the motion, defendants submit copies of the pleadings, the bill of particulars, an affidavit of William Sierra, an expert affidavit, certified hospital records, transcripts of the parties' deposition testimony, and the transcript of the deposition testimony of nonparty Betty Knight, decedent's sister.

William Sierra, PA, avers in his affidavit that he was not involved in the care and treatment of decedent while she was in the emergency department at Good Samaritan Hospital on January 1, 2008, nor did he treat her on January 2 or January 3, 2008. Sierra states that his only involvement with decedent was when he received the results of her blood culture tests after she had passed away. He states that received the preliminary report at 8:38 a.m. on January 3, 2008 and on January 4, 2008 at 2:17 p.m. It is undisputed that decedent passed away at 4:21 a.m. on January 3, 2008.

Dr. Michelle Gebhard testified that she is board certified in emergency medicine and has worked at Good Samaritan Hospital since 2004. She testified that she was working in the emergency department on January 1, 2008 when decedent was brought in by ambulance at 4:35 a.m. She testified that decedent was initially seen by Nurse Allison Lace, and that she saw decedent at 5:07 a.m. Dr. Gebhard testified that her shift ended at 7:00 a.m., at which time Dr. Michael Mendola assumed decedent's care and treatment in the emergency department. She testified that decedent complained of abdominal pain, that she performed a physical examination, obtained her medical history, ordered morphine which was administered intravenously, ordered a chest x-ray examination and a CT scan of the abdomen. She testified that decedent's temperature and pulse were normal, and that her blood pressure was borderline, but she had a history of hypertension and was taking medication for it. Dr. Gebhard testified that she viewed the chest x-ray image before her shift ended, and that she did not see any abnormality. She testified decedent's hospital chart indicated that the chest x-ray images were reviewed by Dr. Jeffrey Lieberman, that a report of the findings was created by Dr. Lieberman at 10:42 a.m., that the abdominal CT scan was conducted between 10:00 a.m. and 10:30 a.m., and that Dr. Lieberman's report was reviewed by Dr. Mendola. Dr. Gebhard testified that she was unable to formulate a conclusive diagnosis before her shift ended, but her impression included several possible causes for decedent's abdominal pain, including gastritis, gall bladder disease, pneumonia and acid reflux.

Dr. Michael Mendola testified that he was working in the emergency department at Good Samaritan Hospital on January 1, 2008 and began his shift at 7:00 a.m. He testified that Dr. Gebhard

introduced him to decedent while she was on a stretcher in the emergency department. He stated that she had a history of cirrhosis of the liver and substance abuse, and that cocaine and alcohol were found in her urine. He testified that having examined decedent and reviewed the radiology studies, he attributed her abdominal pain to chronic cirrhosis of the liver, gallbladder disease, alcohol gastritis and acid reflux. He testified that he prescribed pain medication and discharged her from the emergency department at 1:40 p.m. Dr. Mendola testified that he did not believe decedent had an infection, so he did not prescribe antibiotics. He testified that when decedent was discharged, her pain level was one out of ten compared to ten out of ten when she presented to the emergency department.

Dr. David Braunstein, a board certified diagnostic radiologist, testified that he works at Good Samaritan Hospital and was working on January 1, 2008. He testified that his only involvement with decedent was when he reviewed images of the CT scan of her abdomen. He testified that the images revealed two focal opacities in the right lower lobe of her lung, which indicate abnormal lung tissue attributable to either pneumonia or a neoplasm. He explained that the CT scan of the abdomen does not show the entire lung segments. Dr. Braunstein testified that he discovered a mild compression of the lung base known as bibasilar atelectasis, which is caused by either lying down or breathing issues, but that it was "very, very small." He testified that the images revealed that decedent had severe cirrhosis of the liver, and, in his opinion, based on decedent's age of 34, he believed the images indicated that she had pneumonia, a primary neoplasm, or round atelectasis, which is a compressed lung. According to his notes, he testified that the focal opacities were "most likely compatible with focal areas of pneumonia as opposed to the neoplasm or the round atelectasis."

Dr. Jeffrey Lieberman testified that he is a board certified radiologist and was working for Good Samaritan Hospital on January 1, 2008. He testified that he reviewed the ultrasound examination performed on decedent's abdomen, and that he prepared a report at 8:33 a.m. The report states that the images revealed an acute inflammation of the gallbladder, acute cholecystitis, possibly related to cirrhosis. Dr. Lieberman testified that he also reviewed a chest x-ray image and concluded it was normal.

Dr. Shahram Shamekh testified that he is a board certified internist and was working at Good Samaritan Hospital on January 2, 2008 as a hospitalist. He testified that decedent presented to the emergency department of Good Samaritan Hospital by ambulance at 12:31 p.m. on January 2, 2008. He testified that decedent was assigned to him, and that he examined her in the emergency department at 3:15 p.m. He testified that it is his custom and practice to obtain information about the patient from the emergency room doctor before meeting with the patient. He testified to decedent's medical history and to the medications that she was taking. Dr. Shamekh testified that decedent's blood pressure was 148 over 98 when she presented and dropped to 73 over 45 when it was recorded at 3:09 p.m. He testified that she was in shock when he examined her, that her blood pressure was very low, that he ordered Zosyn, a broad-spectrum antibiotic, and that he admitted her to the Intensive Care Unit (ICU). He testified that the decedent's chart indicates there was no bed available in the ICU, so decedent remained in the emergency department, but was treated as an ICU patient. Dr. Shamekh testified that he did not know what type of infection she had: that it could have been pneumonia, intestinal, "anything." He testified that the patient's chart indicated that she had been given Narcan while she was in the emergency

department, that she was in renal failure, had respiratory acidosis, decreased profusion to all of her organs and had to be intubated. Dr. Shamekh testified that he did not create any orders regarding the monitoring of decedent's vitals, as ICU has their own protocol. He testified that he did not see decedent again, and that his shift ended at 7:00 p.m. Dr. Shamekh testified that he ordered consultations with an infectious disease doctor and a hematologist, and the chart indicates that they saw decedent at 5:58 p.m. in the emergency department. He testified that after his shift terminates, a covering physician treats his patients.

Dr. Robin Mackoff testified that she is board certified in family medicine and was working in the emergency department at Good Samaritan Hospital on January 2, 2008. She testified that decedent arrived at the hospital at 12:31 p.m., and that she conducted a physical examination on her at 12:40 p.m. She testified that decedent was awake, lethargic, and obtunded, that her pupils were pinpointed, and that she was in severe respiratory distress. Dr. Mackoff testified that she gave decedent Narcan to determine if she had overdosed, but she needed to be intubated, as she did not respond to the Narcan. She testified that she ordered glucose, lab tests, and Rocephin and Zithromax, which are antibiotics, as her impression was that decedent may have had pneumonia. Dr. Mackoff testified that she ordered a chest x-ray examination and a blood gas examination, and that the results indicated that decedent had severe respiratory acidosis. She then contacted Dr. Shamekh for a consultation, and he admitted decedent to the ICU at 3:47 p.m. She testified that a heart monitor and oximeter were connected to decedent some time between 12:38 p.m. and 3:09 p.m. Dr. Mackoff testified that the emergency department was very busy on January 2, 2008, that there were between 10 and 15 patients being treated in the emergency department, and that she did not record her notes of decedent's examination until three hours later. She testified further that her orders were not recorded in the computer until after 6:00 p.m.

Dr. Shahram Hormozi testified that he is a board certified cardiologist and was an attending physician at Good Samaritan Hospital on January 2, 2008. He testified that he was contacted by Dr. Shamekh for a consultation and that he examined decedent in the emergency department at approximately 4:00 p.m. He testified decedent was unconscious and in shock. Dr. Hormozi testified that decedent was not suffering from a cardiac related issue, that she was suffering from severe respiratory distress and kidney malfunction. He testified that her blood pressure was very low at 3:09 p.m., and that it was 148/98 at 12:38 p.m.

Dr. Ralph Barbato, a board certified nephrologist and internist, testified that he was contacted by Dr. Shamekh for a consultation regarding decedent, and that he examined her on January 2, 2008 at approximately 7:30 p.m. He testified that decedent was in septic shock, acute renal failure, and had pneumonia in both lungs and respiratory acidosis. He testified that he reviewed the CT scan report concerning decedent's abdomen prepared on January 1, 2008 and her hospital chart. He testified the chart showed decedent was given saline fluids, dextrose and sodium bicarbonate at 3:54 p.m. He testified that the chart also indicated she was given steroids and fresh-frozen plasma (FFP). According to Dr. Barbato, decedent's kidney failure was due to hypotension.

Dr. Gerry Rubin testified that he is a board certified hematologist and was contacted by Dr. Shamekh for a hematologic consultation. He testified that he examined decedent on January 2, 2008 at

approximately 4:00 p.m. to determine if she was suffering from a blood disorder known as thrombotic thrombocytopenic purpura (TTP), and concluded that she was not. He testified that decedent was critically ill, hypoxic, that there was blood around her mouth, and that she was on pressor medications to raise her blood pressure. He testified that the bleeding around her mouth was most likely the result of liver failure. His summary in the patient chart states that "this is a 34 year old black female with a clear history of chronic cirrhosis and portal hypertension presents with what looks like sepsis and rapidly developing pneumonia."

Dr. Narendra Singh testified that he is a board certified internist, pulmonologist, and critical care physician, and that he was contacted by Dr. Shamekh on January 2, 2008 for a consultation regarding decedent. He testified that he met decedent at approximately 1:00 p.m. on January 2, 2008 in the emergency department at Good Samaritan Hospital, and that he believed she was in septic shock. He testified that decedent was on a ventilator, that she had been given various antibiotics, and that he ordered Levophed and Vasopressin, both of which are pressor medications utilized to raise blood pressure. Dr. Singh testified that at 8:00 p.m., he ordered sodium bicarbonate to raise decedent's blood pressure, and that she was connected to a machine that continuously monitored her blood pressure. He testified that patients on pressor medications are constantly monitored by the nursing staff. Dr. Singh testified that his differential diagnosis included pneumonia, acute respiratory distress syndrome (ARDS), and TTP, and that he ordered a FFP transfusion and Solu-Medrol for inflammation given every six hours.

Brunilda DeJesus testified that she works for Good Samaritan Hospital as a nursing assistant and works in the emergency department from 7:00 a.m until 3:00 p.m. She testified that the emergency department is divided into four districts, and that one nursing assistant is assigned to each district. She testified that the emergency department typically treats 10 to 12 patients and that they are treated in cubicles. Ms. DeJesus testified that occasionally an ICU patient remains in the emergency department when there are no beds available, and that she is verbally told about such cases. She testified that there is usually one nurse assigned to the ICU patient, but other nurses help out too. She testified that such patients are checked on every hour as opposed to every four hours, and that she is responsible for ensuring that they are clean and comfortable and for recording their blood pressure. DeJesus testified that she recorded decedent's systolic pressure after 3:00 p.m., and that it was 56, but she did not record her diastolic pressure. She testified that she tested decedent's blood sugar at 2:19 p.m., and that it was normal. DeJesus testified that she did not record decedent's input and output, as she did not received any orders to record it.

Erin Mortensen Shrieber testified that she is a registered nurse and works for Good Samaritan Hospital. She testified that she was working on January 2, 2008, that she was the triage nurse when decedent arrived by ambulance at 12:31 p.m., and that she assigned nurse Colleen Martella to be her primary nurse.

Colleen Martella testified that she is a registered nurse and was working in the emergency department at Good Samaritan Hospital on January 2, 2008. She testified that she was assigned to decedent as her primary nurse, and that she met her at 12:38 p.m. in the emergency department. She

testified that decedent arrived by ambulance and was on a stretcher, that she was conscious and uncooperative, and that she had to help her put a hospital gown on. Nurse Martella testified that she took decedent's vital signs. She testified decedent had a very low oxygen saturation, so she reported it to Dr. Mackoff. She testified that, among other things, she placed decedent on oxygen and sat her upright, among other things, to increase her oxygen saturation. Nurse Martella testified that she took decedent's vitals at 12:45 and her oxygen saturation improved significantly, from 30 to 88. She testified that she did not take decedent's blood pressure until 3:09 p.m., and that her systolic pressure was 56, but there is no diastolic pressure indicated because it was taken by a Doppler. Nurse Martella testified that decedent's blood pressure was abnormally low, and that she notified Dr. Mackoff. She testified that decedent was admitted to the ICU at 3:39 p.m., but that there were no beds available, so she stayed in the emergency department with decedent until her shift ended at 8:30 p.m. She testified that vital signs are taken every hour for ICU patients, that decedent was given pressor medications and antibiotics, and that decedent was being treated for pneumonia. Nurse Martella testified that decedent was given Diprivan for sedation at approximately 1:43 p.m., and that the hospital chart indicates "soft restraints were removed at 4:25 p.m." She testified that the chart does not indicate what time the Levophed was administered or what time decedent was intubated. She testified further that decedent was given the normal amount of fluids on a continuous basis and a Foley catheter was inserted at 1:49 p.m., but she did not record any input or output, as she was not directed to do so by any doctors. Nurse Martella testified that she contacted Dr. Singh at 5:58 p.m. to notify him that decedent's oxygen saturation was not improving, and that the respiratory therapist adjusted the ventilator to increase the positive and expiatory pressure (PEE) to 18. She testified that the chart indicates that at 7:30 p.m., Nurse Renata Flevor applied a Bair Hugger warming blanket to decedent because she was hypothermic.

It is well settled that a party moving for summary judgment must make a prima facie showing of entitlement to judgment as a matter of law, tendering sufficient evidence to eliminate any material issue of fact (***Alvarez v Prospect Hosp.***, 68 NY2d 320, 508 NYS2d 923 [1986]; ***Friends of Animals v Associated Fur Mfrs.***, 46 NY2d 1065, 1067, 416 NYS2d 790 [1979]). The failure of the moving party to make a prima facie showing requires the denial of the motion regardless of the sufficiency of the opposing papers (***Winegrad v New York Univ. Med. Ctr.***, 64 NY2d 851, 487 NYS2d 316 [1985]). The burden then shifts to the party opposing the motion, who must produce evidentiary proof in admissible form sufficient to require a trial of the material issues of fact (***Zuckerman v City of New York***, 49 NY2d 557, 427 NYS2d 595 [1980]).

A professional health care provider may be liable for medical malpractice if he or she departed from accepted community standards of practice, and such departure was a proximate cause of a plaintiff's injuries (***Abakpa v Martin***, 132 AD3d 924, 19 NYS3d 303 [2d Dept 2015]; ***Schmitt v Medford Kidney Ctr.***, 121 AD3d 1088, 996 NYS2d 75 [2d Dept 2014]). A professional health care provider who moves for summary judgment dismissing a complaint asserting a cause of action in medical malpractice must establish, prima facie, that he or she did not depart from the applicable standard of care or that such departure was not a proximate cause of plaintiff's injuries. To establish a prima facie showing of entitlement to summary judgment, a defendant must establish through medical records and competent expert affidavits that he or she did not deviate or depart from accepted medical practice in his or her treatment of the patient or that any departure was not a proximate cause of a

plaintiff's injuries (***Lau v Wan***, 93 AD3d 763, 940 NYS2d 662 [2d Dept 2012]; ***Castro v New York City Health & Hosps. Corp.***, 74 AD3d 1005, 903 NYS2d 152 [2d Dept 2002]).

Hospitals are vicariously liable for the acts of their employees and may be vicariously liable for the malpractice of a physician, nurse, or other health care professional that it employs under the doctrine of respondeat superior (*see* ***Hill v St Clare's Hosp.***, 67 NY2d 72, 499 NYS2d 904 [1986]; ***Bing v Thunig***, 2 NY2d 656, 163 NYS2d 3 [1957]; ***Seiden v Sonstein***, 127 AD3d 1158, 7 NYS3d 565 [2d Dept 2015]). Generally, a hospital is not vicariously liable for the malpractice of a physician who is not employed by the hospital. However, "an exception to the general rule exists where a patient comes to the emergency room seeking treatment from the hospital and not from a particular physician of the patient's choosing" (***Smolian v Port Auth. of N.Y. & N.J.***, 128 AD3d 796, 801, 9 NYS3d 329, 334 [2d Dept 2015]). Under a theory of apparent or ostensible agency, a hospital may be vicariously liable for the malpractice of a physician, who is not an employee of the hospital, if a patient reasonably believes that the physicians treating him or her were provided by the hospital or acted on behalf of the hospital (***Hilsdorf v Tsioulias***, 132 AD3d 727, 17 NYS3d 655 [2d Dept 2015]; ***Loaiza v Lam***, 107 AD3d 951, 968 NYS2d 548 [2d Dept 2015]).

Here, the testimony of the parties, the hospital records and the affirmation of Dr. Gregory Mazarin, establish William Sierra's prima facie entitlement to summary judgment, as he was not involved in the treatment and care of decedent. Dr. Mazarin states that he is board certified in emergency medicine and is affiliated with several hospitals which he names. He states that he has reviewed the pleadings, the bill of particulars, the certified hospital records of decedent, and he specifies each of the transcripts of deposition testimony that he read. Regarding the liability of the hospital based upon the doctrine of respondeat superior for the conduct of the nurses and physicians who treated decedent on January 2, 2008, Dr. Mazarin states that Dr. Adriane Collins, an infectious disease physician, examined decedent, reviewed the CT scan and appreciated the focal opacity in her right lung. He states that Dr. Collins ordered Zosyn, an antibiotic that treats many different bacterial infections, and Azithromycin, also used to treat various infections, including respiratory infections. Dr. Mazarin avers that Dr. Collins treatment and recommendations were limited to her field of infectious disease, and opines with a reasonable degree of medical certainty that her treatment did not depart from accepted medical standards and was not a cause of decedent's injuries or death.

Dr. Mazarin reviewed the documentation regarding the fluids decedent received and the amounts given, and opines that she was properly given adequate fluids and boluses. Further, he states that decisions regarding fluid resuscitation are not made by the nursing staff or by infectious disease doctors such as Dr. Collins. He further opines that it was not within Dr. Collin's or the nursing staffs's duties to order that vitals be taken more frequently, and, in any event, it was not warranted. He states that vital signs are taken every four hours in emergency departments and every one hour when a patient is in an intensive care unit. He states that the nurses followed the orders of the physicians, and that decedent was placed on a cardiac monitor which continuously monitored her vital signs, including her respiratory rate, pulse, and blood pressure. He opines, with a reasonable degree of medical certainty, that it was not a departure from accepted medical care to fail to take her vitals every fifteen minutes, and that it was not within the purview of Dr. Collins or the nurses to take her vitals more than once every hour. Further, he

states that it is not within their purview to record and chart decedent's input and output without, and that there were no orders by her treating physicians to do so. He states that decedent was documented to be in acute renal failure and urinary output was not expected.

Dr. Mazarin states that decedent was treated as an ICU patient and provided with the same level of care, despite being situated in the emergency department, and that Nurse Martella is a trained critical care nurse who stayed by her side. He states that Dr. Collins became involved with decedent's care after she was admitted to the ICU, and that her blood pressure was too low to transfer her to another institution. Dr. Mazarin states that Dr. Collins ordered a sputum culture, but that it takes 24 hours for a potential organism to grow and additional time to determine the sensitivity to antibiotics, and that when Dr. Collins saw decedent, blood and urine tests were already being conducted. He opines that the allegation that the nurses and doctors failed to timely test her blood, urine, and sputum tests is without merit.

Dr. Mazarin also states that on January 1, 2008, decedent was discharged from the hospital by Dr. Mendola, and that she was provided with discharge instructions. He states that the nursing staff has no authority to discharge patients, and that Dr. Collins did not treat decedent on January 1, 2008.

With respect to the allegations that the staff physicians and nursing staff improperly ordered a blood transfusion, steroids, and administered fresh frozen plasma for coagulopathy, Dr. Mazarin opines that such medications did not cause any negative effects and were properly administered to address various concerns. Further, he avers that the orders were given by decedent's treating physicians and were not given by Dr. Collins or the nursing staff. Dr. Mazarin opines that sodium bicarbonate was not warranted on January 1, 2008, and that it was not within Dr. Collin's purview to order sodium bicarbonate, nor did she cancel the first chest x-ray. He states that Dr. Singh ordered the x-ray examination on January 2, 2008 as the critical care pulmonologist who was monitoring her arterial blood gas results.

Dr. Mazarin opines, with a reasonable degree of medical certainty, that the nursing staff and doctors at the Hospital properly treated decedent and were not a cause of her injuries or death. He states that various specialists were called to examine her, that decedent was critically ill when she presented to the emergency room on January 2, 2008, that her prognosis was poor, and that she succumbed to her injuries.

In opposition, plaintiff submits an affirmation by counsel and the affidavits of Dr. Peter Marshall and Carol Alvin. In his affirmation, counsel states he is not opposing the motions for summary judgment by defendants Dr. Gebhard, Dr. Braunstein, Dr. Lieberman, PA Sierra, Dr. Barbato, Dr. Hormozi, and Dr. Rubin. Accordingly, the branch of the motion for summary judgment dismissing the complaint and any cross claims against William Sierra is granted, and the action is severed as against him.

Regarding the Hospital's application for summary judgment, Dr. Peter Marshall submits an affidavit. In his affidavit, Dr. Marshall states that he is board certified in pulmonology and critical care

medicine and regularly treats patients with pneumonia, sepsis, septic shock, acute respiratory distress syndrome, cirrhosis and multi-organ dysfunction syndrome. He states that on January 1, 2008, the CT scan revealed that decedent had pneumonia, as did her elevated white blood count, her upper right quadrant abdominal pain, and her elevated heart and respiratory rates. Dr. Marshall opines that Dr. Mendola failed to recognize these signs and was negligent in failing to prescribe antibiotics on January 1, 2008. He opines that patients with cirrhosis have a higher risk of developing sepsis, and that if she had been given antibiotics on January 1, 2008, she probably would have survived.

Dr. Marshall states that on January 2, 2008, decedent presented at 12:31p.m. by ambulance and that Dr. Mackoff, the emergency room physician, did not record her notes of the physical examination she conducted on decedent until 3:34 p.m. He opines that it is a departure from accepted medical practice to fail to record the notes of a patient's examination contemporaneously with the examination. He states that decedent's oxygen saturation was 29 per cent at 12:58 p.m., which is exceptionally low, that she was critically ill with significant metabolic acidosis and respiratory acidosis, and that Dr. Mackoff should have ordered sodium bicarbonate at that time rather than waiting until 3:43 p.m. Further, he opines that it was a departure from accepted medical standards to fail to adjust the ventilator to address the respiratory acidosis, and that these departures decreased decedent's chance of survival. Dr. Marshall opines that Dr. Mackoff departed from accepted medical practice by failing to diagnose decedent with severe sepsis and early stages of septic shock. He opines that, given the imaging studies, decedent's elevated white blood cell count, severe respiratory distress, her altered mental status, decreased platelet count, internal bleeding, manifested by her bloody spit up and stool, and her abnormal blood gas result, it was a departure from proper medical practice to fail to diagnose sepsis. He opines, with a reasonable degree of medical certainty, that the failure to initiate a septic shock protocol and take decedent's blood pressure between 12:38 p.m. and 3:09 p.m. was a departure from accepted medical practice. He explains that sepsis can be a life threatening infection, and that if it is not treated aggressively, it can progress to septic shock; blood pressure drops significantly and vital organs do not receive adequate blood flow placing the patient at a risk of death. Dr. Marshall notes that Dr. Mackoff ordered two antibiotics which were timely delivered and appropriate.

Dr. Marshall explains the importance of initiating fluid resuscitation in septic patients, and that the standard of care is to commence fluid resuscitation with a fluid bolus to increase blood pressure. He states that the patient must be challenged with a large volume of fluid in a short period of time, and that a bolus consisting of 1 to 2 liters should have been administered to decedent over a period of 30 minutes prior to or at the same time as the antibiotics were administered. Here, however, decedent was only given maintenance fluids, and not the necessary fluid challenge. Dr. Marshall opines that Dr. Singh, Dr. Mackoff and Dr. Shamekh departed from generally accepted standards of medical practice by failing to order the bolus of fluid when decedent was under their care. He states that Dr. Singh's order to administer the bolus of fluids at 8:00 p.m. was too late, as decedent's blood pressure had been so low for so long that her organs were already damaged, and it would not have made a difference.

Dr. Marshall further explains the appropriate ventilator settings for patients suffering from acute respiratory distress syndrome and explains tidal volume and how it is calculated. He opines that Dr. Singh selected a setting for tidal volume that was inappropriate for decedent's body weight and height,

and that the vent setting of 500 cc's fell below the generally accepted standard of care and decreased decedent's chance of survival. Further, he opines that Dr. Singh did not adjust the vent settings frequently enough to address decedent's acidosis: there was an arterial blood gas (ABG) test at 12:58 p.m., 3:28 p.m. and 7:41 p.m. He opines that the 12:58 ABG test result should have been reported immediately by the nurse to a physician, and that a nurse's note created at 1:01 p.m., but not reported until 2:06 p.m., indicated decedent was spitting up pink-colored sputum. He opines that as soon as decedent was put on the ventilator at 1:21 p.m., good and accepted nursing practice require taking and documenting vital signs every 15 to 30 minutes, as decedent was critically ill. Dr. Marshall opines that Nurse Martella departed from accepted standards of nursing practice by failing to record decedent's vital signs between 12:38 p.m. and 3:09 p.m. He notes that there is no indication in the hospital chart that Nurse Martella spent any time with decedent between 1:01 p.m. and 4:25 p.m., except for when she administered Diprivan at 2:13 p.m. Further, he opines that it was a departure from accepted nursing practice to fail to document the times that the medications were administered as ordered by the physicians. Dr. Marshall opines that it is a departure from accepted nursing practice to fail to document that she titrated the Levophed, and that it is the primary nurse's duty to conduct, monitor and record titration. He opines that it is the primary nurse's duty to record and document fluid input and output, and but for the limited output note, Nurse Martella departed from accepted nursing practice. Dr. Marshall opines that Nurse Martella departed from accepted nursing practice by failing to record the time that the central line and arterial line were placed. He opines that when vasopressors such as Levophed, vasopressin, and epinephrine are required, blood pressure monitoring and heart rate should be monitored every 15 minutes.

Dr. Marshall opines that vasopressors should not be started without a fluid challenge, and that the hospital records do not indicate what time the Levophed was administered, nor was it documented if Epinephrine or Vasopressin was administered, although ordered by Dr. Singh. He opines that such failure is a departure from acceptable standards of medical practice. Dr. Marshall opines that the choice of the vasopressors was appropriate, but that when given without a fluid challenge, it is a departure from generally accepted standards of medical practice. According to Dr. Marshall, Dr. Mackoff, Dr. Singh, and Dr. Shamekh departed from such standard and that such departure decreased decedent's chance of survival.

In addition, Dr. Marshall opines, with a reasonable degree of medical certainty, that decedent's vital signs should have been recorded every 15 to 30 minutes and that this should have been ordered by Dr. Mackoff, Dr. Shamekh, and Dr. Singh. Further, he opines that Dr. Singh and Dr. Shamekh should have monitored decedent's blood sugar more frequently, as hyperglycemia has adverse effects on vital organs in septic patients, and that the failure to monitor her blood hourly prevented them from diagnosing and treating hyperglycemia, which he believes she had based on her documented glucose levels. Dr. Marshall opines, with a reasonable degree of medical certainty, that if decedent received the appropriate standard of care, she would have had a 10 to 12 percent chance of survival when she presented to the emergency department on January 2, 2008, and that her reported use of alcohol and cocaine were not substantial factors in causing her death.

The affidavit of Dr. Marshall raises triable issues of fact regarding the Hospital's liability for the conduct of its nursing staff. "Summary judgment is not appropriate in a medical malpractice action where the parties adduce conflicting medical expert opinions" (***Feinberg v Feit***, 23 AD3d 517, 519, 806 NYS2d 661 [2d Dept 2005]). Here, the conflicting affirmations of Dr. Marshall and Dr. Mazarin raise credibility issues properly determined by a trier of fact (***Leavy v Merriam***, 133 AD3d 636, 20 NYS3d 117 [2d Dept 2015]; ***Kunic v Jivotovski***, 121 AD3d 1054, 995 NYS2d 587 [2d Dept 2014]; ***Loaiza v Lam***, 107 AD3d 951, 968 NYS2d 548 [2d Dept 2013]). However, the affidavit does not address the conduct of Dr. Adriane Collins, the infectious disease doctor. Therefore, summary judgment dismissing any claims of vicarious liability for the conduct of Dr. Collins is granted, but the claims against the Hospital imposing vicarious liability for the conduct of the nursing staff are denied. Accordingly, the application of Good Samaritan Hospital for summary judgment in its favor is denied.

The motion of Dr. Hormozi and Dr. Singh for summary judgment dismissing the complaint against them is granted with respect to Dr. Hormozi and denied as to Dr. Singh. Plaintiff has stated that she is not opposing the motion of Dr. Hormozi. In support of Dr. Singh's motion, an affirmation by Dr. Malcom Phillips, a board certified internist and cardiologist, is submitted. In his affirmation, Dr. Phillips opines, with a reasonable degree of medical certainty, that Dr. Singh's treatment of decedent did not depart from accepted medical standards and was not the cause of her injuries or death. Dr. Phillips states that decedent was "timely and properly diagnosed with septic shock shortly after admission to the Hospital on January 2, 2008." However, this statement is not supported by the deposition testimony or the medical records. Notwithstanding, Dr. Phillips opines that when decedent presented to the Hospital on January 2, 2008, "her condition was incompatible with life," that she was in renal failure, liver failure, respiratory failure, and "no matter what the care provided, the patient would have expired." He states that decedent's Albuim level was .6, which is the lowest level he has seen in his 36 years of treating critically ill patients, and that this critically low level hampers the ability to improve blood pressure by fluid resuscitation. He opines that Dr. Singh properly ordered vasopressors and did not deviate from acceptable standards of care by administering the fluids at 8:00 p.m. rather than initially. Further, he opines that the attempts at fluid resuscitation only worsened her oxygenization. In summary, Dr. Phillips opines that there was no way to treat the condition decedent was in, and that any action or inaction taken by Dr. Singh would have been unsuccessful.

In opposition, the affidavit of Dr. Marshall refutes many of the opinions by Dr. Phillips. Dr. Marshall states that the Albumin level of .6 was from blood drawn at 10:24 p.m., ten hours after decedent had been in septic shock. Further, he states that there is nothing in the decedent's chart to indicate that there was an issue with her Albuim level or that she had edema. He opines that the standard of care is to administer the boluses of fluid as soon as shock is recognized and to administer Albuim. He opines that without the fluid challenge, the chance of increasing the patient's blood pressure is decreased, which, in turn, decreases the patient's chance of survival. Dr. Marshall further refutes Dr. Phillip's opinion regarding Dr. Singh's selection of the tidal volume and vent settings, as discussed above in the determination of the Hospital's motion. It is evident that the conflicting expert affidavits preclude the award of summary judgment in favor of Dr. Singh, and his motion is, thus, denied.

Dr. Shahram Shamekh moves for summary judgment dismissing the complaint and any cross claims against him, and he submits the expert affirmation of Dr. Reed Phillips, a board certified internist. However, this affirmation is conclusory as it is based on facts not in evidence, and this is insufficient to satisfy Dr. Shamekh's burden. In his affidavit, Dr. Phillips states that decedent was timely diagnosed with pneumonia and septic shock. However, Dr. Shamekh's own deposition testimony indicates that he was uncertain of decedent's diagnosis. Dr. Phillips further states that Dr. Shamekh ordered and consulted with various specialists. Again, Dr. Shamekh did not testify that he spoke to any of the consultants after they examined decedent. Rather, he testified he did not see decedent after 3:15 p.m., and the record reveals that the specialists saw decedent at approximately 6:00 p.m. Dr. Shamekh testified that he was the hospitalist assigned to decedent, that he was his patient, and that his shift ended at 7:00 p.m. Neither the testimony of Dr. Shamekh nor the opinion of Dr. Phillips explain the standard of care and responsibility of a hospitalist to their patient, and if it is acceptable medical practice for a hospitalist to cease treatment of their patient for four hours prior to the completion of their shift. Having failed to establish the applicable standard of care and competent proof that Dr. Shamekh did not depart from such standard, he failed to establish, prima facie, his entitlement to summary judgment (***Tomeo v Beccia,*** 127 AD3d 1071, 7 NYS3d 472 [2d Dept 2015]; ***Geffner v North Shore Univ. Hosp.***, 57 AD3d 839, 871 NYS2d 617 [2d Dept 2008]). Accordingly, the motion is denied.

The motion of Dr. Barbato for summary judgment dismissing the complaint as against him is granted, as Dr. Barbato has established, prima facie, that he is a nephrologist who was one of many specialists who were contacted to examine decedent, and he did not breach a duty of care owed to her. Physicians owe a general duty of care to their patients, but that duty is typically limited to those medical functions undertaken by the physician (***Donnelly v Parikh***, 150 AD3d 820, 55 NYS3d 274 [2d Dept 2017]). It is for the court to determine whether the physician owes such duty (***Burns v Goyal***, 145 AD3d 952, 44 NYS3d 180 [2d Dept 2016]). It is undisputed that Dr. Barbato examined decedent, and that he opined that she was in septic shock, had pneumonia, and was in acute renal failure. His duty of care as a consulting nephrologist did not extend to the departures alleged by plaintiff. As plaintiff's counsel states that he does not oppose the motion, Dr. Barbato's motion for summary judgment is granted and the action is dismissed as against him.

The motion of Dr. Michelle Gebhard and Dr. Robin Mackoff for summary judgment dismissing the complaint against them is granted to the extent that the branch of the motion for summary judgment dismissing the complaint as against Dr. Michelle Gebhard is granted. Plaintiff's counsel has stated in his affirmation that he does not oppose such motion, and Dr. Gebhard established her prima facie case by the affirmation of Dr. Mazarin who opines, with a reasonable degree of medical certainty, that Dr. Gebhard's treatment did not depart from accepted emergency room practice and was not a cause of decedent's injuries or death. In his affirmation, Dr. Mazarin opines that on January 1, 2008, Dr. Gebhard appropriately reviewed decedent's medical history and appropriately ordered a chest x-ray examination and other diagnostic tests, and that she transferred decedent's care to another emergency room physician, Dr. Mendola, when her shift was completed. He opines that it would have been a departure from accepted medical practice to diagnose decedent in such a short time with no test results available. Dr. Mazarin opines, with a reasonable degree of medical certainty, that Dr. Gebhard's

treatment and care of decedent did not depart from acceptable emergency room practice, and was not a cause of her injuries or death. Accordingly, the complaint is dismissed as against Dr. Gebhard.

Turning to Dr. Robin Mackoff, who treated decedent on January 2, 2008 in the emergency department of the Hospital, Dr. Mazarin, opines with a reasonable degree of medical certainty, that when Dr. Mackoff treated decedent at 12:40 p.m., her pupils were pin pointed, and she was unable to obtain her medical history. He states that Dr. Mackoff appropriately administered Narcan to rule out an overdose and the "patient's sepsis was immediately recognized by Dr. Mackoff," as she prescribed antibiotics. Dr. Mackoff's own testimony, however, indicates that she thought decedent had pneumonia and was in respiratory acidosis. Thus, Dr. Mazarin's opinion is unsupported by the record and insufficient to establish a prima facie case in Dr. Mackoff's favor. Accordingly, the branch of the motion for summary judgment dismissing the action against Dr. Mackoff is denied.

The unopposed motion of defendants Dr. Braunstein and Dr. Lieberman, supported by the expert affidavit of Dr. James Naidich, is granted. Dr. Naidich, a board certified radiologist, opines, with a reasonable degree of medical certainty, that Dr. Braunstein and Dr. Lieberman properly interpreted the radiological reports and images and were not a cause of decedent's injuries or death.

Finally, the motion of defendant Dr. Gerry Rubin for summary judgment dismissing the complaint and any cross claims against him is granted, as plaintiff does not oppose the motion and Dr. Rubin has established, prima facie, through her testimony and the expert affidavit of Dr. Philip Reed, that her treatment did not depart from accepted medical practice, and was not a cause of decedent's injuries or death. According to the evidence submitted, Dr. Rubin was called in for a hematological consultation for the limited purpose of determining whether decedent was suffering from thrombotic thrombocytopenic purpura and concluded that she was not.

Dated: 8/30/17

THOMAS F. WHELAN, J.S.C.

____ FINAL DISPOSITION __X__ NON-FINAL DISPOSITION

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