SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF KINGS

MARIE LARIE, as Administrator of the Goods, Chattels and Credits which were of MARIE NICOLAS, deceased, Index No.: 509171/2017

Plaintiff,

DECISION/ORDER

-against-

MUHAMMAD F. KHAN, M.D., and NEW YORK METHODIST HOSPITAL, Hon. Bernard J. Graham Supreme Court Justice

Defendants.

Recitation, as required by CPLR 2219(a), of the papers considered on the review of this motion to: award summary judgment to the defendants, pursuant to CPLR § 3212

Papers	**Numbered**
Notice of Motion and Affidavits Annexed.....	___1-2, 3-4__
Order to Show cause and Affidavits Annexed.....	_____
Answering Affidavits	_____ 5_____
Replying Affidavits.....s.....	_____6_____
Exhibits.....	_____
Other: ..... (memo).....	_____

Upon the foregoing cited papers, the Decision/Order on this motion is as follows:

Defendant, Muhammad F. Khan, M.D., ("Dr. Khan") has moved, pursuant to CPLR § 3212(a)(b)(c), for an Order awarding summary judgment and a dismissal of plaintiff's complaint, upon the grounds that he did not depart from accepted medical practice in the care and treatment rendered to the plaintiff's decedent, Marie Nicolas ("Ms. Nicolas") and that any alleged departure was not the proximate cause of Ms. Nicolas' alleged injuries and death.

Defendant New York-Presbyterian Brooklyn Methodist Hospital s/h/a New York Methodist Hospital ("NYPBMH") has likewise moved, pursuant to CPLR§ 3212, for an Order awarding summary judgment and a dismissal of plaintiff's complaint, upon the grounds that they did not depart from accepted medical and hospital practice in the care and treatment rendered to Ms. Nicolas, and that any alleged departure was not the proximate cause of her alleged injuries and death.

The plaintiff, Marie Larie ("Ms. Larie"), the Administrator of the Estate of Marie Nicolas, has opposed the motions by the defendants for summary judgment upon the grounds that there are material issues of fact with regard to the causes of action that have been pled by the plaintiff, as against the defendants, for medical and hospital malpractice and negligence in the care and treatment that was rendered to Ms. Nicolas while she was a patient at NYPBMH.

Background:

An action was commenced on behalf of the plaintiff, on or about May 9, 2017, by the filing of a summons and complaint, alleging causes of action sounding in medical malpractice, lack of informed consent, and wrongful death against the defendants, Dr. Khan and NYPBMH. Issue was joined on behalf of defendant NYPBMH by service of a verified answer, on or about May 30, 2017, and by the service of a verified answer on behalf of defendant, Dr. Khan, on or about August 15, 2017. On or about July 27, 2017 and September 7, 2017, plaintiff served a verified Bill of Particulars in response to defendants' demands.

The plaintiff's complaint alleges that the defendants improperly performed a cardiac catherization and percutaneous coronary intervention procedure on October 21, 2015, failed to properly secure the percutaneous firth femoral sheath upon completion of the procedure and delayed removing the sheath. As a result, the sheath became dislodged causing Ms. Nicolas to hemorrhage from the femoral artery resulting in hemorrhagic shock, cardiac arrest and her death on October 21, 2015.

A deposition was conducted of Ms. Larie on February 7, 2018. Depositions were also conducted of Dr. Kahn on September 7, 2018 and Nicole Mavroudis, R.N. ("Nurse Mavroudis") an employee of NYPBMH, on May 2, 2019.

A Note of Issue and Certificate of Readiness was filed on behalf of the plaintiff on or about October 22, 2018.

Facts:

On October 6, 2015 at approximately 7:58 p.m., Ms. Nicolas, who was 80 years old, presented to the emergency department of NYPBMH by ambulance after having been found on the floor of her home by her grandson following a fall. Her medical history included cardiovascular disease, for which she had undergone triple-vessel coronary artery bypass grafts in 2004, as well as cerebral infarction (right carotid artery), hypertension, high cholesterol,

diabetes, congestive heart failure and paroxysmal atrial fibrillation. While in the emergency department of NYPBMH, Ms. Nicolas underwent an EKG which revealed sinus bradycardia and T-wave inversions in the lateral leads. A CT scan of the brain revealed findings for acute cerebrovascular accident ("CVA"). Ms. Nicolas was admitted to the telemetry unit of the hospital for cardiac monitoring.

On October 7, 2015, an MRI taken of the brain exhibited an occlusion of the right and left anterior cerebral arteries, atherosclerotic changes of the bilateral, distal carotid arteries and middle cerebral arteries and irregularity with stenosis with the bilateral posterior cerebral arteries; an occlusion of the right posterior cerebral artery; a 1.3 cm x 0.9 cm area of restricted diffusion/abnormal flair signal in the right basal ganglia and evidence of prior micro bleeds and hemorrhagic subacute infarcts.

Between October 7, 2015 and October 21, 2015, via telemetry monitoring, Ms. Nicolas was observed having numerous arrhythmic episodes which included ventricular tachycardia or NSVT and multiple premature ventricular contractions. Dr. Buckner, a neurologist, noted that Ms. Nicolas had new brain stem and basal ganglia strokes and multifocal intracranial and extracranial large artery atherosclerosis.

On October 9, 2015, Ms. Nicolas was seen by Dr. Bezuevsky, a vascular surgeon, for bilateral carotid stenosis with right stroke mild left neurological deficit. The doctor noted that the patient might benefit from right coronary endarterectomy (CEA) for risk reduction of recurrent CVA.

On October 11, 2015, Ms. Nicolas was consulted by cardiology, at which time it was noted she had multiple episodes of non-sustained ventricular tachycardia and bilateral carotid stenosis. As a result, the scheduled plan was for Ms. Nicolas to undergo a left heart catheterization with anticoagulation. On October 12, 2015, the cardiology unit noted that Ms. Nicolas had sinus bradycardia with occasional NSVT and elevated blood pressure.

On October 19, 2015, Ms. Nicolas experienced multiple episodes of non-sustained ventricular tachycardia despite being given a dose of beta blockers. Her blood pressure was elevated. On that date Dr. Haq, an interventional cardiologist, performed a cardiac catheterization which revealed significant native vessel coronary disease, the breakdown of which was 80% occlusion of the left main ostial, 100% in the mid-left anterior descending, 75% in the distal left circumflex and 100% of the proximal right coronary artery.

On October 21, 2015, Dr. Haq also performed an angiography of the left coronary with placement of metal stents in the left posterior descending artery, left main and distal circumflex. The procedure which lasted approximately ninety-five minutes was allegedly performed without any complications. Thereafter, heparin was administered through the femoral sheath. Dr. Haq noted his impression as "severe ostial left main disease 80% stenosis treated with a base metal stent with good results". While Ms. Nicolas was in CVCU, her respiratory and heart rate, blood pressure and oxygen saturation were all within normal limits, and along with her vital signs, they were assessed every fifteen to thirty minutes.

While in the progressive cardiac unit, Ms. Nicolas was monitored by Nurse Mavroudis who assessed both her vital signs and the femoral sheath site. The nurse noted that the sheath area was intact without evidence of bleeding, bruising or hematoma.

The initial plan was for the right femoral artery sheath to be pulled out at 8:30 P.M. Since Ms. Nicolas' blood pressure was elevated[1], a nurse advised Dr. Kahn, the cardiac fellow[2], who then instructed the nurse to continue to administer the blood pressure medication with the time to remove the sheath changed to 10:00 p.m. Additionally, Dr. Khan suggested to the nurse that the administration of the 10:00 p.m. medication be given a little earlier to avoid a delay in the femoral sheath pull.

At 10:13 p.m., Nurse Mavroudis was called to the patient's room by the nurse's assistant who observed blood on the bed sheet. Nurse Mavroudis found the sheath to have been dislodged from the right groin. She noted a pool of blood around the groin which was still bleeding and Ms. Nicolas was unresponsive. The nurse applied pressure to the bleeding site and a code 66 was activated. Ms. Nicolas' pulse was eventually lost, she was then intubated and IO and IV central lines were inserted. By the use of epinephrine, fluid and blood resuscitation, there was a return of circulation. However, within thirty minutes Ms. Nicolas coded again, and after unsuccessful attempts at resuscitation, she was pronounced dead at 11:51 p.m.

[1] Ms. Nicolas' blood pressure was 207/90 at 8:30 and 8:47 p.m.; 202/84 at 9:00 p.m.; 202/86 at 9:30 p.m. and 200/84 at 10:00 p.m.

[2] The evening of October 21, 2015, Dr. Khan was the on-call fellow in NYPMH who was assigned to patients in the cardiac unit.

Discussion:

On a motion for summary judgment seeking a dismissal of a medical malpractice cause of action, a defendant must make a prima facie showing either that there was no departure from good and accepted medical practice, or, if there was a departure, that the departure was not the proximate cause of plaintiff's alleged injuries (Williams v. Bayley Seton Hosp., 112 AD3d 917, 918, 977 NYS2d 395 [2nd Dept. 2013]; Giacinto v. Shapiro, 151 AD3d 1029,1030, 59 NYS3d 42 [2nd Dept. 2017]; Brinkley v. Nassau Health Care Corp., 120 AD3d 1287, 993 NYS2d 73 [2nd Dept. 2014]). Thus, on a motion for summary judgment, the defendant has the initial burden of establishing the absence of any departure from good and accepted practice or that the plaintiff was not injured by any departure (see Terranova v. Finklea, 45 AD3d 572, 845 NYS2d 389 [2nd Dept. 2007]). "In order to sustain this burden, the defendant is only required to address and rebut the specific allegations of malpractice set forth in the plaintiff's complaint and bill of particulars" (Bhim v. Dourmashkin, 123 AD3d 862, 864, 999 NYS2d 471 [2nd Dept. 2014]).

Once the defendant has made such a showing, the burden shifts to the plaintiff to submit evidentiary facts or materials to rebut the prima facie showing made by the defendant, so as to demonstrate the existence of a triable issue of fact (see Fritz v. Burman, 107 AD3d 936, 94, 968 NYS2d 167 [2nd Dept. 2013]; Brinkley v. Nassau Health Care Corp., 120 AD3d at 1287). The plaintiff must "lay bare her proof and produce evidence, in admissible form, sufficient to raise a triable issue of fact as to the essential elements of a medical malpractice claim, to wit, (1) a deviation or departure from accepted medical practice, [and/or] (2) evidence that such departure was a proximate cause of injury" (Sheridan v. Bieniewicz, 7 AD3d 508, 5089 [2nd Dept. 2004]; Gargiulo v. Geiss, 40 AD3d 811, 911-812 [2nd Dept. 2007]). In order to prevail on a claim for medical malpractice, "expert testimony is necessary to prove a deviation from accepted standards of medical care and to establish proximate cause" (Nicholas v. Stammer, 49 AD3d 832, 833 [2008]).

In addressing the issue of proximate cause, the Court notes that "in a medical malpractice action, where causation is often a difficult issue, a plaintiff need do no more than offer sufficient evidence from which a reasonable person might conclude that it was more probable than not that the injury was caused by the defendant" (Johnson v. Jamaica Hosp. Med. Ctr., 21 AD3d 881, 883 [2nd Dept. 2005], quoting Holton v. Sprain Brook Manor Nursing Home, 253 AD2d 852 [2nd Dept. 1998]). "A plaintiff's evidence of proximate cause may be found legally sufficient

even if his or her expert is unable to quantify the extent to which the defendant's act or omission decreased the plaintiff's chance of a better outcome or increased the injury, as long as evidence is presented from which the jury may infer that the defendant's conduct diminished the plaintiff's chance of a better outcome or increased the injury" (Semel v. Guzman, 84 AD3d 1054, 1055-1056 [2nd Dept. 2011], quoting Goldberg v. Horowitz, 73 AD3d 691, 694 [2nd Dept. 2010], quoting Alicea v. Liguori, 54 AD3d 784, 786 [2nd Dept. 2008]).

Here, this Court is presented with the issue as to whether the defendants deviated or departed from good and accepted medical practice in the care and treatment rendered to Ms. Nicolas, with respect to their management and handling of Ms. Nicolas as to the percutaneous firth femoral sheath, and if so, whether that departure from good and accepted medical and hospital practice was the proximate cause of the injuries/damages that Ms. Nicolas allegedly sustained and her subsequent death. In addition, at issue is whether the risks and alternatives to the procedures that were performed by the defendants were communicated to the plaintiff by said defendants.

Defendant Muhammad F, Khan:

In support of the motion for summary judgment by defendant Dr. Khan and a dismissal of plaintiff's causes of action as against said defendant, counsel offers the affidavit of James N. Slater, board certified in internal medicine and sub-certified in both cardiovascular disease and interventional cardiology.

Dr. Slater notes that Dr. Khan as a cardiology fellow had limited decision making authority and involvement in the treatment and care of Ms. Nicolas. Dr. Slater stated that Dr. Khan had no involvement in the prior catherization procedures performed at the hospital, and the only time he treated Ms. Nicolas was in the evening of October 21, 2015, when he properly recommended earlier administration of antihypertensive medication to ensure the timely removal of the sheath.

As to any claims by the plaintiff related to the negligent performance of cardiac catheterization procedures by Dr. Khan, the expert opines that they are baseless since at the time Dr. Khan had never performed a cardiac catherization and as a cardiac fellow his responsibility was limited to overseeing the care of various cardiac patients at NYPBMH.

Dr. Slater opined that Ms. Nicolas appropriately administered 2,000 units of heparin through the femoral sheath, with an intravenous bolus dose of angiomax. The expert opined that since Ms. Nicolas had an infiltration and was being re-administered heparin, it was necessary and proper to delay removal of the sheath from 8:00 p.m. to 10:00 p.m., to prevent the patient from bleeding out. Additionally, given Ms. Nicolas' high blood pressure and re-heparinization, she was at an extremely high risk of hematoma formation. The expert opined that it was medically appropriate and within the standard of care for Dr. Khan to order the administration of antihypertensive medication ten to fifteen minutes prior to the scheduled 10:00 p.m. removal of the sheath, in order to control Ms. Nicolas' elevated blood pressure and to ensure the timely removal of the sheath. In fact, Nurse Mavroudis testified that it was an acceptable practice for medications to be administered to progressive cardiac unit patients up to an hour earlier than the scheduled time (see Nurse Mavroudis EBT p. 61, 63-64).

Dr. Slater opined that Dr. Khan met the standard of care by delaying the removal of the sheath given the elevated blood pressure, ordering earlier administration of antihypertensive medication and appropriately monitoring Ms. Nicolas through communications with the cardiac unit.

As to the cause of action of lack of informed consent, there is no evidence that any lack of informed consent was a proximate cause of the alleged injuries and Dr. Kahn had no involvement in the actual cardiac catherization procedures.

Additionally, claims of vicarious liability or negligent hiring/supervision and/or training as to Dr. Khan are meritless, since he was a fellow at NYPBMH and was acting under the direction of the attending cardiologist.

Defendant New York Presbyterian Brooklyn Methodist Hospital (NYPBMH):

In support of the motion for summary judgment by defendant NYPBMH and a dismissal of plaintiff's cause of action as against said defendant, counsel also offers the affidavit of James N. Slater, board certified in internal medicine and sub-certified in both cardiovascular disease and interventional cardiology.

Defendant NYPBMH maintains that there is no merit to plaintiff's claim that NYPBMH improperly performed the cardiac catherization and percutaneous coronary intervention, failed to secure the femoral sheath or delayed in removing the sheath in an appropriate manner, and/or

failed to appropriately monitor, care for and treat Ms. Nicolas post operatively. Instead, the evidence indicates that the procedure was properly performed and the post-operative care was appropriately managed.

Dr. Slater explained that the technical aspects of the interventional cardiology procedure were performed in the proper sequence and medications were administered at appropriate times, intervals and dosages. The procedure report demonstrates that the stent placement in all three arteries was successful and performed without complication.

Dr. Slater opined that there is no merit to the claim by the plaintiff that the failure to timely remove the femoral sheath following the interventional cardiology procedure on October 21, 2015 was a deviation from the standard of care. Rather, it would have been a deviation from the standard of care if the sheath had been removed by Dr. Khan at 8:00 p.m., because Ms. Nicolas' intravenous site had been infiltrated, and heparin was administered, and her blood pressure was elevated, making it necessary to delay removal until a later time.

Dr. Slater opined that the nursing staff of NYPBMH had appropriately monitored the patient's vitals and performed timely assessments of the PCI access site/catheter pursuant to the post procedure orders. This was evidenced by the records of NYPBMH and the testimony of Nurse Mavroudis who stated that on October 21, 2015, Ms. Nicolas was appropriately monitored, as she was checked on and the sheath site was assessed every fifteen minutes. Nurse Mavroudis instructed Ms. Nicolas that she should remain flat on her back until removal of the sheath and advised the patient as to the risk of movement. In addition, the vitals were checked every thirty minutes.

Dr. Slater also opined that the interventional cardiologist exercised appropriate judgment in making the determination not to suture the sheath in place and in placing a bandage at the site since Ms. Nicolas was alert and oriented and had no prior history of being non-compliant where she would pull out or tug IV lines or Foley catheters.

At 10:13 p.m. when the nurse's aide discovered blood on the bedsheet, Nurse Mavroudis promptly responded and applied pressure to the site of the bleeding and activated a code 66. At 10:18 p.m., the code team responded by intubating Ms. Nicolas, wherein IO and IV central lines were placed. Despite the return of circulation, Ms. Nicolas coded again within thirty minutes and died at 11:51 p.m. The expert opined that all life saving measures were timely and appropriately implemented which included blood transfusion, IV fluids and medications and that

the administration of vitamin k, hypertonic solution and additional blood products and/or fluids would not have changed the outcome.

In addressing the allegation that NYPBMH failed to consult with a vascular surgeon and an infectious disease specialist, the expert opined that there is no merit to the claim, as the records demonstrate that Ms. Nicolas was consulted by a vascular surgeon on October 9 and October 12, 2105. Additionally, based upon the patient's complaints, an infectious disease consultation was not indicated.

Defendant argues in its reply that the plaintiff's contention that NYPBMH deviated from the standard of care amounts to nothing more than hindsight and speculation and that the determining factor should not be based upon Ms. Nicolas suffering an adverse result.

As to the claim of lack of informed consent, Dr. Slater opined that proper consent was obtained for performance of the procedure from Ms. Larie, the daughter of Ms. Nicolas. Ms. Larie who was named as Ms. Nicolas' health care proxy, routinely made medical decisions on behalf of her mother and provided consent for treatment. The consent form for the October 21, 2015 procedure was obtained from Ms. Larie over the phone. In addition, the medical chart contains documentation by Dr. Haq, physician assistants, as well as anesthesiologists that the risks and alternatives to the procedure were explained. Further, no reasonable, fully informed person in the position of Ms. Nicolas would have declined the cardiac catheterization and angioplasty given the extent of disease and blockage in the artery and her symptoms.

As to the wrongful death cause of action, said action may not be maintained in the absence of a viable underlying claim for malpractice or negligence (see Geffner v. North Shore University Hospital, 75 AD3d 839, 871 NYS2d 617 [2nd Dept. 2008]).

Further, the defendant argues that the plaintiff cannot simultaneously maintain a cause of action directly against NYPBMH based on its vicarious liability for Dr. Khan and a cause of action directly against NYPBMH for negligent hiring, retention, credentialing and supervision. Additionally, the defendant alleges that if the Court were to grant summary judgment as to Dr. Khan, then the plaintiff's claims against NYPBMH should likewise be dismissed.

Dr. Khan and NYPBMH in moving for summary judgment and a dismissal of the plaintiff's causes of action, maintain that they have met their burden of establishing both the absence of any departure and that any alleged departure was not the proximate cause of Ms. Nicolas' alleged injuries as they fully performed their duties as medical professionals.

This Court finds that defendants Dr. Khan and NYPBMH made a prima facie showing of their entitlement to judgment as a matter of law dismissing the complaint insofar as asserted against these defendants by submitting the affirmation of an expert in internal medicine as well as in cardiovascular disease and interventional cardiology, demonstrating that the defendants did not depart from accepted medical practice and that any alleged departure was not a proximate cause of the claimed injuries (see Gachette v. Leak, 172 AD3d 1327, 1329; Breland v. Jamaica Hosp. 49 AD3d 789, 790). The burden then shifted to the plaintiff to establish the existence of a triable issue of fact.

Plaintiff's opposition to defendant Dr. Khan's and NYPBMH Motions to Dismiss*:*

In opposing the motions by defendants for summary judgment and a dismissal of plaintiff's complaint, the plaintiff offers the expert affirmation of a physician who is board certified in internal medicine and cardiovascular disease. The expert opined that the defendants deviated from accepted standards of medical and hospital care in failing to properly and/or appropriately monitor Ms. Nicolas after the performance of a percutaneous coronary intervention (PCI) procedure, in failing to properly manage the patient's blood pressure, in failing to properly secure the percutaneous right transfemoral sheath and in causing and/or allowing Ms. Nicolas to suffer a hemorrhage as a result of dislodgement of the percutaneous right transfemoral sheath.

In addressing the improper management of Ms. Nicolas' blood pressure, the expert considered that metopropol[3] was ordered to be administered after the PCI at 6:44 p.m. Ms. Nicolas was then transferred to the progressive cardiac unit at 7:56 p.m. At all times that evening Ms. Nicolas' blood pressure was elevated significantly. At 8:30 p.m., Ms. Nicolas' blood pressure was 207/90, which level was reported to Dr. Khan by Nurse Mavroudis. However, while Nurse Mavroudis testified that Dr. Khan had advised her to administer metoprolol at 10:00 p.m., and Dr. Khan in a hand written note stated that he advised Nurse Mavroudis to administer the blood pressure medication a little earlier to avoid delays in the femoral sheath pull, the record and testimony confirms that the metopropol was never administered. Nurse Mavroudis testified that she did not end up giving the medication to the patient. She further stated that the medication did not come up from the pharmacy, and thus she did not have it at the time the incident happened (see Nurse Mavroudis EBT p. 65).

[3] Blood pressure medication

Plaintiff's expert opined that Dr. Khan departed from good and accepted medical practice in failing to place a stat order for the administration of medication to manage Ms. Nicolas' blood pressure and in failing to ensure that the order was carried out. Since Dr. Khan was the physician on call for any issues that Ms. Nicolas may have had in the progressive cardiac unit, it was his responsibility to ensure that the medication order was filled. The expert further opined that Nurse Mavroudis and the staff of NYPBMH departed from good and accepted hospital practice in failing to carry out orders for administering blood pressure medication and/or failing to do so in a timely manner. The expert stated that elderly patients who have elevated blood pressure are at an increased risk for vascular complications which includes both bleeding and hemorrhaging. The failure to manage Ms. Nicolas' blood pressure and the resulting complications therefrom were substantial contributing factors to the dislodgement of the sheath and the hemorrhaging which caused her cardiac arrest and was a proximate cause of her injuries and wrongful death.

The expert further opined that Dr. Khan departed from good and accepted medical practice in failing to timely remove Ms. Nicolas' femoral sheath and it was a proximate cause of her injuries and wrongful death. Plaintiff's expert disagreed with the opinion of defendants' expert Dr. Slater that the standard of care was met by delaying the removal of the sheath given Ms. Nicolas elevated blood pressure. Rather, the continued presence of the femoral sheath with the blood pressure at the high level it was at, placed Ms. Nicolas at a greater risk.

The expert opined that the defendants failed to closely monitor Ms. Nicolas in the progressive cardiac unit. When Nurse Mavroudis noted Ms. Nicolas was unconscious at 10:13 p.m., the patient was in hypovolemic shock. By the time Ms. Nicolas had reached this stage of hypovolemic shock, the heart rate would have already increased to over 120 BPM.

The expert also opined that the defendants departed from good and accepted medical practice in failing to properly secure the percutaneous right transfemoral sheath. In that the patient was elderly with unmanaged blood pressure and with the presence of the sheath due to prior excessive anticoagulation, the good and accepted practice to minimize the risk of bleeding and hemorrhage would have been to properly secure the sheath by use of sutures and bandages to prevent it from being dislodged. The expert stated that if the transfemoral sheath was appropriately secured it should not have dislodged and the notes in the medical record that the patient may have pulled the sheath are unsupported and self-serving.

Finally, as to Dr. Khan, the fact that the defendants maintain that Dr. Khan was simply a cardiology fellow who did not examine Ms. Nicolas prior to the dislodgment of the sheath should not in any way diminish his responsibility for the care of the patient in this matter. Rather, since a physician was not situated in the unit where the patients who had undergone a cardiac catherization were placed, Dr. Khan, as a fellow, was responsible for responding to the nurses and performing such functions as removing a sheath (see Nurse Mavroudis EBT p. 15-17). Neither the medical records nor testimony of any party indicates that Dr. Khan was acting under Dr. Haq's supervision and/or control. Instead, it appears from the record and testimony that Dr. Khan had acted independently in giving directions to Nurse Mavroudis with regard to both the management of the patient's blood pressure as well as the timing of the removal of the femoral sheath.

The expert opined that each of the aforementioned departures from good and accepted medical and hospital practice were a substantial contributing factor and proximate cause of Ms. Nicolas' injuries, significantly diminished the patient's chances for a better outcome, and deprived her of a more favorable prognosis which led to cardiac arrest and wrongful death.

This Court finds that the plaintiff has raised a question of fact with the submission of an expert affidavit which offered a detailed opinion as to the treatment rendered to Ms. Nicolas which conflicted with defendants' experts pinion, sufficient to warrant denial of summary judgment and a dismissal of the causes of action pertaining to claims of malpractice and negligence as to the defendants (see Conteras v. Adeyemi, 102 AD3d 720, 721, 958 NYS2d 430 [2nd Dept. 2013]); Shahid v. NYC Health & Hosps. Corp., 47 AD3d 798, 850 NYS2d 521 [2nd Dept. 2008]).

In reaching this determination, this Court considered that the medical experts have offered conflicting opinions pertaining to whether the defendants properly and/or appropriately monitored Ms. Nicolas after the performance of a percutaneous coronary intervention (PCI) procedure, properly managed her blood pressure, properly secured the percutaneous right transfemoral sheath, recognized that Ms. Nicolas' heart rate had accelerated beyond normal limits, and caused and/or allowed the patient to suffer a hemorrhage as a result of dislodgement of the sheath. There are also differing opinions offered as to the involvement and responsibility of Dr. Khan, as to whether he was acting merely as a resident under Dr. Haq's supervision and/or

control, or did he have decision making responsibilities while Ms. Nicolas was a patient in the progressive cardiac unit which raises an issue of fact requiring a trial.

It is well settled that where parties to a medical malpractice action offer conflicting expert opinions on the issue of malpractice and causation, issues of credibility require resolution by the factfinder (see Loaiza v. Lam, 107 AD3d 951, 953 [2013]; Omane v. Sambaziotis, 150 AD3d 1126, 1129 [2nd Dept. 2017]; Dandrea v. Hertz, 23 AD3d 332, 333 [2005]). Summary judgment is not appropriate in a medical malpractice action where the parties adduce conflicting medical opinions (see Elmes v. Yelon, 140 AD3d 1009, 1011 [2nd Dept. 2016]; Feinberg v. Feit, 23 AD3d 517, 519 [2nd Dept. 2005]; Shields v. Baktidy, 11 AD3d 671, 672 [2nd Dept. 2014]).

In addressing the portion of the motion by the defendants which seeks a dismissal of the cause of action as to lack of informed consent, a plaintiff must prove (1) the person providing the professional treatment failed to disclose alternatives thereto and failed to inform the patient of reasonably foreseeable risks associated with the treatment, and the alternatives, that a reasonable medical practitioner would have disclosed in the same circumstances; 2) that a reasonably prudent patient in the same position would not have undergone the treatment if he or she had been fully informed; and (3) that the lack of informed consent is a proximate cause of the injury (see Zapata v. Buitriago, 107 AD3d 977, 979, 969 NYS2d 79 [2nd Dept. 2013]; Spano v. Bertocci, 299 AD2d 335, 749 NYS2d 275 [2nd Dept. 2002]).

In determining this motion, this Court considered the argument by defendants that both Ms. Larie and her mother, Ms. Nicolas, were informed of the reasonably foreseeable risks and alternatives to the interventional cardiology procedure on October 21, 2015 at several times throughout her admission to NYPMH. Telephone consent was obtained to perform the cardiac catheterization and percutaneous coronary intervention from Ms. Larie at 3:10 p.m. on October 21, 2015 (see "Permission for Operation and/or Procedure" contained in NYPMH med. records p. 630 annexed as Exhibit "D" to defendant NYPMH Motion to Dismiss). The defendant maintains that the telephone consent was properly witnessed and executed by the physician who attests that he explained the purpose, benefits, risks and alternatives to the proposed procedure. In addition, PA Naverette documented that telephone consent was also obtained on October 21, 2015 from Ms. Larie in a pre-procedure interventional cardiology note. Finally, Dr. Haq in a cardiac catheterization comprehensive report documented that the risks and alternatives of the procedures and conscious sedation were explained and informed consent was obtained (see

NYPMH med. records p. 391 annexed as Exhibit "D" to defendant NYPMH Motion to Dismiss). Additionally, Dr. Kahn maintained that he had no involvement in the actual cardiac catherization procedures, and thus he was not involved in obtaining the plaintiff's consent.

This Court finds that the plaintiff did not offer adequate proof nor set forth the elements necessary to establish the prima facie claim of lack of informed consent. Here, it appears that the defendants explained the procedure as well as the ramifications to Ms. Larie who provided her consent. This Court further determined that a reasonably prudent person in the same position as Ms. Nicolas would have undergone the procedures and would not have declined the cardiac catheterization and angioplasty given the extent of disease and blockage in the artery and her symptoms. Further, any lack of informed consent did not proximately cause any injury (see Johnson v. State Is. Med. Group, 82 AD3d 708, 918 NYS2d 132 [2nd Dept. 2011]); Trabal v. Queens Surgi-Center, 8 AD3d 555, 557, 779 NYS2d 504 [2004]).

As such, this Court finds that the plaintiff failed to raise an issue of fact with respect to the cause of action of lack of informed consent (see Johnson v. State Is. Med. Group, 82 AD3d at 709-710), and that portion of the motion by defendants to dismiss the cause of action for lack of informed consent is granted.

Conclusion:

The motions by the defendants, Dr. Khan and New York-Presbyterian Brooklyn Methodist Hospital s/h/a New York Methodist Hospital (NYPMH) for summary judgment and a dismissal of plaintiff's complaint, pursuant to CPLR§ 3212(a)(b)(c) and 3212, respectively, with regard to the causes of action pertaining to negligence, malpractice, wrongful death and lack of informed consent are granted only to the extent of dismissing the cause of action of lack of informed consent against both defendants. In addition, the cause of action for negligent hiring/supervision and/or training as to defendant Dr. Khan, who was a fellow at NYPMH, lacks merit and is therefore dismissed. In all other respects, the relief sought by the defendants in their motions is denied.

This shall constitute the decision and order of this Court.

Dated: May 28, 2020
Brooklyn, New York

ENTER

Hon. Bernard J. Graham, Justice
Supreme Court, Kings