| **Evans v Sandoval** |
| --- |
| 2018 NY Slip Op 32948(U) |
| November 9, 2018 |
| Supreme Court, Kings County |
| Docket Number: 503069/13 |
| Judge: Bernard J. Graham |
| Cases posted with a "30000" identifier, i.e., 2013 NY Slip Op 30001(U), are republished from various New York State and local government sources, including the New York State Unified Court System's eCourts Service. |
| This opinion is uncorrected and not selected for official publication. |

At an IAS Term, Part 36 of the Supreme Court of the State of New York, held in and for the County of Kings, at the Courthouse, at Civic Center, Brooklyn, New York, on the 9th day of November, 2018.

PRESENT:

HON. BERNARD J. GRAHAM,
Justice.

----------X

KATRINA EVANS,

Plaintiff,

- against -

Index No. 503069/13

JUAN SANDOVAL, THE BROOKDALE HOSPITAL MEDICAL CENTER D/B/A THE BROOKDALE UNIVERSITY AND HOSPITAL MEDICAL CENTER, MELISSA DWORKIN, LLOY ANDERSON AND PARKMED PHYSICIAN, P.C.,

Defendants.

----------X



The following e-filed papers read herein:

| | Papers Numbered |
|---|---|
| Notice of Motion/Order to Show Cause/ Petition/Cross Motion and Affidavits (Affirmations) Annexed | 294-318 319-338, 375 339-365 366-374 |
| Opposing Affidavits (Affirmations) | 378-386 |
| Reply Affidavits (Affirmations) | 393 |
| Supplemental Affirmations in Support | 376, 390-391 388 |

Upon the foregoing papers, in this action by plaintiff Katrina Evans (plaintiff) against defendants Juan Sandoval, M.D. (Dr. Sandoval), the Brookdale Hospital Medical Center d/b/a the Brookdale University and Hospital Medical Center (Brookdale), Melissa Dworkin, M.D. (Dr. Dworkin), Lloy Anderson, M.D. (Dr. Anderson), and Parkmed Physician, P.C (Parkmed) (collectively, defendants), Brookdale moves, under motion sequence number 11,

for an order: (1) pursuant to CPLR 3212, granting it summary judgment dismissing plaintiff's complaint as against it in its entirety, with prejudice; (2) deleting its name from the caption of this action and amending the caption, accordingly; and (3) permitting the clerk of the court to enter judgment in its favor without further order of the court. Dr. Dworkin moves, under motion sequence number 12, for an order: (1) pursuant to CPLR 3212, granting her summary judgment in her favor and severing and dismissing plaintiff's complaint as against her, with prejudice; (2) amending the caption of this action to delete her name; and (3) directing the clerk of the court to enter judgment in her favor; or, in the alternative, (4) pursuant to CPLR 3212 (e) and (g), granting her partial summary judgment and dismissing all claims for which plaintiff fails to raise a triable issue of fact in opposition hereto and limiting the issues for trial accordingly. Dr. Anderson moves, under motion sequence number 13, for an order: (1) pursuant to CPLR 3212, granting her summary judgment dismissing plaintiff's complaint as against her on the ground that there are no triable issues of fact sufficient to defeat this motion; (2) pursuant to CPLR 3211, dismissing this action as against her; (3) directing the clerk of the court to enter judgment in her favor and against plaintiff, and awarding her statutory costs and disbursements. Parkmed moves, under motion sequence number 14, for an order: (1) pursuant to CPLR 3212, granting it summary judgment and dismissing plaintiff's complaint as against it on the ground that there are no triable issues of fact requiring submission to a jury in the event that this court grants the motions for summary judgment made on behalf of Dr. Dworkin and Dr. Anderson; and

(2) granting it leave to enter judgment and directing the clerk of the court to enter judgment accordingly.

**Factual and Procedural Background**

On August 23, 2012, plaintiff, who was then 37 years old, underwent an Essure hysteroscopic sterilization surgery because she did not want to have any more children. This sterilization surgery was performed at Brookdale by Dr. Sandoval, plaintiff's private attending physician. Plaintiff had previously given birth to four children and had about three abortions. A urine test for pregnancy was ordered by Dr. Sandoval on August 23, 2012, and it was performed prior to the sterilization surgery. The urine test came back positive for pregnancy prior to the performance of the sterilization surgery, but plaintiff was not made aware of that result at the time of the sterilization surgery.

Nearly three months later, on a December 17, 2012 visit to Dr. Sandoval, plaintiff reported that she was experiencing fetal movements. Dr. Sandoval performed further tests and informed plaintiff that she was pregnant. Plaintiff decided to terminate her pregnancy.

On December 19, 2012, plaintiff presented to Parkmed for an abortion, and was found to be 24 weeks (six months) pregnant. On that same day, Dr. Dworkin, an employee of Parkmed, performed a dilator insertion/removal transabdominal injection procedure on plaintiff, which was the first step of a two-step abortion procedure for the termination of plaintiff's pregnancy. On the next day, December 20, 2012, Dr. Dworkin performed the second step, which was a dilation and evacuation procedure (D&E). Dr. Anderson, who was

employed by Omnicare, with which Parkmed had contracted to provide anesthesia services, was the anesthesiologist who administered the anesthesia during the December 20, 2012 D&E procedure. During the D&E, plaintiff made bucking movements, and plaintiff's uterus was perforated. Plaintiff was taken by ambulance to Beth Israel Medical Center, where, as a result of the uterine perforation, she underwent a hysterectomy.

On June 7, 2013, plaintiff commenced this action against defendants by filing her summons and complaint. Defendants interposed their respective answers. By a stipulation filed on July 23, 2015, this action was dismissed against Dr. Sandoval, who was a federal employee, with prejudice, pursuant to the Federal Tort Claims Act (*see* 28 USC §§ 2675, 2401). Discovery in this action has been completed, including the disclosure of plaintiff's medical records and the taking of the parties' depositions. On May 9, 2017, plaintiff filed her note of issue. By an order dated June 16, 2017, the court extended the time for Brookdale, Dr. Dworkin, Dr. Anderson, and Parkmed to move for summary judgment to October 16, 2017. Thereafter, Brookdale, Dr. Dworkin, Dr. Anderson, and Parkmed each moved for summary judgment.

**Discussion**

**Brookdale's Motion**

In support of the motion to dismiss, Brookdale has submitted an affirmation of a medical expert, Elizabeth A. Eden, M.D. (Dr. Eden), a licensed physician in the State of New York and board certified in gynecology and obstetrics. Dr. Eden opines that any injury

suffered by the plaintiff was the failure of the plaintiff's own private physician, Dr. Sandoval, to properly advise plaintiff of her medical options. Dr. Eden also addresses claims against Brookdale's nurse employees and opines that the nursing staff has no duty to advise plaintiff of her results and cannot be held negligent in this case.

Brookdale has establish a prima facie showing entitlement to a judgment as a matter of law.

The Court notes that the motion by Brookdale is unopposed by plaintiff and has not raised any triable issues of fact. Accordingly, Brookdale's motion for summary judgment dismissing the plaintiff's complaint against it is granted.

**Dr. Dworkin's Motion**

Dr. Dworkin asserts that she is entitled to summary judgment because she did not commit medical malpractice with respect to the perforation of plaintiff's uterus during the D&E procedure. In support of her motion, Dr. Dworkin has submitted the affirmation of her medical expert, Jonathan Lanzkowsky, M.D. (Dr. Lanzkowsky), who is licensed to practice medicine in the State of New York and is board certified in obstetrics and gynecology. Dr. Lanzkowsky opines, within a reasonable degree of medical certainty, that there were no departures from the standard of care in Dr. Dworkin's treatment of plaintiff before, during, or after plaintiff's D&E procedure. He further opines that there was no proximate causal relationship between any of the alleged departures and the injuries being sued upon by plaintiff.

Based upon the opinion of Dr. Lanzkowsky which sets forth a detailed analysis of Dr. Dworkin's treatment of the plaintiff and considering the known risks involved with the D&E procedure, the defendant Dr. Dworkin has established a prima facie case for dismissal of the complaint against her.

Plaintiff has not opposed the motion of Dr. Dworkin. Accordingly, the summary judgment motion is granted and the complaint against the defendant, Dr. Dworkin, is dismissed.

**Dr. Anderson's Motion**

Dr. Anderson contends that she is entitled to summary judgment dismissing plaintiff's complaint as against her. She asserts that she did not commit any medical malpractice during the D&E procedure, in which she was the anesthesiologist.

In support of her motion, Dr. Anderson has submitted the affirmation of her medical expert, Michael Luvin, M.D. (Dr. Luvin), a physician licensed to practice medicine in the State of New York, who is board certified in anesthesiology. Dr. Luvin opines, with a reasonable degree of medical certainty, that Dr. Anderson's care and treatment of plaintiff was, at all times, entirely consistent with the standards of good and accepted medical practice, and that such care and treatment was not the proximate cause of plaintiff's injuries.

Dr. Luvin states that the Anesthesia Flow Sheet documents the medications that Dr. Anderson administered to plaintiff as: 250 mg of Brevital, which is a rapid-onset anesthesia induction agent; 0.2 mg of Glycopyrolate, which is an antisialagogue administered with

anesthesia to reduce salivary, tracheobronchial, and pharyngeal secretions; 25 mg of Ketamine, which is an anesthesia induction agent that provides pain relief, sedation, and memory loss; 100 mcg of Fentanyl, which is a rapid onset opioid pain medication; 500 cc of Intravenous Lactated Ringers solution with 20 units of Pitocin (a medication used to induce uterine contractions) and 10 mg of Reglan (an anti-nausea agent). Dr. Luvin notes that plaintiff was 199 pounds or 90 kilograms, and that Dr. Anderson testified that the appropriate dosage would be 1 to 2 mg per kilogram of body weight. Dr. Luvin states that at 2 mg per kilogram, the dosing of Brevital would have been 180 mg to begin. Dr. Luvin further states that since the total documented amount of Brevital administered during the procedure was 250 mg, this indicated the infusion of the additional 60 mg of Brevital, as needed, throughout the course of the procedure. Dr. Luvin also states that the dosages of Glycopyrolate, Ketamine, and Fentanyl were all appropriate for plaintiff's weight and the duration of the procedure. Dr. Luvin asserts that the standard of care did not require Dr. Anderson to administer any additional medications, different dosages of the medications administered, or to not administer any of the medications that she administered.

Dr. Luvin further asserts that Brevital is a fast-acting anesthesia induction agent with a circulation time (time it takes to reach the brain), as testified to by Dr. Anderson, of no more than 60 seconds. He states that the Anesthesia Flow Sheet reveals that the procedure start time, which, according to Dr. Dworkin's testimony would have been when she examined plaintiff, removed the gauze and lumen from her vagina, and cleaned plaintiff with

Zephiran solution, was 9:22:30 a.m. He notes that according to the record, the anesthesia was started at 9:22:27 a.m. (three seconds before the procedure start time). He opines that Dr. Anderson allowed sufficient time for the anesthetic and sedative drugs administered to take effect and did not prematurely allow surgery to commence on plaintiff.

Dr. Luvin notes that the Anesthesia Flow Sheet documented that plaintiff was in the lithotomy position (on her back with her knees raised and supported in stirrups), and that measurements of plaintiff's heart rate, blood pressure, and oxygen saturation were monitored and were taken at the requisite frequency. Dr. Luvin points to the fact that plaintiff's heart rate and oxygen saturation were monitored throughout the procedure by specialized monitoring equipment, which would sound an alarm if plaintiff's oxygen saturation level dropped or if her heart rate rose or dropped above or below safe levels. Dr. Luvin notes that both Dr. Anderson and Dr. Dworkin testified that this alarm sounded, showing that there was oxygen desaturation, and that Dr. Dworkin testified that in response to this alarm, a nasal canula, which provided oxygen, was placed on plaintiff by Dr. Anderson. Dr. Luvin asserts that Dr. Anderson's response to plaintiff's oxygen desaturation by placing a nasal canula on her comported with standards of good and acceptable medical practice. Dr. Luvin sets forth his opinion that plaintiff's brief episode of oxygen desaturation was likely due to the presence of secretions, and that the presence of secretions and the oxygen desaturation were not the result of any departure on the part of Dr. Anderson.

Dr. Luvin explains that the type of anesthesia administered by Dr. Anderson for the procedure was Monitored Anesthesia Care, which is a planned procedure which involves the intravenous administration of sedatives, anesthesia inducing agents, and pain control agents during procedures that do not require general anesthesia. Dr. Luvin asserts that the administration of Monitored Anesthesia Care anesthesia in the setting of an abortion performed at 24 weeks gestation is in accordance with the standard of care in such procedures.

Dr. Luvin states that the coughing or bucking that is documented to have occurred during the abortion procedure is a known, acceptable risk of anesthesia and can occur under any form of anesthesia. He notes that Dr. Dworkin testified that bucking can occur due to increased secretions and that the appropriate medication to minimize these secretions is Glycopyrolate, which Dr. Anderson administered in this procedure. He further notes that Dr. Anderson testified that she has encountered this sort of movement on multiple occasions. He also points to the fact that Dr. Michael Molaei, a board certified OB/GYN and president of Parkmed, testified that in his over 25 years of practicing, he has frequently encountered this type of movement. Dr. Luvin concludes that, therefore, the coughing or bucking movement of plaintiff during this procedure was not due to any deviation from the standard of care on the part of Dr. Anderson. Dr. Luvin asserts that Dr. Anderson appropriately administered Glycopyrolate to minimize secretions during the procedure, appropriately responded to the situation, and adjusted the anesthesia agents to calm plaintiff.

Dr. Luvin additionally points out that uterine perforation is a known and well documented risk of any abortion procedure, and that the longer the gestation period at the time of the procedure, the higher the risk of perforation. He sets forth that the Parkmed records document that the risks, benefits, and alternatives to the procedure were discussed with plaintiff, and that plaintiff consented to the procedure. He points to the informed consent signed by plaintiff on December 19, 2012, which, at numbers 4 (d) and 4 (e), sets forth that "the risks of any abortion may include . . . perforation of the uterus" and "the possibility of complication leading to further surgery, including but not limited to removal of the uterus." He opines that the uterine perforation that occurred during this abortion procedure was a known risk of the abortion procedure and not the result of any departure on the part of Dr. Anderson from good and accepted medical practice.

Dr. Luvin sets forth that the coughing or bucking movement of a patient is also a known, acceptable, and documented risk of any procedure performed under any type of anesthesia. He explains that it can result from increased secretions in the patient's airway, oxygen desaturation, or reaction to surgical stimuli even when anesthesia is adequate and properly titrated.[1] He asserts that the fact that plaintiff had coughing or bucking does not mean that she was not given adequate anesthesia or that the proper amount of medication to reduce secretions was not given. He states that there is no evidence in the medical record or

---

[1]Titration is defined as "volumetric analysis by means of the addition of definite amounts of a test solution to a solution of the substance being assayed" (Stedman's Medical Dictionary 1994 [28th ed 2006]).

witness testimony to support plaintiff's allegation that her coughing or bucking during this procedure was a result of inadequate levels of anesthesia. He opines that plaintiff's movement during this abortion procedure was not the result of a departure on the part of Dr. Anderson from good and acceptable medical treatment.

Dr. Luvin asserts that the standard of care for a D&E procedure during the second trimester of pregnancy does not require the administration of general anesthesia, the utilization of an oxygen mask, or the availability of a gaseous anesthesia machine. He opines that the medications and dosages of the medications administered by Dr. Anderson to anesthetize plaintiff and to maintain the anesthesia were appropriate and complied with good and accepted medical practice.

Dr. Luvin states that Dr. Anderson did not fail to timely discontinue the procedure, and that the procedure was discontinued when Dr. Dworkin determined that the fetal vertex was outside the uterus and when Dr. Dworkin's digital examination revealed a right lateral uterine wall perforation. He notes that Dr. Dworkin documented that a uterine perforation had occurred and the procedure was immediately stopped. He states that there is nothing in the medical records or testimony that supports the claim that Dr. Anderson failed to timely discontinue the procedure.

Dr. Anderson concludes that it is his opinion, with a reasonable degree of medical certainty, that all of the care and treatment rendered to plaintiff by Dr. Anderson was in accordance with good and accepted medical practice. He further sets forth his opinion that

none of the care and treatment rendered by Dr. Anderson caused or contributed to plaintiff's injuries.

In opposition, plaintiff has submitted the redacted[2] affirmation of a physician licensed to practice medicine in New York, who is board certified in anesthesiology (plaintiff's anesthesiologist expert). Plaintiff's anesthesiologist expert states that the Anesthesia Flow Sheet is not an acceptable record as per the mandated standard of care guidelines of the American Society of Anesthesiologists (ASA). Plaintiff's anesthesiologist expert points out that the anesthesia start and stop times, surgical start and end times, and final disposition of the patient are all directly contradicted by the times and events recorded by Dr. Dworkin.

Specifically, plaintiff's anesthesiologist expert points to the fact that while Dr. Anderson's anesthesia note in the Anesthesia Flow Sheet states that the anesthesia start time was 9:22:27 a.m., that the surgery commenced three seconds later at 9:22:30 a.m., and that the surgery ending time was 9:40:20 a.m., Dr. Dworkin documented that plaintiff entered the operating room at 9:10 a.m., the procedure started at 9:15 a.m., the procedure was immediately stopped at 9:20 a.m., and during the procedure, plaintiff had bucking movements secondary to anesthesia. Plaintiff's anesthesiologist expert points out that in the procedure note, Dr. Dworkin, again, documented that plaintiff had bucking movements from anesthesia, that a nasal airway was placed secondary to decreasing oxygen saturation, and that plaintiff required stabilization. Plaintiff's anesthesiologist expert states that Dr.

---

[2]An unredacted copy of this expert affirmation has been submitted to the court.

Anderson and Dr. Luvin have not explained these inconsistencies in the start and stop times. Plaintiff's anesthesiologist expert also notes that the Anesthesia Flow Sheet sets forth the Post Anesthesia Care Unit scoring and that plaintiff was discharged to her home, when, in fact, plaintiff was not discharged to her home, but was emergently transported via ambulance to Beth Israel Medical Center.

Plaintiff's anesthesiologist expert points out that the medications portion of the Anesthesia Flow Sheet contains no indications whatsoever of the timing and/or dosing division of any of the drugs administered by Dr. Anderson. He/she notes that the medical record contains no evidence that any drugs were given to plaintiff at any time other than in advance of the start of the surgery or that they were given in any manner other than as single undivided intravenous doses.

Plaintiff's anesthesiologist expert opines that the failure of Dr. Anderson to properly monitor plaintiff and her failure to provide and maintain an adequate level of anesthesia were each a departure from accepted standards of proper anesthesia practice existing at that time, causing plaintiff to buck. He/she explains that based upon known and accepted pharmacokinetic properties of these drugs, as recorded in the anesthesia record, the timing of the administration of the drugs given to plaintiff at the start of the procedure proves that the depth of anesthesia at the time of the bucking and perforation was inadequate or essentially nonexistent. He/she opines that the anesthetic agent had worn off and plaintiff was experiencing pain, which is what caused her to buck. He/she sets forth that plaintiff

bucked because of an inadequate level of anesthesia, and that this was the result of the substandard care of Dr. Anderson in failing to properly monitor plaintiff and failing to administer appropriate drugs and medication in adequate dosages sufficient to maintain her in an adequately anesthetized and pain-free state.

Plaintiff's anesthesiologist expert points to Dr. Luvin's reference to Dr. Anderson's testimony which characterizes Brevital as an "induction" agent. Plaintiff's anesthesiologist expert states that in anesthetic terminology, induction refers to the induction of general anesthesia and not to the induction of sedation. He/she states that induction is not a concept associated with sedation, and that the Brevital dosage guideline cited by Dr. Luvin refers to the dosage of Brevital necessary for the induction of general anesthesia and, in fact, in the dosage given (250 milligrams), Brevital would be expected to induce a state of general anesthesia. He/she further states that Dr. Luvin's claim that plaintiff received Monitored Anesthesia Care, rather than general anesthesia, is blatantly false, considering that Dr. Anderson previously testified under oath that she administered general anesthesia to plaintiff, as well as the fact that Dr. Anderson administered the dosage of Brevital (250 milligrams) intended and expected to induce a state of general anesthesia. Plaintiff's anesthesiologist expert states that these facts and circumstances directly contradict Dr. Luvin's claim, in his affirmation, that Dr. Anderson rendered Monitored Anesthesia Care to plaintiff and demonstrates the impossibility and unreliability of the opinions expressed by Dr. Luvin in his affirmation.

Plaintiff's anesthesiologist expert opines, based upon reasonable medical probability, that Dr. Anderson departed from the accepted standards of proper anesthesia practice existing in 2012 by failing to properly monitor plaintiff to ascertain her level of anesthesia and failing to maintain an awareness of the plaintiff's level of anesthesia during the course of the abortion surgery. He/she additionally opines that Dr. Anderson departed from accepted standards of proper anesthesia practice by failing to administer appropriate drugs and medications in sufficient dosages, and by proper routes of administration and at proper intervals, causing plaintiff to be inadequately anesthetized. He/she concludes that these departures, singly and/or in combination, caused plaintiff to buck, as described in the medical record and in the deposition of Dr. Dworkin.

In addition, plaintiff has submitted the redacted[3] expert affirmation of her gynecologist expert, who is licensed to practice medicine and surgery in the State of New York and is board certified in the specialty of obstetrics and gynecology (plaintiff's gynecologist expert). Plaintiff's gynecologist expert notes that the records reveal that the surgery had proceeded uneventfully with no difficulties until the fetal parts and trunk were disconnected and removed from the uterus. He/she points to Dr. Dworkin's testimony that there was no uterine perforation prior to that time. He/she notes that after removal of the fetal limbs and trunk, plaintiff suddenly began to buck in a jerking manner for approximately a minute, lifting her bottom at least two inches off the operating table. He/she points to the

[3]An unredacted copy of this expert affirmation has been submitted to the court.

fact that Dr. Dworkin has testified that it was during this period that she believes plaintiff's uterine perforation occurred. The note by Dr. Dworkin in the medical record also states that "[d]uring the procedure, the patient had some 'bucking movements,' likely from the anesthesia."

Plaintiff's gynecologist expert underscores that the gravid (pregnant) uterus is extremely soft and prone to injury by instruments placed in the uterus, and that a Bierers forceps was in plaintiff's uterus at the time of her bucking. He/she states that the Bierers forceps was capable of and most probably caused the perforation of plaintiff's uterus because of plaintiff's bucking and jerking. He/she opines that the forces generated by plaintiff, who was almost 200 pounds, by her bucking and jerking two inches or more off the operating table for a minute or more were more than sufficient to cause and most probably did cause the instrument in her uterus to perforate it. Plaintiff's gynecologist expert sets forth his/her opinion, based upon reasonable medical probability, that the bucking and jerking of plaintiff, as described by Dr. Dworkin, caused by inadequate anesthesia as opined by plaintiff's anesthesiologist expert, was a significant contributing factor in causing the perforation of plaintiff's uterus on December 20, 2012 and the necessity for her to undergo an emergency hysterectomy.

In reply, Dr. Anderson asserts that while plaintiff's anesthesiologist expert states that the Anesthesia Flow Sheet contained in the anesthesia record is not an acceptable anesthesia record as per the ASA mandated standard of care guidelines, such expert does not state what

the ASA standard of care is or how the anesthesia record is deficient. Plaintiff's anesthesiologist expert, however, specifically states that Anesthesia Flow Sheet does not properly document the anesthesia start times and the start and stop times of the operation and states that plaintiff was discharged to home, when, in fact, she was emergently transported by ambulance to Beth Israel Medical Center. While Dr. Anderson points to Dr. Dworkin's deposition testimony that her single page supplement to the medical record was prepared about an hour after the procedure and the times she mentioned were only estimates, these inconsistencies raise triable issues of fact. The timing of when the drugs were administered to plaintiff and when the operation began are pertinent to plaintiff's claim that she did not receive adequate anesthesia, causing her bucking movements. While Dr. Anderson asserts that the error in the Anesthesia Flow Sheet, which states that plaintiff was discharged home and does not mention the bucking or uterine perforation that occurred, was due to using a template and is irrelevant, it is indicative of the inaccuracy of the information contained on the Anesthesia Flow Sheet. Adverse reactions in response to anesthesia and efforts made in response to them are a significant responsibility of the anesthesiologist and require accurate documentation.

With respect to plaintiff's anesthesiologist expert's assertion that Dr. Anderson failed to properly monitor plaintiff, Dr. Anderson points to the fact that a medical technician recorded plaintiff's vital signs, and that these vital signs were monitored throughout the procedure, and that plaintiff's heart rate and oxygen saturation were monitored throughout

the procedure by specialized monitoring equipment. Dr. Anderson asserts that the presence of secretions and the oxygen desaturation were not the result of any departure on her part. However, the fact remains that plaintiff had an episode of oxygen desaturation and while Dr. Luvin asserts that Dr. Anderson appropriately responded to the situation and adjusted the anesthesia agents to calm plaintiff, there is no evidence in the medical record that Dr. Anderson adjusted any anesthesia agents nor did Dr. Anderson testify, at her deposition, as to any such adjustment. Proper charting during the administration of anesthesia includes identifying various drugs and anesthetic agents, along with the time and frequency of dosage. As plaintiff points out, the medical record and the deposition testimony do not show that any further doses were given of Brevital, other than the one dose at the beginning of the surgery.

Dr. Anderson contends that plaintiff's anesthesiologist expert ignores Dr. Luvin's assertion that the bucking movement of the patient is a known, acceptable, and documented risk of any procedure performed under any type of anesthesia. Dr. Luvin's assertion, however, is not supported by any medical literature documenting this claim. Plaintiff's anesthesiologist expert specifically sets forth his/her opinion that the inadequate level of anesthesia caused the bucking movement, which would not be a risk assumed by a patient.

Significantly, Dr. Anderson testified, at her deposition, that bucking could occur if the patient was responding to stimuli because he or she was "not deep enough," and that a patient is not supposed to respond to stimuli while under anesthesia (Dr. Anderson's deposition tr at 30). In addition, Dr. Molaei testified, at his deposition, that plaintiff was reacting to the

stimulus of the surgeon when she bucked and that one of the duties of an anesthesiologist is to address such a reaction (Dr. Molaei's deposition tr at 51, 55-56).

Furthermore, as discussed above, Dr. Dworkin noted, in the medical record, that "[d]uring the procedure, the patient had some 'bucking movements,' likely from the anesthesia." Dr. Dworkin testified, at her deposition, that the uterine perforation most likely occurred during plaintiff's bucking movements, which persisted for a minute and in which plaintiff raised her buttocks approximately two inches off the operating table (Dr. Dworkin's deposition tr at 33-34, 46). Dr. Dworkin further testified that such bucking movement was not customary (*id.* at 32). Dr. Dworkin also testified that plaintiff should not have been experiencing the oxygen desaturation that she experienced because she was a young, healthy woman (*id.* at 38). In addition, Dr. Dworkin testified that there tends to be an increase in a patient's bucking when given Brevital (*id.* at 58).

Dr. Anderson notes that plaintiff's anesthesiologist expert refers to the known and accepted pharmacokinetic properties of the drugs listed in the anesthesia record in stating that the depth of the anesthesia was inadequate. Dr. Anderson complains that plaintiff's anesthesiologist expert does not state what those pharmacokinetic properties are, nor does he/she state how he/she used those properties to calculate that the anesthesia wore off at the time of bucking or perforation. However, Dr. Luvin also does not describe, in the first instance, the properties of the drugs used and how they operated to cause an adequate level of anesthesia. Dr. Anderson also complains that plaintiff's anesthesiologist expert fails to

state how he/she calculated when the anesthesia would have worn off. However, as previously noted, issues are raised as to the timing of when the doses of the drugs given to plaintiff were administered.

Dr. Anderson points to plaintiff's anesthesiologist expert's statement which characterizes Dr. Luvin's statement that plaintiff received Monitored Anesthesia Care as blatantly false. Dr. Anderson notes that this ignores the Anesthesia Flow Sheet contained in the medical records, which expressly stated: "Type of anesthesia given MAC [which stands for Monitored Anesthesia Care]." However, as noted above, there were discrepancies in the Anesthesia Flow Sheet, which calls into question the reliability of the notations contained therein. Furthermore, there are questions of fact based upon Dr. Anderson's deposition testimony as to the anesthesia care given by her.

Dr. Anderson complains that plaintiff's gynecologist expert relies upon plaintiff's anesthesiologist expert's opinion that plaintiff's bucking was caused by inadequate anesthesia. However, such reliance is appropriate, and plaintiff's gynecologist expert (as discussed above), specifically opines that plaintiff's bucking was a significant contributing factor in causing the perforation of plaintiff's uterus, which raises triable issues of fact as to causation.

"'Summary judgment is not appropriate in a medical malpractice action where the parties adduce conflicting medical expert opinions'" (*Elmes v Yelon*, 140 AD3d 1009, 1011 [2d Dept 2016], quoting *Feinberg v Feit*, 23 AD3d 517, 519 [2d Dept 2005]; *see also*

*Nisanov v Khulpateea*, 137 AD3d 1091, 1094 [2d Dept 2016]; *Guctas v Pessolano*, 132 AD3d 632, 633 [2d Dept 2015]; *Schmitt v Medford Kidney Ctr.*, 121 AD3d 1088, 1089 [2d Dept 2014]). Here, Dr. Luvin's opinion conflicts with plaintiff's experts' opinions. These conflicting expert opinions raise credibility issues which must be resolved by the factfinder (*see Stucchio v Bikvan*, 155 AD3d 666, 667 [2d Dept 2017]; *Omane v Sambaziotis*, 150 AD3d 1126, 1129 [2d Dept 2017]; *Elmes*, 140 AD3d at 1011; *Nisanov*, 137 AD3d at 1094; *Guctas*, 132 AD3d at 633; *Schmitt*, 121 AD3d at 1089; *Loaiza v Lam*, 107 AD3d 951, 953 [2d Dept 2013]).

Dr. Anderson contends, however, that the opinions of plaintiff's experts are speculative and conclusory, and, therefore, insufficient to defeat her motion for summary judgment. "General allegations of medical malpractice, merely conclusory and unsupported by competent evidence tending to establish the essential elements of medical malpractice, are insufficient to defeat [a] defendant['s] . . . summary judgment motion" (*Alvarez*, 68 NY2d at 325; *see also Arocho v D. Kruger, P.A.*, 110 AD3d 749, 750 [2d Dept 2013]). "In order not to be considered speculative or conclusory, expert opinions in opposition should address specific assertions made by the movant's experts, setting forth an explanation of the reasoning and relying on 'specifically cited evidence in the record'" (*Tsitrin v New York Community Hosp.*, 154 AD3d 994, 996 [2d Dept 2017], quoting *Roca v Perel*, 51 AD3d 757, 759 [2d Dept 2008]; *see also Brinkley v Nassau Health Care Corp.*, 120 AD3d 1287, 1290 [2d Dept 2014]). Contrary to Dr. Anderson's contention, the opinions of plaintiff's experts

are not conclusory or speculative, but address the specific assertions made by Dr. Luvin, and are based upon plaintiff's medical record and the deposition testimony. Since the opinions of plaintiff's experts raise triable issues of fact as to whether Dr. Anderson departed from accepted standards of medical practice, and whether that alleged departure was a proximate cause of plaintiff's alleged injuries, Dr. Anderson's motion for judgment dismissing plaintiff's complaint as against her must be denied (*see Kunic*, 121 AD3d at 1055 [where there was found to be an issue of fact as to whether the anesthesiologist assigned to the procedure departed from accepted standards of care during the procedure];[4] *Pinto v Putnam Hosp. Ctr., Inc.*, 107 AD3d 869, 870 [2d Dept 2013] [where it was found that the conflicting opinions of the medical experts raised triable issues of fact]).

**Parkmed's Motion**

In support of its motion for summary judgment, Parkmed notes that plaintiff has made no direct allegations of negligence against it, but, rather, claims that it is vicariously liable for the allegedly negligent acts and omissions of Dr. Dworkin and Dr. Anderson. Parkmed argues that it cannot, as a matter of law, be held vicariously liable for the acts and/or omissions of Dr. Dworkin and Dr. Anderson if their motions for summary judgment are granted.

---

[4] In *Kunic*, the plaintiff therein similarly alleged that the anesthesiologist improperly sedated her based on the fact of her movement during surgery (*see* brief for plaintiffs-respondents, available at 2013 WL 10167044, *4).

While the court has granted Dr. Dworkin's motion for summary judgment, it has denied Dr. Anderson's motion for summary judgment. Since the court has denied Dr. Anderson's motion for summary judgment, and Parkmed (as conceded by it) may be held vicariously liable for Dr. Anderson's allegedly negligent acts and/or omissions, it is not entitled to summary judgment dismissing plaintiff's complaint as against it. Thus, Parkmed's motion for summary judgment must be denied.

**Conclusion**

Accordingly, Brookdale's motion and Dr. Dworkin's motion for summary judgment dismissing plaintiff's complaint as against them are granted. Dr. Anderson's motion and Parkmed's motion for summary judgment dismissing plaintiff's complaint as against them are denied. The caption of this action is amended to delete the names of Brookdale and Dr. Dworkin, and this action is severed and continued as against Dr. Anderson and Parkmed.

This constitutes the decision and order of the court.

E N T E R,

J. S. C.
HON. BERNARD J. GRAHAM