SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NEW YORK, PART 10

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RENUKA TYAGI AND VIJAY BONDADA **Index №.805206/2015**

Plaintiffs

-against-

FARIDA GADELLA, M.D., ANASTASIA GRIVOYANNIS, M.D., AND NEW YORK PRESBYTERIAN HOSPITAL

Defendants

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HON. GEORGE J. SILVER:

In this medical malpractice action, defendants FARIDA GADALLA, M.D. ("Dr. Gadalla"), ANASTASIA GRIVOYANNIS, M.D. ("Dr. Grivoyannis"), and THE NEW YORK AND PRESBYTERIAN HOSPITAL ("NYPH")(collectively, "defendants") move for summary judgment and an order dismissing the complaint of plaintiff RENUKA TYAGI ("plaintiff") as against them. Plaintiff opposes defendants' application.

BACKGROUND AND ARGUMENTS

As is relevant to this motion, plaintiff alleges that defendants inappropriately administered anesthesia during plaintiff's orthopedic surgery, thereby causing plaintiff to experience a hypoxic episode, or brain injury precipitated by the lack of oxygen. As a result of the foregoing, plaintiff alleges that she suffers from permanent brain damage, including a frontal lobe injury, and impairment of her optic nerve. In addition, plaintiff submits that she experiences lingering balance issues, fatigue, and depression. Plaintiff further states that she has a decreased earning capacity as a result of her alleged deficits.

In support of the instant motion, defendants submit that the anesthesia plan at issue was discussed with plaintiff by both her attending orthopedic surgeon, Dean Lorich, M.D. ("Dr. Lorich") and her attending anesthesiologist, Dr. Gadalla. Defendants further emphasize that plaintiff specifically requested that Dr. Gadalla perform the anesthesia, because Dr. Gadalla had previously performed epidurals for plaintiff, thereby evidencing an awareness of the anesthesia plan. In addition, defendants argue that the records and testimony indicate that discussions regarding the risks, benefits, and alternatives to the procedure were discussed with plaintiff.

To support their claims, defendants annex the expert affirmation of board-certified neurologist David M. Kaufman, M.D., ("Dr. Kaufman") who opines that the evidence within the record cannot support plaintiff's claim of optic nerve damage. Specifically, Dr. Kaufman emphasizes that the records indicate that

plaintiff had a prior history of seeing spots in her visual acuity, and had been diagnosed with salt and pepper retinopathy prior to the events at issue. In addition, neuro-ophthalmologist Janet Rucker, M.D. ("Dr. Rucker") specifically states that plaintiff's records are devoid of any evidence of optic nerve or chiasmal dysfunction.[1] Moreover, Dr. Rucker opines that plaintiff's MRI was normal and showed no evidence of optic nerve damage.

In addition, defendants' expert anesthesiologist, James Eisenkraft, M.D. ("Dr Eisenkraft") opines that plaintiff maintained a normal heart rate, pulse rate, and was never cyanotic (exhibiting a bluish or grayish in skin color) as a result of the anesthesia at issue. Therefore, Dr. Eisenkraft opines that an analysis of the level of oxygen in plaintiff's blood would not have changed the management of plaintiff's care. Dr. Eisenkraft further opines that plaintiff's anesthesia was properly and timely administered and that defendants properly responded to plaintiff's needs throughout plaintiff's operation. Moreover, Dr. Eisenkfraft opines that it was within Dr. Grivoyannis' medical judgment to administer additional anesthesia when she believed that the same was necessary to protect the integrity and safety of the ongoing orthopedic surgery, which included the placement of hardware. Additionally, Dr. Eisenkraft explains that complications of anesthesia, including respiratory depression, can occur in the absence of negligence and the proper way to alleviate these complications is to timely and appropriately respond to them, which happened in this case. As a result, Dr. Eisenkraft opines that plaintiff's heart rate properly increased slightly as an appropriate coping mechanism to make sure that her body was perfused with oxygenated blood. Following plaintiff's surgery, Dr. Eisenkraft opines that plaintiff showed no objective signs of brain damage. Dr. Eisenkraft also opines that the 10 mg of Propofol administered by Dr. Grivoyannis to plaintiff was within normal limits, even on top of plaintiff's Propofol infusion rate of 50 mcg/kg/min.

In totality, defendants' experts opine that the care and treatment rendered by defendants was at all times within the standard of care. To be sure, defendants' experts collectively submit that defendants properly obtained informed consent, properly and appropriately administered anesthesia intra-operatively, and appropriately utilized their medical judgment when it appeared that plaintiff moved intra-operatively. Moreover, defendants' experts submit that defendants timely and appropriately responded to plaintiff's desaturation episode and properly intubated plaintiff, thereby ending any potential hypoxic events. As defendants submit that their care was at all times appropriate, and therefore was not the proximate cause of plaintiff's alleged injuries, defendants ask that this court issue an order granting judgment in their favor.

In opposition, plaintiff annexes two expert affirmations from an anesthesiologist and neurologist, respectively.[2] Significantly, plaintiff's expert anesthesiologist opines that Dr. Grivoyannis, Dr. Gadalla and NYPH deviated from accepted medical practice by failing to administer a safe dosage of Fentanyl and Propofol to plaintiff. In addition, plaintiff's expert anesthesiologist opines that Dr. Gadalla failed to properly instruct and/or supervise resident physician Dr. Grivoyannis when Dr. Gadalla stepped out of the operating

[1] Chiasmal syndrome is the set of signs and symptoms that are associated with lesions of the optic chiasm, manifesting as various impairments of the sufferer's visual field according to the location of the lesion along the optic nerve.
[2] The affirmations of the plaintiffs' experts have the experts' names and signatures redacted in order to conceal the experts' identities in accordance with CPLR §3101(d)(l)(i).

room for a break. Furthermore, plaintiff's expert anesthesiologist states that Dr. Grivoyannis failed to properly monitor the plaintiff's condition, and failed to immediately respond to the decline in plaintiff's oxygen saturation rates. Collectively, plaintiff's anesthesiologist opines that defendants deviated from accepted medical practice by failing to implement proper measures in response to plaintiff's decline in oxygen saturation, including applying a masked ventilation to check for a response. For each identified departure, plaintiff's expert anesthesiologist states that defendants' actions proximately contributed to plaintiff's alleged injuries, including hypoxic brain damage.

More specifically, plaintiff's expert neurologist describes how plaintiff's present condition is consistent with what is called "delayed post anoxic/hypoxic encephalopathy" and how a respiratory arrest has an effect on the brain and on the rest of the body. Plaintiff's expert neurologist also discusses how the pathophysiology and micro-pathologies of plaintiff's brain damage are beyond the resolution of ordinary MR and CT brain imaging. Most significantly, plaintiff's expert neurologist challenges Dr. Kaufman's assertion that plaintiff's alleged injuries are inconsistent with a respiratory arrest of the length that plaintiff endured. Plaintiff's expert conclude that defendants' actions were substantial factors in causing plaintiff's injuries. Consequently, plaintiff argues that judgment in defendants' favor is inappropriate at this juncture.

In reply, defendants' challenge plaintiff's expert affirmations and the conclusions drawn therefrom. To be sure, defendants argue that plaintiff failed to submit sufficient expert testimony proving deviations from accepted standards of medical care that proximately caused plaintiff's alleged injuries. Most glaringly, defendants state that plaintiff's opposition is not confined to the alleged malpractice identified in plaintiff's bill of particulars. Rather, defendants submit that plaintiff's opposition raises new theories of liability that were not previously advanced by plaintiff. Defendants also state that plaintiff does not oppose several branches of defendants' motion, including defendants' application to dismiss plaintiff's claim of a lack of informed consent. In sum, defendants reiterate the arguments made in their moving papers, and renew their argument that judgment in their favor is warranted.

DISCUSSION

In an action premised upon medical malpractice, a defendant doctor or hospital establishes prima facie entitlement to summary judgment when he or she establishes that in treating the plaintiff there was no departure from good and accepted medical practice or that any departure was not the proximate cause of the injuries alleged (*Roques v. Noble*, 73 AD3d 204, 206 [1st Dept 2010]; *Thurston v Interfaith Med. Ctr.*, 66 AD3d 999, 1001 [2d Dept. 2009]; *Myers v Ferrara*, 56 AD3d 78, 83 [2d Dept. 2008]; *Germaine v Yu*, 49 AD3d 685 [2d Dept 2008]; *Rebozo v Wilen*, 41 AD3d 457, 458 [2d Dept 2007]; *Williams v Sahay*, 12 AD3d 366, 368 [2d Dept 2004]). In claiming that treatment did not depart from accepted standards, the movant must provide an expert opinion that is detailed, specific and factual in nature (*see e.g., Joyner-Pack v. Sykes*, 54 AD3d 727, 729 [2d Dept2008]). The opinion must be based on facts within the record or personally known to the expert (*Roques*, 73 AD3d at 207, *supra*). Indeed, it is well-settled that expert testimony must be based on facts in the record or personally known to the witness, and that an expert cannot reach a conclusion by assuming material facts not supported by record evidence (*Cassano v Hagstrom*, 5 NY2d 643, 646 [1959]; *Gomez v New York City Hous. Auth.*, 217 AD2d 110, 117 [1st Dept 1995]; *Matter of Aetna Cas.*

& Sur. Co. v Barile, 86 AD2d 362, 364-365 [1st Dept 1982]). Thus, a defendant in a medical malpractice action who, in support of a motion for summary judgment, submits conclusory medical affidavits or affirmations, fails to establish prima facie entitlement to summary judgment (*Winegrad v New York Univ. Med. Ctr.*, 64 NY2d 851, 853 [1985]; *Cregan v Sachs*, 65 AD3d 101, 108 [1st Dept 2009]; *Wasserman v Carella*, 307 AD2d 225, 226 [1st Dept 2003]). Further, medical expert affidavits or affirmations, submitted by a defendant, which fail to address the essential factual allegations in the plaintiff's complaint or bill of particulars do not establish prima facie entitlement to summary judgment as a matter of law (*Cregan*, 65 AD3d at 108, *supra*; *Wasserman*, 307 AD2d at 226, *supra*). To be sure, the defense expert's opinion should state "in what way" a patient's treatment was proper and explain the standard of care (*Ocasio-Gary v. Lawrence Hosp.*, 69 AD3d 403, 404 [1st Dept 2010]). Further, it must "explain 'what defendant did and why'" (*id. quoting Wasserman v. Carella*, 307 AD2d 225, 226 [1st Dept 2003]).

Once the defendant meets its burden of establishing prima facie entitlement to summary judgment, it is incumbent on the plaintiff, if summary judgment is to be averted, to rebut the defendant's prima facie showing (*Alvarez v Prospect Hosp.*, 68 NY2d 320, 324 [1986]). The plaintiff must rebut defendant's prima facie showing without "[g]eneral allegations of medical malpractice, merely conclusory and unsupported by competent evidence" (*id.* at 325). Specifically, to avert summary judgment, the plaintiff must demonstrate that the defendant did in fact commit malpractice and that the malpractice was the proximate cause of the plaintiff's injuries (*Coronel v New York City Health and Hosp. Corp.*, 47 AD3d 456 [1st Dept. 2008]; *Koeppel v Park*, 228 AD2d 288, 289 [1st Dept. 1996]). To meet the required burden, the plaintiff must submit an affidavit from a medical doctor attesting that the defendant departed from accepted medical practice and that the departure was the proximate cause of the injuries alleged (*Thurston*, 66 AD3d at 1001, *supra*; *Myers*, 56 AD3d at 84, *supra*; *Rebozo*, 41 AD3d at 458, *supra*).

Here, defendants' submission of deposition transcripts, medical records and expert affirmations based upon the same established a prima facie defense entitling them to summary judgment (*Balzola v Giese*, 107 AD3d 587 [1st Dept 2013]). To be sure, Drs. Kaufman, Rucker, and Eisenkraft collectively opine, based upon ample support within the record, that the care and treatment rendered to plaintiff by defendants was within the parameters of good and accepted medical practice. To be sure, Dr. Kaufman makes repeated reference to the records when advancing his position that there is no evidence to support plaintiff's claims of optic nerve damage. On this point, Dr. Kaufman's opinion is buttressed by the opinion of Dr. Rucker, who highlights that plaintiff's MRI was normal and showed no evidence of optic nerve damage. In addition to referencing the lack of evidence supporting plaintiff's claim of optic nerve damage, each physician also emphasizes that defendants care comported with accepted standards of medical practice.

Beyond these observations, Dr. Eisenkraft challenges plaintiff's supposition that testing to measure the level of oxygen, carbon dioxide, and pH within plaintiff's blood would have yielded evidence of plaintiff's alleged compromised state. To be sure, Dr. Eisenkraft highlights evidence within the record that reveals that defendants observed the fact that plaintiff maintained a normal heart rate, and was never cyanotic during her surgery. Such findings, in Dr. Eisenkraft's view, show that blood testing was unnecessary, and would not have changed plaintiff's course of treatment. Dr. Eisenkraft further notes that defendants' administration of Fentanyl and Propofol was proper, as both medications were administered in small doses.

Dr. Eisenkraft also posits that even as a resident physician, Dr. Grivoyannis was within right as a medical professional to administer anesthetic medications without the direct supervision of her attending physician, Dr. Gadalla.

Collectively, the opinions advanced by defendants' experts present a reasoned, and medically sound conclusion that the administration of anesthetic medications and treatments to plaintiff did not proximately cause the injuries alleged. As defendants' experts' opinions are predicated upon ample support within the record, defendants have shown that plaintiff was treated in full accord with good and accepted standards of medical care, and that there were no departures of care attributable to defendants that proximately caused plaintiff's alleged injuries.

In opposition to defendants prima facie showing, plaintiff raises limited triable issues of fact sufficient to preclude a full finding of summary judgment in defendants' favor. To be sure, plaintiff highlights that plaintiff's experts differ with the opinions espoused by defendants' experts on the issue of whether blood testing would have revealed that plaintiff's desaturation episode was of sufficient length to impair perfusion to plaintiff's vital organs. Indeed, while Dr. Eisenkraft indicates that blood testing was not indicated in face of plaintiff's normal heart rate, plaintiff's experts opine that it was a deviation of care not to provide such testing. Plaintiff's experts further opine that defendants' deviation of care had a material impact on plaintiff's outcome, as plaintiff was allegedly caused to suffer a respiratory arrest and allowed to continue in such a state for approximately 8.5 minutes as a result of defendants' failure to properly respond and intervene. In plaintiff's experts' view, defendants' deviations caused plaintiff to suffer anoxia and significant cognitive deficits, including the loss of her job as a physician, surgeon and faculty member.

When tasked with differing opinions on the ultimate issue of causation, a court cannot substitute the fact-finding role of a jury with its own judgment. Indeed, while defendants' experts opinion that blood testing to measure the level of oxygen, carbon dioxide, and pH in plaintiff's blood would not have yielded a different outcome, plaintiff's experts opine that plaintiff's present condition could have been circumvented entirely had defendants appropriately responded to plaintiff's respiratory arrest. As plaintiff's experts' affirmations, like the affirmations of defendants' experts, are predicated upon support within the record on this point, a triable issue of fact has been raised. Where, as here, the affirmation of defendants' experts is credibly challenged on a material point by plaintiff's own expert affirmations, there is insufficient evidence to credit the conclusions of one set of experts over the conclusions of others. Indeed, the weight to afford the respective expert's conclusions is for a jury, not this court, to decide. To be sure, the very fact that plaintiff's experts' opinions differ from those proffered by defendants' experts illustrates the existence of issues of triable fact. "Summary judgment is not appropriate in a medical malpractice action where the parties adduce conflicting medical expert opinions" (*Elmes v. Yelon*, 140 AD3d 1009 [2d Dept 2016] [citations and internal quotation marks omitted]). Instead, the conflicts must be resolved by the fact finder (id.). Indeed, it is well-established that summary judgment is not appropriate in a medical malpractice action where the parties adduce conflicting medical expert opinions (*Barbuto v Winthrop Univ. Hosp.*, 305 AD2d 623, 624 [2d Dept 2003]), and the experts' competing opinions on causation present an issue of fact for a jury to decide (*Carnovali v Sher*, 121 AD3d 552 [1st Dept 2014]).

However, plaintiff's opposition notably does not challenge defendants' prima facie showing in a number of other areas. In the case at bar, as noted in defendants' moving papers, plaintiff alleges, *inter alia*, a lack of informed consent; the improper administration of an overdose of Fentanyl epidural bolus; improperly causing ischemic optic nerve injury; failure to do timely blood testing; and failure to recognize the significance of performing timely blood testing. Plaintiff's opposition adequately address the latter two claims with respect to blood testing, however, plaintiffs' experts wholly ignore the remaining allegations and do not address them in their opposition, other than to admit that the Fentanyl that was injected by the defendants in the epidural space "would not be expected to have any effect on the patient's ability to ventilate or oxygenate."

Relevantly, plaintiffs' experts never opine that the consent provided to plaintiff was inadequate. Accordingly, the cause of action for lack of informed consent is dismissed. As the Court of Appeals has stated, "[t]o succeed in a medical malpractice cause of action premised on lack of informed consent, a plaintiff must demonstrate that (1) the practitioner failed to disclose the risks, benefits and alternatives to the procedure or treatment that a reasonable practitioner would have disclosed and (2) a reasonable person in the plaintiffs position, fully informed, would have elected not to undergo the procedure or treatment (*Orphan v. Pilnik*, 15 NY3d 907, 908 [2010]; *see also* Public Health Law §2805-d [1], [3]). Expert medical testimony is required to prove the insufficiency of the information disclosed to a plaintiff (CPLR §4401-a). Here, plaintiff herself testified that "she was in agreement prior to the procedure about the anesthesia plan and consented to it." Moreover, plaintiffs' experts do not opine that informed consent was inadequate. Therefore, plaintiffs' claim for lack of informed consent is dismissed as a matter of law.

In addition, with respect to plaintiff's claim that defendants' actions caused damage to plaintiff's optic nerve, neither of plaintiffs' experts specifically address this allegation. More specifically, neither plaintiffs' anesthesiology expert nor plaintiffs' neurology expert refute Dr. Rucker's contemporaneous medical record that specifically states that no evidence of damage to plaintiff's optic nerve exists. Therefore, plaintiff's claim that defendants caused damage to plaintiff's optic nerve is dismissed.

Likewise, plaintiff's allegation that defendants improperly administered an overdose of Fentanyl epidural bolus, is inadequately supported by plaintiff's experts. In the first instance, defendants properly established, via the expert opinion of Dr. Eisenkraft, that the administration of Fentanyl was proper. First, Dr. Eisenkraft expressed the opinion that since Dr. Grivoyannis was a resident, i.e., she had already obtained her medical degree, it was within her medical judgment to order and/or administer anesthetic medication without direct supervision of her attending physician, Dr. Gadalla. Dr. Eisenkraft further states that the 10 mg of Propofol administered by Dr. Grivoyannis was within her medical judgment to administer and was a very small dose that would not be expected to cause a respiratory depression, even on top of the patient's Propofol infusion rate of 50 mcg/kg/min. Moreover, Dr. Eisenkraft opines that the additional epidural of 4cc Bupivacaine 0.5% and 50 meg Fentanyl would also not be expected to cause a respiratory depression, as it was administered in the epidural space, not intravenously. Nonetheless, Dr. Eisenkraft opines that complications from anesthesia, including respiratory issues, can occur in the absence of negligence and that it was possible that the medication infusion may have contributed to plaintiff's respiratory depression, absent any negligence, but due to an unforeseen sensitivity to these medications. In opposition, plaintiffs'

anesthesiology expert acknowledges experience with the administration of anesthesia, but never once criticizes the documented administration doses of Fentanyl or Propofol. Specifically, plaintiffs' anesthesiology expert opines that Fentanyl was injected into the epidural space and "would not be expected to have any effect on the patient's ability to ventilate or oxygenate." As such, plaintiff's anesthesiology expert directly acknowledges that the Fentanyl administered was not an overdosed amount. As such, all of plaintiffs' allegations as to the administration of Fentanyl by the defendants necessary warrant dismissal, as the court has searched the record and finds no triable issue of fact with respect to the administration of Fentanyl.

Notably, plaintiff's allegations about the improper administration of Propofol emerged for the first time in opposition to defendants' motion for summary judgment. To be sure, plaintiff does not allege that defendants improperly administered Propofol in plaintiff's original bill of particulars. Instead, plaintiff only now raises the specter of plaintiff's alleged decrease in oxygen saturation being attributable to an alleged overdose of Propofol. It is axiomatic that a plaintiff cannot defeat a summary judgment motion that made out a prima facie case by merely asserting, without more, a new theory of liability for the first time in opposition papers (*Biondi v. Behrman*, 149 AD3d 562, 563-564 [1st Dept 2017]). Therefore, this court cannot consider this new theory of liability raised here for the first time in opposition to defendants' motion for summary judgment.

Notably, even if this were not the case, plaintiffs' anesthesiology expert admits that it is "medically impossible for an additional 10 mg bolus of Propofol to have caused a complete respiratory arrest...". Therefore, plaintiffs' anesthesiology expert acknowledges that this dose, which the records and testimony specifically establish was administered by Dr. Grivoyannis, was not an overdosed amount. Consequently, plaintiff has no support for the theory that Dr. Grivoyannis administered an overdose of Propofol. Therefore, plaintiff cannot support a claim premised on defendants' improper administration of Propofol. As such, any such claim is dismissed.

Accordingly, based on the foregoing, it is hereby

ORDERED that defendants' motion for summary judgment is granted to the extent that plaintiff's claims of malpractice predicated upon a lack of informed consent, the improper administration of an overdose of Fentanyl epidural bolus and Propofol, and improperly causing ischemic optic nerve injury, are dismissed; and it is hereby

ORDERED that defendants' motion is denied as to plaintiff's claims of malpractice premised on the failure to do timely blood testing, and the failure to recognize the significance of performing timely blood testing; and it is further

ORDERED that defendants are directed to file and serve a copy of this decision and order, with notice of entry, within 20 days of its issuance; and it is further

ORDERED that the Clerk is directed to enter judgment in favor of defendants to the extent indicated; and it is further

ORDERED that the parties are directed to appear for a virtual pre-trial conference on Tuesday July 15, 2020 at the courthouse located at 111 Centre Street, Room 1227 (Part 10). Time to be determined.

This constitutes the decision and order of the court.

Dated: June 15, 2020

George J. Silver

GE... J.S.C.

Tyagi and Bondada
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