Kuhfeldt v New York Presbyt./Weill Cornell Med. Ctr.
2021 NY Slip Op 30921(U)
March 16, 2021
Supreme Court, New York County
Docket Number: 805415/2013
Judge: John J. Kelley
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SUPREME COURT OF THE STATE OF NEW YORK
NEW YORK COUNTY

PRESENT: **HON. JOHN J. KELLEY** **PART** **IAS MOTION 56EFM**

Justice

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SHERRY KUHFELDT, individually and as Administratrix of the Estate of JONATHAN KUHFELDT, Deceased,

Plaintiff,

- v -

NEW YORK PRESBYTERIAN/WEILL CORNELL MEDICAL CENTER, CRITICAL CARE SYSTEMS, INC. and ACCREDO HEALTH GROUP, INC.,

Defendants.

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INDEX NO. 805415/2013

MOTION DATE 01/25/2021

MOTION SEQ. NO. 004

DECISION AND ORDER

The following e-filed documents, listed by NYSCEF document number 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, and 129 (Motion 004)

were read on this motion to/for SUMMARY JUDGMENT.

In this action to recover damages for medical malpractice and wrongful death, the defendant New York Presbyterian/Weill Cornell Medical Center (NYPH) moves pursuant to CPLR 3212 for summary judgment dismissing the complaint. The plaintiff opposes the motion. The motion is granted to the extent that the causes of action to recover for lack of informed consent and wrongful death are dismissed, and the motion is otherwise denied.

The crux of the plaintiff's claim is that NYPH and its employees departed from good and accepted medical practice in monitoring and treating infections that her decedent developed in December 2011 at NYPH as sequellae to a liver transplant that he underwent at that hospital earlier that year. NYPH contends that the decedent was treated at NYPH in December 2011 by a nonparty infectious disease specialist who was a private attending physician and not an employee of the hospital, but merely had privileges to treat patients there, that it thus cannot be held vicariously liable for that physician's conduct, and that it cannot directly be held liable because its employees committed no independent acts of malpractice. NYPH further contends that, in any event, this physician did not depart from accepted practice.

In opposition to the defendants' prima facie showing of their entitlement to judgment as a matter of law, the plaintiff raised triable issues of fact as to whether NYPH was in fact the employer of Rosemary Soave, M.D., who allegedly committed malpractice in administering and monitoring the antibiotic Gentamicin to her decedent. The plaintiff also raised a triable issue of fact as to whether the failure adequately to monitor the effects of that drug, and the administration of the drug once per every 24 hours, rather than once per every 36 hours, caused drug toxicity and consequent injury to the decedent. The plaintiff, however, failed to raise a triable issue of fact as to whether her decedent was not fully informed of the risks of treatment arising from administration of the drug, and makes no argument in her papers that the alleged malpractice caused or contributed to the death of her decedent.

The plaintiff's decedent underwent a liver transplant at NYPH in June 2011, followed by multiple subsequent admissions for continued infections. In her bill of particulars, the plaintiff alleges, among other things, that the defendants were negligent in administering Gentamicin to her decedent from December 21, 2011 through December 23, 2011, during the decedent's admission to NYPH for treatment of Klebsiella pneumoniae, a bacterial infection, and continuing via home intravenous administrations from December 23, 2011 until December 31, 2011. In this regard, she asserts that NYPH departed from good practice in failing appropriately to monitor the decedent while he was being administered Gentamicin, including a failure properly to monitor the timing of the Gentamicin "troughs" that allegedly resulted in blood toxicity that led to various vestibular (inner-ear) disturbances such as dizziness, as well as other related maladies. Specifically, the bill of particulars alleges that NYPH departed from good and accepted standards of care

> "in failing to provide the decedent with the proper, adequate and required medication, advice, referral, recommendation, instructions, directions, warnings and information relative to the prescription and administration of medication commonly known for its manifested by ototoxicity, known to of the drug Gentamicin, a neurotoxicity, specifically cause serious nerve damage resulting in permanent otological dysfunction, hearing loss, imbalance and impairments; in ignoring, overlooking, dismissing and/or disregarding decedent's history and

> presenting signs, symptoms, complaints and manifestations of new onset hearing loss, extreme and unremitting dizziness, imbalance, sensorineural hearing loss and abnormality of gait following the administration of Gentamicin, reportedly worsening to such extent that he was unable to stand, walk or drive and requiring the use of a wheelchair."

The plaintiff's bill of particulars additionally asserts that NYPH failed to observe that Gentamicin, when administered along with Vancomycin, created bilateral vestibular dysfunction and toxicity, "which may lead to permanent chronic disequilibrium and oscillopsia." The plaintiff further alleges that NYPH committed malpractice by overprescribing Gentamicin for an excessive period of time, failing to conduct proper monitoring and testing to ascertain the cause of the decedent's symptoms, and failing to administer medications to counteract its toxic effects. In addition, the bill of particulars asserts that NYPH failed to obtain the decedent's informed consent to such an extended course of Gentamicin. The plaintiff asserts that her decedent suffered from the adverse effects of Gentamicin toxicity from at least December 2011 until his death on December 24, 2012, subsequent to a second liver transplant and kidney failure.

NYPH asserts that all of the decisions and administrations of Gentamicin were made by an infectious disease specialist, Rosemary Soave, M.D., who was not employed by NYPH, but was the decedent's private attending or consulting physician who merely had admission and treatment privileges at NYPH. It further contends that "the decision by Dr. Soave to administer Gentamicin at 440mg via IVPB (intravenous piggyback) once per day starting on December 21, 2011 and continuing through December 31, 2011 was appropriate and in accordance with good and accepted practice," in that the decedent "was a critically ill patient who had a history of recurrent Klebsiella and bacteremia since his liver transplant in June, 2011," such that "Dr. Soave had no option but to prescribe the Gentamicin."

In addition to the transcripts of the parties' depositions, NYPH submitted the expert affidavit of Kieren A. Marr, M.D., an infectious disease specialist and the Director of Transplant and Oncology Infectious Diseases at John Hopkins University Medical Center. She asserted that she was familiar with the standard of care in 2011 and 2012 for the treatment of Klebsiella

pneumoniae and the administration of Gentamicin with respect to the dosing and monitoring of a patient, both during a hospital admission as well as during at-home administrations of the drug. Based on her review of the medical and hospital records, and the parties' deposition transcripts, she opined that:

> "The defendants at all times acted in accordance with good and accepted practice in their care and treatment of the patient, Jonathan Kuhfeldt;
>
> "That the decision by Dr. Soave to administer Gentamicin at 440mg via IVPB once per day starting on December 21, 2011 and continuing through December 31, 2011 was appropriate and in accordance with good and accepted practice;
>
> "That ototoxicity and vestibular toxicity are known and accepted risks of Gentamicin, even with normal trough levels. The patient was appropriately advised of these potential risks;
>
> "That this was a critically ill patient who had a history of recurrent Klebsiella and bacteremia since his liver transplant in June, 2011. Dr. Soave had no option but to prescribe the Gentamicin. It was either Gentamicin or death;
>
> "That the decision to discharge the patient on December 23, 2011 for home IV antibiotic treatment with Gentamicin was also in accordance with good and accepted practice;
>
> "That the Gentamicin troughs were timely checked and at all times normal with no indication whatsoever of a potential toxicity;
>
> "That the patient at no time exhibited any signs or symptoms of Gentamicin toxicity while being administered the drug;
>
> "That even if the patient had signs or symptoms of ototoxicity and vestibular toxicity, it would have still been appropriate to complete the full course of the Gentamicin to ensure that the bacteria was completely eradicated rather than risking it coming back, causing further complications, which would have resulted in the patient's death;
>
> "That nothing that the defendants did or did not do in this case in any way resulted in the patient's death."

Dr. Marr described the course of the treatment of the decedent's liver as follows:

> "On June 14, 2011, the patient received a liver transplant at NYPH performed by Daniel Cherqui, M.D. and Michael Kluger, M.D. members of his liver transplant surgery team [ ] who the patient had been treating with prior to this surgery. The patient developed obstruction of the blood supply to the transplanted liver and also developed a Klebsiella infection. These bacteria are harmless when they are in your intestines. But if they spread to other parts of your body, they cause severe infections. On June 28, 2011, Rosemary Soave, M.D., an infectious

> disease physician, evaluated the patient at the request of the patient's other transplant surgeon, Michael Kluger, M.D. in connection to the patient's bacteremia. She started him on IV ampicillin. Dr. Soave continued treating the patient throughout the remainder of the admission. On July 1, 2011, Dr. Kluger noted that a decision was made to broaden the antibiotics to Zosyn, Ampicillin and Fluconazole, and that the same was discussed with the family at length as well as Dr. Soave. The patient was eventually discharged home on July 8, 2011, as all subsequent cultures were negative, with home IV Zosyn until July 19, 2011 as per Dr. Soave. On discharge, it was noted that the patient would follow-up with Dr. Soave during the appointment he had scheduled with James Spellman, NP as an outpatient."

Dr. Marr explained that, on July 21, 2011, Dr. Soave had examined the decedent on an outpatient basis in conjunction with Dr. Kluger and Dr. Sonja Olsen, and he was neither febrile nor symptomatic. She asserted that, on July 26, 2011, the decedent was readmitted to NYPH with a fever and was diagnosed with recurrent gram-negative bacillary bacteremia. She initially prescribed the antibiotic Zosyn for his fever and bacteremia. On July 28, 2011, Dr. Soave documented that a blood culture from a sample extracted on July 26, 2011 revealed that the decedent was infected with Klebsiella pneumoniae bacteria. Consequently, Dr. Soave switched the decedent's antibiotics to carbapenem-type antibiotics, based upon results of sensitivity testing, and discharged the decedent to his home, with home infusion IV services. On August 5, 2011, the decedent was admitted to NYPH for management of Cytomegalovirus (CMV) viremia that resulted in flu-like symptoms after his July 26, 2011 discharge. The decedent's hospital charts noted that Dr. Soave had been treating him. Michael Satlin, M.D., an infectious disease specialist at NYPH, saw the patient in the hospital and discussed the decedent with Dr. Soave. As Dr. Marr interpreted the decedent's charts, he was treated with antivirals and antibiotics, and discharged to his home on August 19. 2011.

On September 4, 2011, the decedent, again, was admitted to the NYPH emergency room with complaints of a fever of 103 degrees, at which point Dr. Kluger evaluated him. In a chart entry, Dr. Kluger noted that the decedent's outpatient team consisted of Kluger himself, Dr. Olsen, Dr. Cherqui, and Nurse Practitioner Spellman. Dr. Kluger consulted with Dr. Soave, who, at his request, saw the decedent on six occasions during his admission, beginning on

September 5, 2011. The decedent's team concluded that the source of his Infection was bile secreted by his liver, and that his blood cultures were positive for E. coli and Vancomycin-resistant enterococcal (VRE) bacteria. Dr. Soave treated the decedent with various antibiotics, and NYPH discharged him to his home, prescribing and providing him with IV antibiotics Meropenem and Daptomycin. On September 23, 2011, Dr. Soave reported that she examined the decedent at her clinic and, according to Marr's interpretation of the clinic notes, he looked well, was eating, walking, and exercising, and was still taking IV antibiotics. On September 29, 2011, the decedent yet again presented to the NYPH emergency room with a fever of 102 degrees, despite reporting that he was still taking intravenous antibiotics for his E. coli and VRE infections. At the request of Drs. Cherqui and Kluger, Dr. Soave examined the patient in the emergency room. Although Dr. Soave continued the decedent on his course of IV antibiotics, by October 1, 2011, she noted that all blood cultures were negative and that the decedent was afebrile. She thus recommended that the decedent be discharged to his home to continue with IV Meropenem and Daptomycin to treat his ongoing bacteremia, at which point Dr. Kluger discharged him to his home.

Nonetheless, on December 20, 2011, the decedent presented to the NYPH emergency room and was admitted with a 102.6-degree fever. Dr. Kluger reviewed a chest X-ray, concluding that there was no evidence of acute pulmonary disease, but that the decedent had a low white blood cell (WBC) count of 1.3 x 10^9/L. Dr. Kluger admitted the decedent via NYPH's Hepatobiliary Surgery and Liver Transplantation Service, obtained an ultrasound of the liver, and administered one dose each of Meropenem and Daptomycin, as well as the antibiotic Bactrim.

Beginning at 10:00 p.m. on December 20, 2011, the patient received a course of antibiotic administrations, beginning with a 500 mg dose of Meropenem via IV, an identical dose at 4:00 a.m. on December 21, 2011, and another at 10:00 a.m. on that date. His WBC count nonetheless fell to 1.0 x 10^9/L, and his blood culture results were positive for Klebsiella

pneumoniae. At 4:00 a.m., the decedent received a 500 mg dose of Meropenem via IV. At Dr. Kluger's request, Dr. Soave examined the decedent, reviewed his laboratory results, and discussed them with hospital staff. According to Dr. Marr, Dr. Soave's notes indicated that the decedent exhibited resistance to all antibiotics except for Gentamicin and Tigecyline. She thus recommended that, although the Meropenem and Daptomycin should be continued for a short period of time, Gentamicin should be added to the decedent's regimen of antibiotics once per day at a dose of 5mg/kg of body weight. Dr. Soave further recommended that the Gentamicin "trough level" be checked prior to each subsequent administration of that drug, that the decedent only be administered the next dose when the Gentamicin was undetectable, and that kidney function should be carefully monitored. Thus, over the next day, the decedent was administered several doses of Meropenem, Daptomycin, and Gentamicin, the latter at a dose level of 440 milligrams via IV, which is equivalent to 5mg/kg. At 4:00 p.m., the decedent's Gentamicin trough was less than 0.5 µg/mL, his creatinine level was 1.02 mg/dL, and his WBC count had fallen to 0.9 x 10^9/L.

At 6:35 p.m. on December 22, 2011, Dr. Soave saw and examined the decedent, and noted that he was feeling better without any complaints. Dr. Soave documented that a polymerase chain reaction test reflected that the CMV that he had previously manifested was undetectable and that, although the decedent exhibited neutropenia, that was likely a result of the administration of the antiviral drug Valacyclovir, which is employed to prevent CMV reactivation, and not the result of a CMV infection itself. The plan with respect to the Klebsiella pneumoniae bacteremia was to continue the administration of Meropenem and Gentamicin, but to discontinue the Daptomycin, inasmuch as the VRE infection had been treated.

Thus, as of December 22, 2011, the decedent was being administered 440 mg of Gentamicin via IV piggyback every 24 hours. Although the decedent's charts reflected that he was by then asymptomatic, his neutropenia persisted. Dr. Soave's plan was that when the patient was discharged from the hospital to his home, he would be taking only Gentamicin, at

the same dose, for 10-12 days with close follow-up of his renal function. She also directed that the NYPH team provide him with Tigecycline for the remainder of his admission, but to discontinue it when he was discharged. She also asked that Nurse Practitioner Spellman call her when the decedent again presented to the liver transplant clinic. She directed that the Gentamicin trough was to be checked at home before each administration of the drug, and that the decedent's creatinine level was to be checked every other day. While still at NYPH, the decedent received one more 440 mg dose of Gentamicin via intravenous piggyback.

NYPH discharged the decedent on December 23, 2011, providing him with five doses of Gentamicin at 440 mg per dose, and authorized him to have outside laboratory perform blood testing on December 26, 2011 so that the results would be available when he met Dr. Soave on December 27, 2011 at her Hepatobiliary clinic. On December 27, 2011, the decedent acknowledged receipt of an additional seven doses of the Gentamicin at 440 mg per dose, so that he now had 12 doses in his possession for use at the rate of one dose per day.

On December 28, 2011, the decedent presented as an outpatient to Nurse Practitioner Spellman at Weill Cornell Medicine's Department of Gastroenterology and Hepatology for a follow-up visit, as scheduled prior to his discharge from NYPH. Dr. Soave was also present during this visit. The chart from this visit reflected that the decedent was to discontinue the home administration of Gentamicin after the December 31, 2011 dose. The decedent's Gentamicin trough level was tested at this visit. The results of the test reflected that his trough level was less than 0.5 µ/mL, a result within the normal range, and that his creatinine level was normal.

On December 29, 2011, the decedent was evaluated at home by Nurse Debra Rasmussen of Critical Care Systems, Inc., at which point he reported feeling well, and was having no problems with the home administration of the IV drug. The laboratory report analyzing blood samples that had been taken that day indicated that the Gentamicin trough was 1.0 µ/mL, which again was not too high, and that his creatinine level was 1.3 mg/dL.

According to Dr. Marr's interpretation of the relevant records and deposition testimony, the decedent, after taking his final dose of Gentamicin on December 31, 2011, started to experience dizziness, loss of balance, and visual disturbances. At Dr. Soave's deposition, she testified that she received a call on New Year's Day from the decedent, in which he complained of lightheadedness after completing his regimen of Gentamicin treatment. Dr. Marr further interpreted the decedent's medical and hospital records that had been generated between January 2012 and December 2012 as reflecting that he complained of lightheadedness, dizziness, visual impairment, and vestibular problems, and that those problems may indeed have been caused by Gentamicin toxicity, but that his more severe problems arose from biliary obstruction and inflammation, ureteral bleeding, fevers, and continued bacterial infections, as well as the implantation of stents to drain bilirubin from his bile ducts, along with a subsequent liver transplant and kidney failure.

Dr. Marr concluded that

> "I can opine to a reasonable degree of medical certainty that the treatment rendered to the patient in this case at all times comported with good and accepted practice. Specifically, I opine that decision to provide the patient with Gentamicin on December 21, 2011 was in accordance with good and accepted practice. This was a critically ill patient who had a history of recurrent Klebsiella bacteremia since his liver transplant in June, 2011. Dr. Soave had no option but to prescribe the Gentamicin. The decision was to either give the patient the Gentamicin, or he was going to die from sepsis from the Klebsiella. Klebsiella is a dangerous organism, especially in transplant patients, where complicated biliary drainage can serve as a persistent and recurrent nidus of infection, and the organism becomes resistant to many antibiotics. In this case, blood culture sensitivities documented resistance to all antibiotics except Gentamicin and Tigecycline.
>
> "However, Tigecycline would not have been an appropriate alternative as it is not an appropriate drug to treat a bacterial infection in the blood stream, especially that caused by Klebsiella. At the time, Tigecycline had only been introduced a few years prior to this admission. It was initially put on sensitivity panels to determine whether or not it was effective. However, Tigecycline has a large volume of distribution with low serum levels, with concerns of efficacy when the minimal inhibitory concentration (MIC) of the drug approximates serum levels. MICs are defined as the lowest concentration of an antimicrobial that will inhibit the visible growth of a microorganism after overnight incubation, i.e. the lowest amount of the antibiotic that you can administer that would still stop the growth of the bacteria. In this situation, the MIC of the organism to tigecycline was 2

> µg/mL, which is a relatively high MIC. At this level, the bacteria is considered to have only intermediate susceptibility, meaning that it would not be reassuring to a clinician that the Klebsiella would respond to the Tigecycline, especially when it involves the blood stream as blood levels of this drug are notably low.

Dr. Marr continued:

> "The Klebsiella that was implicated in infection here had a persistent focus from the biliary tract, and had become resistant to many antibiotics. Tigecycline would not have been an appropriate drug to give this patient at that time, as the MIC was relatively high, especially for bloodstream infection; it is likely that the organism would have become yet further resistant to Tigecycline by upregulating efflux pumps. Also, administration of the drug is complicated by requiring twice daily slow infusions, with high amounts of GI side effects (nausea, vomiting). Therefore, the best option was to prescribe Gentamicin. This is a better killing drug, amenable to once-daily administration as an outpatient. It was imperative that the patient be given the Gentamicin as soon as possible, which was done here, or he would have become Klebsiella septic and died. In fact, I can opine that it would have been a departure from good and accepted practice had the patient here not been administered Gentamicin."

Dr. Marr further opined that ototoxicity and vestibular toxicity, including symptoms of dizziness and loss of balance, as well as nephrotoxicity, are known and accepted risks of receiving Gentamicin. She additionally explained that, as she understood Dr. Soave's deposition testimony, Dr. Soave had a long conversation with the decedent and his wife concerning the potential ototoxicity, vestibular toxicity, and nephrotoxicity of Gentamicin, and the decedent agreed to proceed with the administration of Gentamicin. The transcript of Dr. Soave's testimony corroborates that understanding. Dr. Marr also concluded that, based on the decedent's height and weight, the dosage of Gentamicin administered to him, as well as the frequency of administration, were appropriate and in accordance with good and accepted practice, both as to mitigating the likelihood of adverse effects of toxicity and allowing for appropriate timing of the monitoring of Gentamicin troughs. Dr. Marr was also of the opinion that, while checking the trough every day before administration of each dose might be ideal, it is not the standard of care, especially in the setting of a patient that is being administered the drug at home. Rather, she opined that the standard of care requires checking troughs every two to seven days.

Dr. Marr asserted that, in any event, all of the laboratory results indicated the decedent's Gentamicin trough levels were normal at all times between December 21, 2011 and December 31, 2011, that there was absolutely no evidence that he exhibited any signs or symptoms of a potential ototoxicity, nephrotoxicity, or vestibular toxicity issue during the course of his treatment with Gentamicin, and that there were no signs or symptoms that would have indicated a reason to stop the Gentamicin. She further stated:

> "I can opine that even if the patient had started exhibiting signs of ototoxicity or vestibular toxicity, it would still have been appropriate to continue the patient on the Gentamicin as it would be more important to ensure that the bacteria was completely eradicated in a patient like this as discussed herein, especially in the setting of no viable alternatives. This just further illustrates how precarious of a situation the patient was in in this case. Death was truly the only alternative."

Dr. Marr further concluded that she could "opine to a reasonable degree of medical certainty that there is absolutely no evidence to support" the plaintiff's claim that the administration of Gentamicin to the decedent caused or contributed to his death. As she explained it,

> "[t]he defendants saved this patient's life with the Gentamicin, and cleared the infection from his system. Unfortunately, for reasons completely unrelated to the care at issue, this patient required second liver transplant in December, 2012. The surgery was notably complicated by extreme blood loss, and the patient went into hemorrhagic shock resulting in kidney failure. He also was yet again diagnosed with Klebsiella pneumoniae, which he had contracted numerous times over the course of two years. He then went into multi-organ failure without any meaningful chance of recovery. His family signed a DNR and he expired shortly thereafter. Thus, nothing that the defendants or Dr. Soave did or did not do in any way caused the death of this patient."

With respect to Dr. Soave's relationship to NYPH, Dr. Soave testified at her deposition that she was an infectious disease consultant, that she didn't give "orders," but instead "ma[de] recommendations to the primary team and . . . communicate[d] to them" any proposals for treatment of a particular patient. She confirmed that Drs. Kluger and Olsen were the primary members of the decedent's liver transplant team. She gave her work address as "Weill Cornell Medical College, Division of Infectious Disease," and asserted that she was employed as an associate professor by "Weill Cornell Medical College," and also had a clinical practice where she consulted with respect to New York Hospital inpatients or outpatients at various Cornell

clinics. She noted that she did not see or consult with patients outside of New York Hospital or the Cornell clinics, asserting that her only contract was with Weill Cornell Medical College, and that she did not have a contract with New York Hospital, but only admitting privileges. Dr. Soave testified that the Division of Infectious Diseases that she described was part of Weill Cornell Medical College, but that, as far as she knew, there was no department known as the department of "Infectious Diseases/Intern[al] Medicine at New York-Presbyterian Hospital or New York Hospital."

As part of her opposition papers, the plaintiff submitted the affidavit of her retained expert physician, who is an internist as well as a pharmacist, pharmacologist, and toxicologist. The expert averred that he or she was

> "fully familiar with the standards of care relating to the administration of gentamicin, an aminoglycoside antibiotic used for the treatment of certain infections. Gentamicin can cause serious dose-related side effects including nephrotoxicity and irreversible hearing loss (from which patient KUHFELDT suffered), so it is important to ensure patients receive the correct dose and are monitor[ed]."

Although the expert did not challenge the propriety of prescribing Gentamicin to treat the decedent's bacteremia, the expert opined that NYPH and its physicians, residents, pharmacists, nurses, social workers, and agents departed from good and accepted standards of medical care

> "and that the departures caused Mr. Kuhfeldt to suffer irreparable and irreversible personal injuries including ototoxicity, vestibular dysfunction, dizziness and imbalance. It is further my opinion within a reasonable degree of medical and pharmaceutical certainty that NYPH's failure to extend the interval between gentamicin doses by 12 hours beginning on 12/29/12 as well as failing to check serum creatinine and gentamicin trough levels prior to the administration of the next dose directly resulted in the development of the well known potential toxicities of gentamicin."

The expert continued that,

> "[f]urthermore, the failure of NYPH to document gentamicin administration times; and the failure to evaluate patient KUHFELDT's neurological status including noting baseline neurology findings all are deviations which led to his permanent and severe personal injuries including irreversible ototoxicity, vestibular dysfunction, hearing loss, dizziness and vertigo. It is my opinion within a reasonable degree of pharmacological and medical certainty had NYPH properly

> monitored the gentamicin trough levels and kidney function of patient KUHFELDT as recommended NYPH would have discovered that the gentamicin level was trending upward and kidney function was trending downward, then appropriate measures could have been taken, such as increasing the dosing interval gentamicin administration, and Mr. Kuhfeldt would not have suffered from these irreparable and irreversible injuries."

In reaching his or her conclusion, the plaintiff's expert relied, in part, on NYPH's guideline for administration of a drug such as Gentamicin, which provides that a once-per-day dosage is a high-dose method, as contrasted with a conventional dosing method that could have been adopted as an alternative. As the expert interpreted the guideline, when employing the high-dose, once-daily method, blood serum concentration monitoring of the drug is required. As the expert recounted it, the guideline provides that

> "trough concentrations should be checked 30 to 60 minutes prior to the next dose. The desired trough level for gentamicin was less than 0.5 mcg [µg]/mL. If level is greater than desired trough, extend dosing interval by 12 hours and repeat level prior to next dose (or use conventional dosing and monitoring methods). If the next level continues to be high, then change to conventional dosing method."

While the expert concedes that NYPH performed creatinine and WBC monitoring during the decedent's late December 2011 hospital admission, the expert noted that NYPH performed only one Gentamicin trough level test while the decedent remained an inpatient. The expert further conceded that the decedent had a blood workup at an outside laboratory on December 26, 2011, a few days after he was discharged, but noted that no new Gentamicin trough level test was conducted until December 28, 2011.

The expert concluded that the departures that proximately caused the decedent's year-long ototoxicity and vestibular and visual dysfunctions arose because of how Dr. Soave supervised and monitored the at-home administration of Gentamicin in intravenous form over the last three days of December 2011. The expert opined that the one-dose-per-day protocol, at the dosage level prescribed by Dr. Soave, was implemented without the necessary monitoring of trough levels, causing the trough to increase above normal levels after the administration of the dosage on December 29, 2011. The expert further opined that this

increase, in turn, caused or contributed to the unnecessary toxicity that led to the decedent's condition throughout 2012.

The expert explained that Dr. Soave had written a note shortly before the decedent's December 23, 2011 discharge, recommending that the decedent's nurses or caregivers should "check gentamicin troughs before the next dose and give the next dose when gentamicin is undetectable" and indicating that "[a]t home needs" included that "gentamicin trough to be checked before each dose and every other day creatinine." The expert contrasted that with an NYPH's social worker's note indicating that the decedent could go to an independent laboratory near his Connecticut home within a few days after discharge, and the absence of a daily bloodwork protocol in the "Things you should do" and "special instructions" sections of his discharge papers. The expert explained that, even though the December 28, 2011 Gentamicin trough test revealed normal levels, the failure to assure that daily testing was undertaken to confirm that the levels remained normal, coupled with administration of the drug once per 24 hours rather than once per 36 hours, proximately caused the ototoxicity and nephrotoxicity that led to the decedent's dizziness, lightheadedness, visual disturbances, and vestibular dysfunction.

It is well settled that the movant on a summary judgment motion "must make a prima facie showing of entitlement to judgment as a matter of law, tendering sufficient evidence to eliminate any material issues of fact from the case" (*Winegrad v New York Univ. Med. Ctr*., 64 NY2d 851, 853 [1985] [citations omitted]). The motion must be supported by evidence in admissible form (*see Zuckerman v City of New York*, 49 NY2d 557, 562 [1980]), as well as the pleadings and other proof such as affidavits, depositions, and written admissions (*see* CPLR 3212). The facts must be viewed in the light most favorable to the non-moving party (*see Vega v Restani Constr. Corp*., 18 NY3d 499, 503 [2012]). In other words, "[i]n determining whether summary judgment is appropriate, the motion court should draw all reasonable inferences in favor of the nonmoving party and should not pass on issues of credibility" (*Garcia v J.C.*

Duggan, Inc., 180 AD2d 579, 580 [1st Dept 1992]). Once the movant meets its burden, it is incumbent upon the non-moving party to establish the existence of material issues of fact (*see Vega v Restani Constr. Corp*., 18 NY3d at 503). A movant's failure to make a prima facie showing requires denial of the motion, regardless of the sufficiency of the opposing papers (*see id*.; *Medina v Fischer Mills Condo Assn.,* 181 AD3d 448, 449 [1st Dept 2020]).

"The drastic remedy of summary judgment, which deprives a party of his [or her] day in court, should not be granted where there is any doubt as to the existence of triable issues or the issue is even 'arguable'" (*De Paris v Women's Natl. Republican Club, Inc*., 148 AD3d 401, 403-404 [1st Dept 2017]; *see Bronx-Lebanon Hosp. Ctr. v Mount Eden Ctr*., 161 AD2d 480, 480 [1st Dept 1990]). Thus, a moving defendant does not meet its burden of affirmatively establishing entitlement to judgment as a matter of law merely by pointing to gaps in the plaintiff's case. It must affirmatively demonstrate the merit of its defense (s*ee Koulermos v A.O. Smith Water Prods*., 137 AD3d 575, 576 [1st Dept 2016]; *Katz v United Synagogue of Conservative Judaism,* 135 AD3d 458, 462 [1st Dept 2016]).

With respect to the issue of whether NYPH may be held vicariously liable for the negligence of Dr. Soave, "[g]enerally, a hospital cannot be held vicariously liable for the malpractice of a private attending physician who is not its employee" (*Sampson v Contillo*, 55 AD3d 588, 589 [2d Dept 2008], quoting *Quezada v O'Reilly-Green*, 24 AD3d 744, 746 [2d Dept 2005]; *see Hill v St. Clare's Hospital,* 67 NY2d 72, 79 [1986] ["(a)lthough a hospital or other medical facility is liable for the negligence or malpractice of its employees . . . that rule does not apply when the treatment is provided by an independent physician, as when the physician is retained by the patient himself"]; *Dragotta v Southampton Hosp*., 39 AD3d 697, 698 [2d Dept 2007]; *Salvatore v Winthrop Univ. Med. Ctr.,* 36 AD3d 887, 888 [2d Dept 2007]; *Welch v Scheinfeld*, 21 AD3d 802, 807 [1st Dept 2005]; *Christopherson v Queens-Long Is. Med. Group, P.C.,* 17 AD3d 393, 394 [2d Dept 2005]). Hence, a physician's mere affiliation with a hospital is insufficient to hold a hospital vicariously liable for the physician's malpractice (*see Pratt v Haber*,

105 AD3d 429, 429 [1st Dept 2013]). Under most circumstances, where a physician is not employed by a hospital, and the plaintiff makes no allegations of "any separate alleged acts and omissions of" the hospital's staff (*Suits v Wyckoff Heights Med. Ctr.,* 84 AD3d 487, 489 [1st Dept 2011]), the hospital cannot be held liable for the physician's malpractice (*see id*.).

Moreover,

> "[i]t is well settled that a hospital is not vicariously liable for the acts of a private attending physician at its facility who is retained by a patient and is immune from liability where its employees follow the direction of the attending physician, unless that physician's orders 'are so clearly contraindicated by normal practice that ordinary prudence requires inquiry into the correctness of the orders'"

(*Garson v Beth Israel Med. Ctr*., 41 AD3d 159, 160 [1st Dept 2007], quoting *Walter v Betancourt*, 283 AD2d 223, 224 [1st Dept 2001] [internal quotation marks and citations omitted]).

Nonetheless, "an exception to the general rule exists where a patient comes to the emergency room seeking treatment from the hospital and not from a particular physician of the patient's choosing" (*Sampson v Contillo*, 55 AD3d at 589, quoting *Salvatore v Winthrop Univ. Med. Ctr.*, 36 AD3d at 888; *see Christopherson v Queens-Long Is. Med. Group, P.C.,* 17 AD3d at 394). In addition, a hospital may be held liable under the theory of apparent or ostensible agency by estoppel, "for the acts of an independent physician where the physician was provided by the hospital or was otherwise acting on the hospital's behalf, and the patient reasonably believed that the physician was acting at the hospital's behest" (*Malcolm v Mount Vernon Hosp*., 309 AD2d 704, 705 [1st Dept 2003], quoting *Sarivola v Brookdale Hosp. & Med Ctr*., 204 AD2d 245, 245-246 [1st Dept 1994], *see Soltis v State of New York*, 172 AD2d 919 [3d Dept 1991]). Such agency may be inferred from "'words or conduct of the principal, communicated to a third party, that give rise to the appearance and belief that the agent possesses authority' to act on behalf of the principal" (*Thurman v United Health Servs. Hosps., Inc*., 39 AD3d 934, 935-936 [3d Dept 2007], quoting *Searle v Cayuga Med. Ctr. at Ithaca*, 28 AD3d 834, 836 [3d Dept 2006]).

NYPH made a prima facie showing of its entitlement to judgment as a matter of law by demonstrating, through Dr. Soave's deposition testimony and Dr. Marr's expert affidavit, that (a) Dr. Soave was not an NYPH employee, (b) any physician, assistant, nurse, or orderly who was in fact an NYPH employee simply followed Dr. Soave's instructions or recommendations as a consulting physician with respect to the prescription, dosing, administration, and monitoring of Gentamicin (c) those employees did not commit, nor was it alleged that they committed, any independent acts of malpractice, and (d) Dr. Soave's recommendations, even if they were deemed to be "orders," were not so clearly contraindicated by normal practice that ordinary prudence required inquiry into their correctness. Hence, NYPH established, prima facie, that it could not be held liable, vicariously or otherwise, for any malpractice in connection with the prescription, dosing, administration, or monitoring of Gentamicin.

In opposition to this showing, however, the plaintiff raised a triable issue of fact as to whether Dr. Soave was indeed an NYPH employee at the time that she allegedly committed acts of malpractice. In this regard, the plaintiff submitted, with her opposition papers, a copy of a letter dated August 24, 2010 from the New York Presbyterian Medical Staff Office to Dr. Soave, written on the letterhead of New York Presbyterian Hospital, and signed by NYPH's credentialing analyst. In that letter, NYPH purported to reappoint Dr. Soave "to the Medical Staff of New York-Presbyterian Hospital from 07/01/2010 to 6/30/2012 WITH admitting privileges," and indicated that NYPH's credentialing committee approved Dr. Soave when it renewed her privileges. The plaintiff also submitted documentation showing that it was NYPH, not Dr. Soave, any private practice, or any independent Weill Cornell Medical College clinic, that billed the relevant insurers for the services that Dr. Soave rendered to the decedent. Whether NYPH may be held vicariously liable for Dr. Soave's conduct must thus be determined by a jury to resolve this disputed issue of fact.

The court notes that, although the plaintiff's expert alleged that all of NYPH's employees, including its nurses and social workers, departed from good medical practice, the conduct of all

of the medical and support personnel performing tasks in connection with the administration of Gentamicin was undertaken while they were acting pursuant to the recommendations of Dr. Soave, and they did not exercise any independent judgment as to whether or how to override those recommendations; indeed, the parties' submissions suggest that all NYPH employees and affiliated medical and support personnel strictly adhered to Dr. Soave's recommendations.

"To sustain a cause of action for medical malpractice, a plaintiff must prove two essential elements: (1) a deviation or departure from accepted practice, and (2) evidence that such departure was a proximate cause of plaintiff's injury" (*Frye v Montefiore Med. Ctr.*, 70 AD3d 15, 24 [1st Dept 2009]; *see Roques v Noble*, 73 AD3d 204, 206 [1st Dept 2010]; *Elias v Bash*, 54 AD3d 354, 357 [2d Dept 2008]; *DeFilippo v New York Downtown Hosp*., 10 AD3d 521, 522 [1st Dept 2004]). A defendant physician moving for summary judgment must make a prima facie showing of entitlement to judgment as a matter of law by establishing the absence of a triable issue of fact as to his or her alleged departure from accepted standards of medical practice (*Alvarez v Prospect Hosp.,* 68 NY2d 320, 324 [1986]; *Frye v Montefiore Med. Ctr*., 70 AD3d at 24) or by establishing that the plaintiff was not injured by such treatment (*see McGuigan v Centereach Mgt. Group, Inc*., 94 AD3d 955 [2d Dept 2012]; *Sharp v Weber*, 77 AD3d 812 [2d Dept 2010]; *see generally Stukas v Streiter*, 83 AD3d 18 [2d Dept 2011]).

To satisfy the burden, a defendant must present expert opinion testimony that 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 Roques v Noble*, 73 AD3d at 206;.*Joyner-Pack v. Sykes*, 54 AD3d 727, 729 [2d Dept 2008]; *Koi Hou Chan v Yeung*, 66 AD3d 642 [2d Dept 2009]; *Jones v Ricciardelli*, 40 AD3d 935 [2d Dept 2007]). If the expert's opinion is not based on facts in the record, the facts must be personally known to the expert and, in any event, the opinion of a 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]). Stated another way, the defendant's expert's opinion must

"explain 'what defendant did and why'" (*id*., quoting *Wasserman v Carella*, 307 AD2d 225, 226, [1st Dept 2003]).

Furthermore, to satisfy his or her burden on a motion for summary judgment, a defendant must address and rebut specific allegations of malpractice set forth in the plaintiff's bill of particulars (*see Wall v Flushing Hosp. Med. Ctr*., 78 AD3d 1043 [2d Dept 2010]; *Grant v Hudson Val. Hosp. Ctr*., 55 AD3d 874 [2d Dept 2008]; *Terranova v Finklea*, 45 AD3d 572 [2d Dept 2007]).

Once satisfied by the defendant, the burden shifts to the plaintiff to demonstrate the existence of a triable issue of fact by submitting an expert's affidavit or affirmation attesting to a departure from accepted medical practice and opining that the defendant's acts or omissions were a competent producing cause of the plaintiff's injuries (*see Roques v Noble*, 73 AD3d at 207; *Landry v Jakubowitz*, 68 AD3d 728 [2d Dept 2009]; *Luu v Paskowski*, 57 AD3d 856 [2d Dept 2008]). Thus, to defeat a defendant's prima facie showing of entitlement to judgment as a matter of law, a plaintiff must produce expert testimony regarding specific acts of malpractice, and not just testimony that alleges "[g]eneral allegations of medical malpractice, merely conclusory and unsupported by competent evidence tending to establish the essential elements of medical malpractice" (*Alvarez v Prospect Hosp*., 68 NY2d at 325; *see Frye v Montefiore Med. Ctr*., 70 AD3d at 24). In most instances, the opinion of a qualified expert that the plaintiff's injuries resulted from a deviation from relevant industry or medical standards is sufficient to preclude an award of summary judgment in a defendant's favor (*see Murphy v Conner*, 84 NY2d 969, 972 [1994]; *Frye v Montefiore Med. Ctr*., 70 AD3d at 24). 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 Hosp*., 99 NY2d 542, 544 [2002]; *see Frye v Montefiore Med. Ctr*., 70 AD3d at 24).

Consequently, where the parties' conflicting expert opinions are adequately supported by the record, summary judgment must be denied (*see Frye v Montefiore Med. Ctr.*, 70 AD3d at 24 *Cruz v St. Barnabas Hospital,* 50 AD3d 382 [1st Dept 2008]). Here, there is a sharp dispute between the experts as to whether the appropriate standard of care requires a treating physician to undertake a daily check of Gentamicin trough levels in a patient, or whether a test two to seven days after the administration of the most recent dose was sufficient to satisfy that standard. Moreover, there is a dispute between the experts as to whether a once-per-day or a once-per-36-hour regimen for the administration of Gentamicin was within the appropriate standard of care for the situation that the decedent presented. There is also a dispute as to whether the failure to test the trough levels after the December 29, 2011 administration, and the failure to extend the interval between administrations, caused or contributed to toxicity. The court notes that the experts appear to agree that the administration of Gentamicin was indicated for the treatment of the decedent's recurring bacteremia, that the decedent, in fact, suffered from toxicity caused by an excess of Gentamicin, and that this toxicity caused his symptoms; the primary dispute is whether the actual frequency of monitoring of the trough levels and the failure to enlarge the interval between administrations was or was not a departure from good and accepted practice, and whether enlarging those intervals based on more frequent monitoring would have avoided or mitigated the severity of the decedent's symptomatology over the final year of his life. In light of this factual dispute, NYPH's motion for summary judgment dismissing the medical malpractice cause of action against it must be denied.

The elements of a cause of action for lack of informed consent are

> "(1) that 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"

(*Spano v Bertocci*, 299 AD2d 335, 337-338 [2d Dept 2002]). For the claim to be actionable, a defendant must have engaged in a "non-emergency treatment, procedure or surgery" or "a diagnostic procedure which involved invasion or disruption of the integrity of the body" (Public Health Law § 2805-d[2]). Here, NYPH established, prima facie, that the decedent's treatment with Gentamicin was necessary to prevent him from sepsis and thus to save his life and that, consequently, the subject treatment constituted emergency treatment. It further established that both the plaintiff and her decedent were informed in detail of the known risks of Gentamicin, including toxicity and permanent, adverse effects to vestibular functioning and balance, but that the decedent nonetheless agreed to the treatment as a life-saving measure. The plaintiff, in her opposition papers, failed to raise a triable issue of fact, and raised no serious argument against these showings. Hence, the claim to recover for lack of informed consent must be dismissed.

In opposition to NYPH's prima facie showing that any alleged malpractice did not cause or contributed to the decedent's death, the plaintiff failed to raise a triable issue of fact, or even argue to the contrary.

The court further notes that the affidavit of the plaintiff's retained expert physician was executed and notarized in Virginia, but does not include the certificate of conformity required by CPLR 2309, which is a written instrument pursuant to which a person qualified by the laws of the country or state in which an affidavit is executed and notarized, or by the laws of New York, certifies that the out-of-state affidavit has indeed been drafted, executed, and notarized in conformity with the laws of that country or state. This defect does not require the court to disregard the affidavit or reject the plaintiff's motion papers, as the defect may be cured by the submission of the proper certificate nunc pro tunc (*see Bank of New York v Singh*, 139 AD3d 486 [1st Dept 2016]; *Seiden v Sonstein*, 127 AD3d 1158 [2d Dept 2015]).

Accordingly, it is

ORDERED that the motion of the defendant New York Presbyterian/Weill Cornell Medical Center for summary judgment dismissing the complaint insofar as asserted against it is

granted to the extent that the causes of action to recover for lack of informed consent and wrongful death are dismissed, and the motion is otherwise denied.

This constitutes the Decision and Order of the court.

3/16/2021
DATE

JOHN J. KELLEY, J.S.C.

CHECK ONE:		CASE DISPOSED			[X]	NON-FINAL DISPOSITION	
		GRANTED		DENIED	[X]	GRANTED IN PART	OTHER
APPLICATION:		SETTLE ORDER				SUBMIT ORDER	
CHECK IF APPROPRIATE:		INCLUDES TRANSFER/REASSIGN				FIDUCIARY APPOINTMENT	REFERENCE