Yesko v Del Pizzo
2020 NY Slip Op 34054(U)
December 2, 2020
Supreme Court, New York County
Docket Number: 805218/12
Judge: Joan A. Madden

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NEW YORK: PART 11

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WILLIAM YESKO, As Administrator of the Estate of BARBARA YESKO, Deceased, and WILLIAM YESKO, as Executor of the Estate of THOMAS YESKO, Deceased,

Plaintiffs,

-against-

JOSEPH DEL PIZZO, M.D. and NEW YORK PRESBYTERIAN HOSPITAL,

Defendants.

INDEX NO. 805218/12

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JOAN A. MADDEN, J.:

In this action for medical malpractice and wrongful death involving the surgical removal of decedent Barbara Yesko's left kidney, defendants Joseph Del Pizzo, M.D. and New York Presbyterian Hospital ("NYPH" or the hospital) are moving for summary judgment and plaintiffs oppose.[1]

On April 27, 2010, Dr. Joseph DelPizzo performed a laparoscopic hand-assisted nephrectomy (removal of left kidney) on Ms. Yesko at NYPH. She was 73 years old at the time and her left-kidney was non-functioning. Based on the affirmation of their expert urologist, plaintiffs allege that defendants departed from the standard of care by: 1) perforating Ms. Yesko's colon during the April 27, 2010 surgery; 2) failing to properly inspect the bowel/colon

[1]The complaint also asserts claims for lack of informed consent, and negligent hiring, training, supervision, privileging and credentialing. With respect to a lack of informed consent claim, expert medical opinion is required to establish the insufficiency of the information disclosed to a patient. See Orphan v. Pilnik, 15 NY3d 907 (2010). Plaintiffs' expert offers no opinion about the insufficiency of the information Dr. Del Pizzo provided to Ms. Yesko prior to surgery, so the lack of informed consent claim is deemed withdrawn or abandoned, and will be dismissed. Moreover, plaintiffs' opposition is silent as to the claim for negligent hiring, training, supervision, privileging and credentialing, so that claim will be dismissed, as well.

during surgery, recognize the colonic perforation and repair it intraoperatively; 3) failing to have an intraoperative consultation by a colorectal or general surgeon to inspect the colon/bowel prior to closing Ms. Yesko; and 4) failing to timely and properly appreciate and investigate Ms. Yesko's postoperative signs, symptoms and blood work indicating she was suffering from a colonic perforation that evolved into a colonic fistula. Plaintiffs' expert opines that as a result of such departures, Ms. Yesko suffered significant pain, permanent injuries and complications, including rapid infection, severe sepsis, the need for a colostomy, respiratory distress, malnourishment, deconditioning and eventual death.[2]

The following facts are not disputed unless otherwise noted. Ms. Yesko first saw Dr. Del Pizzo on April 12, 2010, on referral from non-party Dr. Rodman for a non-functioning left kidney and recurrent urinary/kidney infections. She had recently been hospitalized in March 2010, when a ureteral stent was inserted for an obstructed left kidney. Dr. Del Pizzo diagnosed a chronically inflamed and a non-functioning left kidney and recommended surgery to remove the kidney, consisting of a hand-assisted laparoscopic left nephrectomy. On April 19, 2010, Ms. Yesko returned to Dr. Del Pizzo and signed a consent form for the surgery.

On April 27, 2010, Dr. Del Pizzo performed a hand-assisted laparoscopic left nephrectomy on Ms. Yesko, and placed a Jackson Pratt drain ("JP drain") at the operative site to prevent infection from forming in the surgical bed. According to the medical records and Dr. Del Pizzo's testimony, during surgery, at least two bowel deserosalizations were repaired with sutures, and a small laceration or disruption to the capsule of the spleen was repaired with

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[2]To the extent the complaint and the bills of particulars allege any other departures that are not addressed by plaintiffs' expert, those departures are deemed abandoned or withdrawn, and the Court will not address them, and they will be dismissed.

Floseal and Surgicel.[3] On May 4, 2010, a CT scan of Ms. Yesko's abdomen showed a colonic fistula through which fecal matter was leaking into the cavity where the kidney had been removed and draining out through the JP drain. The fistula was initially treated with antibiotics, but ultimately required a colostomy. Ms. Yesko was released from the hospital on June 23, 2010, and readmitted on June 27, 2020, where she remained until November 12, 2010. From that time until her death on March 23, 2011, she was either in a nursing home/rehab facility, in the hospital or at home.

On August 14, 2012, plaintiffs commenced the instant action against Dr. Del Pizzo and NYPH, asserting claims against both defendants for medical malpractice, lack of informed consent, wrongful death and loss of services, and against NYPH for negligent hiring, training, supervision, privileging and credentialing.[4] Defendants answered and are now moving for summary judgment dismissing the complaint in its entirety.

A defendant moving for summary judgment in a medical malpractice action must make a prima facie showing of entitlement to judgment as a matter of law by showing 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. Nobel, 73 AD3d 204, 206 (1st Dept 2010). To satisfy this burden, defendant must present expert opinion testimony that

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[3]Dr. Del Pizzo testified that a deserosalization is a opening or "rent" in the serosa of the bowel, which is the outmost portion of the bowel, and that he repaired the deserosalizations intraoperatively with a suture so as to reapproximate the edges of the serosa.

Although the complaint and bills of particulars allege a departure based on the injury to Ms. Yesko's spleen, plaintiffs' expert offers no opinion as to the splenic injury, so the departure based on that injury is deemed abandoned or withdrawn.

[4]As noted above, the claims for lack of informed consent, and negligent hiring, training, supervision, privileging and credentialing, are being dismissed.

is supported by the facts in the record, addresses the essential allegations in the complaint or the bill of particulars, and is detailed, specific and factual in nature. See id; see Joyner–Pack v. Sykes, 54 AD3d 727, 729 (2nd Dept 2008). Expert opinion must be based on facts in the record or those personally known to the expert, and the opinion of defendant's expert should specify "in what way" the patient's treatment was proper and "elucidate the standard of care." Ocasio-Gary v. Lawrence Hospital, 69 AD3d 403, 404 (1st Dept 2010). Defendant's expert opinion must "explain 'what defendant did and why.'" Id (quoting Wasserman v. Carella, 307 AD2d 225, 226 [1st Dept 2003]).

"[T]o avert summary judgment, plaintiff must demonstrate that the defendant did in fact commit malpractice and that the malpractice was the proximate cause of the plaintiff's injuries." Roques v. Nobel, supra at 207. To meet this burden, "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." Id. If the parties' conflicting expert opinions are adequately supported by the record, summary judgment must be denied. See Frye v. Montefiore Medical Center, 70 AD3d 15 (1st Dept 2009); Cruz v. St Barnabas Hospital, 50 AD3d 382 (1st Dept 2008). "Where the expert's ultimate assertions are speculative or unsupported by any evidentiary foundation, however, the opinion should be given no probative force and is insufficient to withstand summary judgment." Diaz v. New York Downtown Hospital, 99 NY2d 542, 544 (2002). "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 Hospital, 154 AD3d 994, 996 (2nd Dept 2017) (quoting Roca v. Perel, 51 AD3d 757, 759 [2nd Dept 2008]); accord Lowe v. Japal, 170 AD3d 701 (2nd Dept 2019).

At the outset, the Court addresses defendants' objection that plaintiffs' expert adds liability claims that are not included in the Amended Bills of Particulars (the "Amended Bills") and which defendants characterize as new theories of liability and therefore improperly raised for the first time in opposition to defendants' summary judgment motion.[5] Defendants argue plaintiffs' expert affirmation includes the following new claims and allegations: 1) defendants failed to recognize that Ms. Yesko's anatomy and pyelonephritis made her a high risk of colonic perforation; 2) defendants failed to obtain an infectious disease consultation; 3) defendants improperly ordered an x-ray of the abdomen on April 30, 2010, instead of a CT scan; 4) defendants did not have enough experience to properly inspect the colon/bowel and determine if it was intact; 5) Ms. Yesko was suffering from Systemic Inflammatory Response Syndrome ("SIRS"); and 6) Dr. Casey Ng and Dr. Mike Herman departed from the standard of care.

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[5]Defendants additionally argue that their motion should be granted as unopposed, given plaintiffs' untimely filing of their opposition after the Court-ordered deadline.

On January 7, 2020, this Court issued an order granting what appears to be plaintiffs' fourth or fifth request for an extension of time to oppose defendants' motion. The order gave plaintiffs until January 28, 2020 to submit opposition, and defendants until February 18, 2020 to reply, and scheduled oral argument for March 5, 2020. The order explicitly stated that January 28, 2020 was a "firm and final date" for plaintiffs' opposition. On January 29, 2020, defendants wrote to the Court advising that plaintiffs failed to file their opposition on January 28. On January 31, plaintiffs filed their opposition papers. Defendants timely replied on February 18 and the motion was argued, as scheduled, on March 5, 2020.

Despite plaintiffs' failure to request another extension of time and to acknowledge the untimeliness of their opposition, under the circumstances presented, where the three-day delay is de minimus, defendants still had adequate time to reply and were not prejudiced by the delay, and the motion was argued on the scheduled date, and in view of the Court's preference for resolving cases on the merits, plaintiffs' opposition will be accepted and considered. The Court, however, must make clear that it does not condone plaintiffs' clear disregard of this Court's order.

Although the purpose of a bill of particulars is to amplify pleadings, limit proof and prevent surprise at trial, "it need not set forth a matter that is evidentiary in nature, which is more appropriately obtained through depositions and expert disclosure." Colwin v. Katz, 90 AD3d 516, 516-517 (1st Dept 2011). In a medical malpractice action, the bill of particulars must simply "provide a general statement of the acts or omissions constituting the alleged negligence," but need not "set forth the manner in which the physician failed to act in accordance with good and accepted medical practice, since a physician is chargeable with knowing those medically accepted standards applicable to the proper care and treatment of the plaintiff." Toth v. Bloshinsky, 39 AD3d 848, 849 (2nd Dept 2007); accord Contreras v. Adeyemi, 102 AD3d 720 (2nd Dept 2013).

Here, an examination of the Amended Bills demonstrates that contrary to defendants' argument, the purportedly "new" claims and allegations in the affirmation of plaintiffs' expert are not new theories of liability. Rather, plaintiffs' expert merely presents a "more detailed picture" of the allegations in the Amended Bills using information obtained during discovery. Anthony v. Smina, 159 AD3d 604, (1st Dept 2018); see Mehtvin v. Ravi, 180 AD3d 661 (2nd Dept 2020); Contreras v. Adeyemi, supra.

Specifically, the Amended Bills allege that defendants "fail[ed] to timely and properly order and/or perform diagnostic and radiological testing to confirm the plaintiff's decedent's fistula." That allegation is amplified by plaintiffs' expert who opines defendants improperly ordered an x-ray and not a CT scan on April 30, 2010. The allegations in the Amended Bills that defendants failed to "timely and properly inspect the plaintiff's decedent's bowel intraoperatively before finishing the nephrectomy . . . [and] request an intraoperative surgical consultation,"

directly relate to the opinion of plaintiffs' expert that defendants were not experienced enough to adequately inspect the bowel intraoperatively and should have consulted with a colorectal or general surgeon before closing Ms. Yesko. The Amended Bills allege that defendants "fail[ed] to properly and timely appreciate and evaluate plaintiff's decedent's postoperative symptoms and complaints." Plaintiff's expert provides more details as to that allegation by opining that Ms. Yesko was suffering from the symptoms of SIRS postoperatively and that defendants failed to timely order an infectious disease consult. As to Ms. Yesko's medical condition prior to surgery, the Amended Bills allege generally that defendants "fail[ed] to properly examine plaintiff's decedent preoperatively . . . [and] to provide plaintiff's decedent proper and timely pre-operative diagnosis, care and treatment." Again, plaintiff's expert offers more detailed information as to those allegations by opining that defendants failed to recognize that Ms. Yesko's anatomy and pyelonephritis made her a high risk of colonic perforation. Finally, the Amended Bills refer generally to defendants' agents and employees, which necessarily include the hospital's surgical residents, Dr. Ng and Dr. Hammer.

In each instance described above, plaintiffs' expert simply provides additional details regarding the allegations in the Amended Bills, and those details neither conflict with, nor are distinct from plaintiffs' theories of liability as to defendants' negligence in performing surgery and caring for Ms. Yesko post-operatively. See Marti v. Rana, 173 AD3d 576 (1st Dept), lv app den, 34 NY3d 906 (2019). Thus, since plaintiffs' expert affirmation does not raise new theories of liability in opposition to defendants' summary judgment motion, the affirmation is properly considered in opposition to the motion. See Mehtvin v. Ravi, supra; Anthony v. Smina, supra; Contreras v. Adeyemi, supra.

Turning to defendants' motion, in support of summary judgment, defendants submit an expert affidavit of Dr. Peter Schulam, a board certified urologist. He reviewed the bills of particulars, party and non-party deposition testimony, the autopsy report, and Ms. Yesko's relevant medical records, including all NYPH records and radiology films, and outpatient records from treatment with Dr. Del Pizzo, Dr. Toyooki Sonoda, Mary Manning Walsh Nursing Home, Dr. Mark Brower, Dr. John Rodman, Dr. Michael Schmerin and 72nd Street Medical Associates.

Addressing the departure that Dr. Del Pizzo perforated Ms. Yesko's colon during surgery, Dr. Schulam opines that the hand-assisted method used by Dr. Del Pizzo was appropriate, and in support points to Dr. Del Pizzo's testimony describing the technique implemented during surgery, that approximately 15 centimeters of left colon were adherent to Gerota's fascia (the outer layer of the kidney), from the splenic flexure to the level of the mid ureter; that he inserted his left hand through the GelPort to retract the descending colon medially; his hand was placed over the colon; and that he used a scissors with his right, dominant hand to try to dissect between the two layers. In further support Dr. Schulam points to Dr. Del Pizzo's testimony that this process took 30-40 minutes, and the typical time is five minutes. With respect to two deserosalizations which occurred at the descending colon, according to Dr. Schulman, this is not evidence of negligence, as deserosalization is a known complication of mobilization of the bowel off other organs, particularly when it is adherent, and, deserosalization is not a perforation, but a "rent" in the outermost, single cell layer of the bowel. Nor, in Dr. Schulman's opinion, is there merit to plaintiff's claim that an intraoperative consult should have been requested, and bases this opinion on Del Pizzo's testimony cited above, and his testimony that prior to closure, he did five to ten minutes of tactile and visual inspection, and that the placement of the JP drain was

reasonable and appropriate in order to reduce the risk of infection and abscess development.

In connection with Thomas Yesko's testimony that after the surgery Dr. Del Pizzo told him that he "made a mistake;" "cut some sort of a tendon or something that had to do with the colon;" and that he "didn't look over the hill;" and "nicked something on the other side of the kidney," Dr. Schulam states that while plaintiffs claim the "mistake" Dr. Del Pizzo referred to related to the bowel, he opines that it referenced a splenic injury as the phrase "'up over the hill' is frequently used when describing the dissection of the spleen off the upper pole of the kidney."[6]

Dr. Schulam further opines that plaintiffs' claims regarding post-operative management are without merit and supports this opinion based on the April 30, 2010 abdominal x-ray indicating no free intraperitoneal air, which ruled out a bowel injury; the abdomen was repeatedly documented to be non-distended; Ms. Yesko was out of bed and ambulating post-surgery; and her JP drain was documented to be serosanguinous, which is normal post-operatively. He opines that Ms. Yesko had a "baseline" elevated white blood cell count and for that reason it was reasonable to suspect "baseline" values in combination with recent surgery as the cause of her elevated white blood count during the initial post-operative period.

Dr. Schulam further opines that Ms. Yesko's colonic fistula was timely and properly diagnosed on May 4, after she began draining brown-colored fluid and that her white blood count increased above her "baseline;" and the colorectal surgeon, Dr. Sonada, was timely called for a consultation, and that the plan to manage the fistula conservatively was reasonable, particularly

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[6] Mr. Yesko's testimony "more likely" refers to the splenic injury, which was timely diagnosed and treated with hemostatic agents. As noted above, plaintiffs' expert offers no opinion as to the splenic injury, so any alleged departure based on that injury is deemed abandoned or withdrawn.

given the results of the May 7 CT scan which showed that the left lower quadrant collection was almost gone and contained only a tiny amount of gas, and the upper left quadrant gas-filled collection was much smaller. In ths connection, Dr. Schulam opines that it was not until late on May 12th, when the JP drain revealed particulate matter and the white blood count remained "elevated," and a repeat CT scan of the abdomen showed persistent extravasation of enteric contrast from a defect within the left colonic wall, that surgery was indicated and, at that time, Dr. Sonada appropriately performed a traverse loop colostomy and placed a Penrose drain for residual fluid.

As to causation, Dr. Schulam opines there is no evidence defendants' actions or inactions caused or contributed to Ms. Yesko's injuries, and in support states that deserosalization cannot result in a fistula, as a defect in the bowel wall would have to reach into the submucosa, the strength layer, before a fistula could develop, and deserosalization is limited to a rent in the outermost, single cell layer; that while a bowel perforation is a known and accepted complication of nephrectomy, based on the absence of any indication in the Operative Report and Dr. Del Pizzo's testimony, a perforation did not occur.

According to Dr. Schulam, Ms. Yesko's postoperative fistula resulted from a delayed perforation of the bowel wall caused by microvascular breakdown at the surgical site, that Ms. Yesko was documented as doing well until May 2, post-operative day five, when brown-colored drainage was first noted. He also points to Ms. Yesko's significant medical history, including xanthogranulomatous pyelonephritis ("XPG," a chronically inflamed kidney), which increased the probability that the inflammatory nature of the healing environment caused a microvascular decrease in blood supply, and in turn caused a local breakdown of tissue in the area, resulting in

the development of a hole in the mucosa.

As to Ms. Yesko's subsequent surgeries and rehabilitation, Dr. Schulam opines that as the fistula that developed was a known complication, and, while most patients heal with conservative measures, Ms. Yesko's ability to heal was complicated by her underlying Zollinger-Ellison syndrome, which is characterized by chronic diarrhea, resulting in dehydration and malnutrition. Regarding plaintiffs' wrongful death claim, Dr. Schulam relies on the death certificate which lists Ms. Yesko's immediate cause of death as cardiac arrhythmia secondary to hypertensive heart disease, and opines that the cause of death was cardiac, and as the death certificate does not mention surgical complications and/or infections, Ms. Yesko's death was not caused by the actions or inactions of defendants.

Based on the foregoing opinions of Dr. Schulam, defendants have made a prima facie showing for entitlement to judgment, and the burden shifts to plaintiffs. In opposition, plaintiffs submit the name-redacted affidavit of a board certified urologist, who reviewed the exhibits annexed to defendants' motion; the affidavit of defendants' expert, Dr. Schulam; the records of NYPH and Dr. Del Pizzo; the records of non-parties Dr. Schmerin, Dr. John Rodman and Dr. Mark Brower; the autopsy report; and the depositions of Thomas Yesko (Barbara Yesko's husband), William Yesko (the son of Barbara and Thomas Yesko), Dr. Del Pizzo and Dr. Toyooki Sonoda.

Plaintiffs' expert opines that Dr. Del Pizzo and the NYPH staff, specifically Dr. Herman and Dr. Ng, departed from the standard of care in the performance of Ms. Yesko's surgery by perforating her colon and then failing to recognize it intraoperatively. In support of this opinion, the expert opines the medical records and deposition testimony show that Ms. Yesko was at high

risk for a colonic perforation, as her history included XPG involving a great deal of inflammation in the operative field along with no real definitive matter between the colon and left kidney; and in accordance with good and accepted practice, before closing Ms. Yesko, they had an obligation to properly inspect the bowel/colon for any perforation.

In this connection, the expert points to the statement in Dr. Del Pizzo's operative report that "[t]he spleen, pancreas, colon and aorta were inspected and found to be free of injury," and notes that Dr. Del Pizzo does not articulate how he inspected these areas, specifically whether he ran her bowel, injected dye to determine its integrity and/or squeezed it. Significantly, the expert opines that Ms. Yesko's post-operative course and complaints, and the postoperative finding of colonic fistula, are all "consistent with colonic perforation," and for that reason, Dr. Del Pizzo and the surgical team missed the colonic perforation on inspection, which was a departure from good and accepted medical practice; and the failure to discover and repair the colonic perforation intraoperatively resulted in Ms. Yesko suffering significant and permanent injuries, including rapid infection, sepsis, need for colostomy and colectomy, a myriad of complications and eventual death.

Plaintiffs' expert also opines that Dr. Del Pizzo and the surgical team departed from the standard of care by not having an intraoperative consultation with a colorectal or general surgeon to inspect the colon/bowel prior to closing, as Ms. Yesko was at high risk of a colonic perforation due to her past surgical history and her XGP, and the absence of a definite separation, as described by Dr. Del Pizzo, between the colon and the left kidney. The expert opines that as a urologist, Dr. Del Pizzo and his surgical team did not have "enough experience" in properly inspecting the colon/bowel to determine if it was intact, and given the difficult operative field,

the standard of care required an intraoperative consult by a colorectal or general surgeon to inspect the integrity of the bowel/colon; and if this had been done, the colonic perforation would have been discovered and repaired, the colonic fistula would not have formed postoperatively, and Ms. Yesko would not have suffered the "torturous postoperative course" leading to her death.

Regarding Mr. Yesko's testimony that Dr. Del Pizzo told him he made a "mistake" during the surgery by losing sight of something and cutting an organ other than the kidney, plaintiffs' expert refers to additional testimony by Ms. Yesko that Dr. Del Pizzo said Ms. Yesko might need a colostomy and another surgery. Plaintiff's expert's opines that this conversation refers to an injury to Ms. Yesko's colon during the surgery, not to an injury to her spleen and supports this interpretation on the absence of any mention of a "splenic laceration" in Dr. Del Pizzo's operative report; that Dr. Del Pizzo specifically mentioned the colon and a colostomy in his conversation with Mr. Yesko; and he would not have mentioned a colostomy if he was referring to the spleen, Dr. Del Pizzo's reference to a "mistake" during surgery could not have meant a splenic laceration or deserosalization, as he testified that such occurrences are not "mistakes" but simply potential complications of surgery.

Plaintiffs' expert further opines that Dr. Del Pizzo and NYPH staff departed from the standard of care post-operatively, by failing to appreciate Ms. Yesko's signs, symptoms and blood work as an indication she was suffering from a colonic perforation that evolved into a colonic fistula. In support, he points to hospital records that after surgery, Ms. Yesko complained of abnormal abdominal pain and discomfort; her laboratory values and vital signs were consistent with an infectious process; she had persistent hypotension; and her white blood

count was "markedly elevated" indicating she was suffering from leukocytosis, tachycardia or rapid pulse. According to the expert, these signs and symptoms show that Ms. Yesko was suffering from Systematic Inflammatory Response Syndrome ("SIRS") immediately after surgery; the standard of care required defendants to investigate the cause within two days after surgery; and defendants did not take any action to rule out an underlying infection until seven days later on May 4, 2010. According to plaintiffs' expert, a patient having a nephrectomy, perforation of the bowel/colon is "high in the differential diagnosis," and the standard of care required a "proper work-up" that included an infectious disease consult, a manual differential of the white blood count and urinalysis, and an abdominal/pelvic CT scan. In plaintiff's expert opinion, the April 30 abdominal x-ray was not the proper diagnostic tool to rule out the possibility of perforation, since a CT scan is a "more sensitive test."

Plaintiffs' expert points to entries in the medical records indicating that brownish material was noted as draining from the JP drain on May 2nd and described as becoming darker over the next few days, as indicating possible colon/bowel perforation. In support, the expert opines that as serosanguinous drainage is pale red or pink, or clear with a red swirl, when it was described on May 2 and May 3 as light and dark brown, it was a "clear sign" of infection. Plaintiffs' expert opines that defendants departed from the standard of care by failing to timely investigate the dark brown drainage, since Ms. Yesko did not have a CT scan of the abdomen until May 4, when the colonic fistula was finally diagnosed, and as a result of the delay, the colonic fistula became "worse pouring fecal matter into the kidney bed resulting in further infection."

As to causation, plaintiffs' expert opines Ms. Yesko's death was a result of complications from the colonic fistula caused by Dr. Del Pizzo's surgery; that following the injury to her colon

during surgery, and the failure to timely and properly diagnose it, Ms. Yesko developed significant complications which progressed to severe sepsis, the need for a colostomy, respiratory distress, malnourishment and deconditioning, and eventually led to her demise. Acknowledging that the autopsy report states the cause of death as cardiac arrhythmia secondary to hypertensive heart disease, plaintiffs' expert opines that Ms. Yesko's deterioration, deconditioning, malnourishment, massive infections and extensive hospital stays all stem from the colonic perforation and the colonic fistula, as cardiac arrhythmia cannot be diagnosed on autopsy but for defendants' departures, Ms. Yesko would not have died, as the multiple surgical interventions and prolonged infection, "takes a toll on the body and eventually her body and heart just gave out."

The foregoing opinions of plaintiffs' expert are insufficient to raise issues of fact as to whether defendants departed from the standard of care during Ms. Yesko's surgery on April 27, 2010, by perforating her colon, and then, before closing, in failing to find and repair a perforation, and consult with a colorectal or general surgeon. The expert's opinions as to such departures are conclusory, speculative and lack factual support in the record. See Diaz v. New York Downtown Hospital, supra; Negron v. Shou, 179 AD3d 516 (1st Dept 2020).

Plaintiffs' expert does not point to any evidence in the record that a negligent act of defendants caused a perforation, but rather opines as to what he/she believes defendants did and from those assumed facts concludes that the perforation was caused by defendants' negligence. See Cassano v. Hagstrom, 5 NY2d 643 (1959); Roques v. Noble, supra. The expert merely opines that given Ms. Yesko's medical history and the difficult and inflamed condition of the surgical site, she had a high risk of colonic perforation, which obligated defendants to inspect the

bowel/colon for any perforation intraoperatively; and while Dr. Del Pizzo's operative notes state that "[t]he spleen, pancreas, colon and aorta were inspected and found to be free of injury," the notes do not state whether he ran her bowel, injected dye or squeezed it. On that basis alone, and without refuting Dr. Del Pizzo's testimony detailing the manner in which he visually and manually inspected the bowel, plaintiff's expert simply concludes, without factual support in the record, that it is "clear" defendants "missed the colonic perforation on inspection."

When plaintiff's expert additionally opines that Ms. Yesko's post-operative course and complaints, and the postoperative finding of a colonic fistula, are "all consistent with colonic perforation," the expert improperly engages in hindsight, by reasoning back from the fact of the injury to establish negligence. See Bogin v. Metz, 180 AD3d 404 (1st Dept 2020); Park v. Kovachevick, 116 AD3d 182 (1st Dept), lv app den 23 NY3d 906 (2014); Fernandez v. Moskowitz, 85 Ad3d 566 (1st Dept 2011). "Malpractice cannot rest solely on 20/20 hindsight," which is insufficient to defeat summary judgment. Bogin v. Metz, supra.

Moreover, the determination of plaintiffs' expert is based principally on an evaluation of Ms. Yesko's post-operative symptoms, and the expert fails to address defendants' expert opinion that these symptoms were attributable to other factors not involving any negligence on the part of defendants. See Lowery v. Lamaute, 40 AD3d 822 (2nd Dept), lv app den 9 NY3d 801 (2007); Lipsuis v. White, 91 AD2d 271 (2nd Dept 1983). Plaintiffs' expert neither acknowledges nor refutes Dr. Schulam's opinion that the colonic fistula was caused by a *delayed* perforation of the bowel wall as a result of a microvascular breakdown at the surgical site, as evidenced by Ms. Yesko's significant medical history, including a chronically inflamed kidney, which increased the probability that the inflammatory nature of the healing environment caused a microvascular

decrease in blood supply, which resulted in a local breakdown of tissue in the area and the development of a hole in the mucosa.

Under these circumstances, plaintiffs' expert affirmation fails to raise an issue of fact as to whether any departure from the standard of care occurred during the April 27, 2010 surgery.[7]

The court reaches a difference conclusion as to the remaining departure relating to Ms. Yesko's post-operative care, and the delay in diagnosing and treating the colonic fistula. Relying on post-operative medical records, plaintiffs' expert opines that immediately following surgery, Ms. Yesko complained of abnormal abdominal pain and had the symptoms of SIRS (Systemic Inflammatory Response Syndrome), i.e. leukocytosis (a markedly elevated white blood count), tachycardia (rapid pulse) and persistent hypotension, raises issues of fact as to whether based on these symptoms, the standard of care required defendants to investigate the underlying cause of SIRS, at the latest, two days after surgery, so as to rule out an infectious process and the possibility of a bowel/colon perforation. In addition, in contrast to Dr. Schulam's opinion that the x-ray of the abdomen taken on April 30 was adequate to "rule out" a bowel injury, plaintiffs' expert opinion is that the x-ray was not the proper diagnostic tool, as it is not as sensitive as a CT-scan for showing free air in the peritoneum. Plaintiff's expert further supports this opinion that defendants departed from the standard of care in failing to timely diagnose the fistula in that they did not investigate the discoloration and brownish material draining from the JP drain beginning on May 2 and May 3, 2010.

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[7]In holding that plaintiff's proof fails to raise an issue of fact as to whether defendants departed from the standard of care during April 27, 2010 surgery based on a perforation of Ms. Yesko's colon, the Court makes no determination as to when or how the leakage from the colon occurred.

record, summary judgment is denied as to the departure based on Ms. Yesko's post-operative care and the delay in diagnosing the colonic fistula. See Frye v. Montefiore Medical Center, supra; Cruz v. St Barnabas Hospital, supra.

Accordingly, it is

ORDERED that defendants' motion for summary judgment is granted in part to the extent of dismissing the lack of informed consent claim; any alleged departures not addressed by plaintiffs' expert; the claim against defendant NYPH for negligent hiring, training, supervision, privileging and credentialing; and the claims that defendants departed from the standard of care during the April 27, 2010 surgery by perforating Ms. Yesko's colon, and then, before closing Ms. Yesko, failing to find and repair the perforation, and consult with a colorectal or general surgeon; and it is further

ORDERED that defendants' motion for summary judgment is denied as to the departure based on Ms. Yesko's post-operative care and the delay in diagnosing the colonic fistula.

DATED: December 2, 2020

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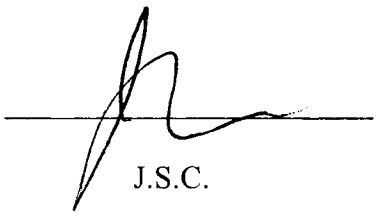

J.S.C.

HON. JOAN A. MADDEN
J.S.C.