At an IAS Term, Part 36 of the Supreme Court of the State of New York, held in and for the County of Kings, at the Courthouse, at 360 Adams Street, Brooklyn, New York, on the 23rd day of November, 2021.

PRESENT:

HON. BERNARD J. GRAHAM,
Justice.

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LUIS RIVERA, as Administrator of the Estate of CARMEN OTERO, Deceased,

Plaintiff,

-against-

WYCKOFF HEIGHTS MEDICAL CENTER, HOWARD EICHENSTEIN, M.D., DALI CHAKHVASHVILI MARDACH, M.D., AKELLA CHENDRASEKHAR, M.D., MUKUL ARYA, M.D., THEOPINE ABAKPORO, M.D., BHAKTI PATEL, P.A., and WYCKOFF EMERGENCY MEDICINE SERVICES, P.C.,

Defendants.

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WYCKOFF HEIGHTS MEDICAL CENTER,

Third-Party Plaintiff,

-against-

MUKUL ARYA, M.D., THEOPINE ABAKPORO, M.D., BHAKTI PATEL, P.A., and WYCKOFF EMERGENCY MEDICINE SERVICES, P.C.,

Third-Party Defendants.

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DECISION AND ORDER

Index No. 9685/11

Mot. Seq. No. 5-8

The following e-filed papers read herein: NYSEF #:

Notice of Motion, Affirmations, and Exhibits Annexed	2-22; 24-43; 49-75; 78-79
Affirmations in Opposition and Exhibits Annexed	76-77; 82-84; 86-88; 90-92; 94-96
Reply Affirmation and Exhibits Annexed	80-81; 99; 100-101; 102-105

In this action to recover damages for medical malpractice, lack of informed consent, and wrongful death, the following motions have been consolidated for disposition:[1]

In Seq. No. 6, defendants Howard Eichenstein, M.D. (Dr. Eichenstein), and Dali Chakhvashvili Mardach, M.D. (Dr. Mardach), move for an order: (1) pursuant to CPLR 3212 (b), granting summary judgment dismissing the amended complaint in its entirety as to each of them; or, in the alternative, (2) pursuant to CPLR 3212 (g), granting partial summary judgment dismissing portions of the complaint as to each of them;

In Seq. No. 5, defendant Mukul Arya, M.D. (Dr. Arya), moves for: (1) an order, pursuant to CPLR 3212, granting summary judgment dismissing the amended complaint in its entirety as against him; or, in the alternative, (2) leave, pursuant to CPLR 2221 (f), to renew and reargue his prior motion based on allegedly new evidence and an alleged misapprehension of fact and law, and, upon renewal and/or reargument, vacating the order which permitted his joinder as a direct defendant in the main action;

In Seq. No. 7, defendant Akella Chendrasekhar, M.D. (Dr. Chendrasekhar), moves for an order, pursuant to CPLR 3212 (b), granting summary judgment dismissing the amended complaint in its entirety as to him; and

In Seq. No. 8, defendant Wyckoff Heights Medical Center (Wyckoff) moves for an order, pursuant to CPLR 3212 (g), granting partial summary judgment dismissing all vicarious liability claims as against it insofar as they are attributable to, and to the extent

[1] The Court is listing the motions out of sequence to fit the chronology of its narrative.

they are dismissed as against, Dr. Chendrasekhar. Separately, Wyckoff opposes Dr. Arya's motion.

Plaintiff Luis Rivera, as the administrator of the estate of Carmen Otero, deceased (plaintiff), opposes all of the consolidated motions with respect to his medical malpractice and wrongful death claims as against the moving defendants, *with the exception of Dr. Eichenstein* as to whom he has no objection to dismissal of all claims. Accordingly, the branch of Dr. Eichenstein and Dr. Mardach's joint motion for summary judgment dismissing the amended complaint *as against Dr. Eichenstein* is granted without opposition. In addition, the branches of the remaining defendants' motions for summary judgment dismissing the cause of action alleging *lack of informed consent* insofar as asserted against them are also granted, since plaintiff has failed to address or specifically oppose these branches of their motions (*see Elstein v Hammer*, 192 AD3d 1075 [2d Dept 2021]). This leaves for the Court's review the sufficiency of the remaining moving defendants' factual and expert showing (and, where appropriate, plaintiff's factual and expert opposition) as to the alleged lack of merit of plaintiff's medical malpractice and wrongful death claims as against Dr. Mardach, Dr. Arya, Dr. Chendrasekhar, and Wyckoff (with Wyckoff seeking dismissal of vicarious liability claims for Dr. Chendrasekhar's acts/omissions in the event the latter is absolved of direct liability to plaintiff).

Background[2]

I. The Prelude

On Thursday, April 2, 2009,[3] the patient, a female aged 66, presented to Wyckoff's emergency room (ER) with complaints of intermittent lower abdominal pain for a period of one month, and of constipation for a period of one week.[4] After passing stool following administration of a Fleet enema in the ER, she was discharged home with a prescription for an over-the-counter stool softener, and with instructions to return to the ER if her condition became worse. None of the moving defendants, with the exception of Wyckoff, was involved in the patient's care on April 2nd.

Post-discharge on April 2nd, the patient's adult children became concerned. The patient's daughter, then residing with the patient, observed that she was: (1) vomiting multiple times; (2) visibly in pain; and (3) unable to use a bathroom.[5] The patient's son, when visiting his mother later in the day of the discharge, observed her to be visibly weak and in pain.[6]

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[2] A lengthy recitation of the facts is necessary to inform the Court's decision. In the current context, "the facts must be viewed in the light most favorable to the non-moving party [here, plaintiff], and every available inference must be drawn in . . . [his] favor" (*Matter of Eighth Jud. Dist. Asbestos Litig.*, 33 NY3d 488, 496 [2019] [internal quotation marks and citations omitted]).

[3] All references are to the year 2009, unless otherwise indicated.

[4] The patient's son corroborated that she had been complaining to him of pain and constipation ten days prior on March 21, 2009, which was his birthday (Plaintiff's June 14, 2013 EBT tr at page 18, line 18 to page 19, line 6; Plaintiff's July 16, 2019 EBT tr at page 21, lines 5-24).

[5] Jennifer Olavarria EBT tr at page 16, lines 14-15; page 17, lines 3-5 and 11-13; page 18, lines 9-19; page 24, lines 13-18; page 25, lines 9-11.

[6] Plaintiff's July 16, 2019 EBT tr at page 30, lines 3-7; page 31, line 23 to page 32, line 2.

II. The Ordeal

The patient, on her return to Wyckoff's ER on Sunday, April 5, 2009, presented with a potentially life-threatening condition – a large bowel obstruction (LBO) which was caused by her underlying chronic diverticulosis which, in turn, had been misdiagnosed as constipation at her April 2nd visit to Wyckoff's ER. Over the course of 2½ days, the patient was treated for the *symptoms* of the LBO but was not treated for the *underlying LBO itself*. When the patient allegedly became septic, having allegedly suffered one or more perforations in her colon, only then did the patient undergo surgery in the early morning hours of Wednesday, April 8, 2009. The *delay* in performing surgery allegedly caused the patient's post-operative complications and her ultimate death on May 1, 2009. The medico-surgical aspects of the patient's April 8th surgery and her post-operative care through May 1st are not at issue.

A. Sunday, April 5, 2009

On Sunday, April 5th, shortly before 11 a.m., the patient returned to Wyckoff's ER with her son's assistance.[7] On presentation to Wyckoff's ER, the patient complained, via her son who acted as her Spanish/English interpreter, of vomiting and abdominal pain for the preceding two weeks. She informed the triage nurse of her prior April 2nd ER visit and that the then-prescribed stool softener had not been effective (Wyckoff's Chart [NYSCEF #28] at 9, 15). The patient further reported that she now "feels worse," with

[7] Plaintiff's July 16, 2019 EBT tr at page 36, lines 17-18 ("My mother was crying and moaning in pain. She could barely walk."); page 33, line 3 to page 34, line 25; page 182, line 9 to page 183, line 5.

a loss of appetite. She described her pain in her lower abdomen to be at 3-to-4 in severity. On physical examination, she exhibited diffuse tenderness in the left and right upper quadrants of her visibly distended abdomen (Wyckoff's Chart at 9-10, 15-16). She was triaged as an emergency patient.

At 10:58 a.m., the patient was admitted to the main ER. Between 10:58 a.m. and 11:45 a.m., the patient was examined by an ER nurse, although the latter did not deem the patient's condition urgent enough to immediately summon an ER attending.[8] At approximately 11:45 a.m., the patient was examined by ER attending defendant Dr. Mardach, a board-certified internist. According to plaintiff, Dr. Mardach, at the time, told him that she would take care of his mother.[9] Contrary to Dr. Mardach's pretrial testimony, plaintiff did not request her to treat his mother as a private patient.[10]

Dr. Mardach, on reviewing the patient's chart, noted as significant her repeated complaints of abdominal pain for the preceding two weeks and her four episodes of vomiting in the preceding 24 hours.[11] Vomiting is a somewhat late finding in the LBO setting, as it reflects an inability to pass stool. On physical examination, Dr. Mardach noted that the patient exhibited diffuse tenderness in all four abdominal quadrants.

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[8] Dr. Mardach's EBT tr at page 35, lines 11-14.

[9] Plaintiff's July 16, 2019 EBT tr at page 59, lines 15-16.

[10] Plaintiff's June 14, 2013 EBT tr at page 26, line 22 to page 28, line 6; Plaintiff's July 16, 2019 EBT tr at page 45, lines 15-17. It is immaterial that the patient's son previously had been treated as an outpatient on two occasions for his own medical condition(s) by the joint practice of Dr. Mardach and nonparty Vanna Morero, M.D., in their private practice (Dr. Mardach's EBT tr at page 109, lines 20-24). What matters is that the patient's son did not choose Dr. Mardach to be his mother's private physician at the April 5th visit to Wyckoff's ER.

[11] Dr. Mardach EBT tr at page 31, line 11; page 33, lines 4-21.

Dr. Mardach further noted that the patient's abdomen was visibly distended on her left side (the side of the sigmoid and descending colon). Dr. Mardach next noted the reassuring absence of abdominal rebound and guarding in the patient – both signs, if present, would have been indicative of peritonitis.[12] Dr. Mardach next noted that the patient was hypertensive at 165/82, tachycardic at 96 beats per minute, and dehydrated (dry oral mucosa) (Wyckoff's Chart at 9).[13] Dr. Mardach documented the patient's subjective complaint of pain as being a "4," and that she was feeling worse than when she had presented to Wyckoff's ER three days prior (Wyckoff's Chart at 9). Dr. Mardach initially ordered for the patient an antacid and an antiemetic for intravenous (IV) administration, as well as a normal saline drip for hydration. After the patient's blood test results came back with a low reading for potassium at 3 (reference range 3.6-5.2), Dr. Mardach added potassium supplementation. Dr. Mardach attributed the patient's decreased potassium, as well as the concurrently reported decreased sodium at 129 (reference range 135-145), to the patient's prior episodes of vomiting, indicative of an LBO.[14]

At 12 noon, Dr. Mardach ordered a CT scan of the patient's abdomen and pelvis (the initial CT scan) (Wyckoff's Chart at 13).[15] After the initial CT scan was performed

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[12] Dr. Mardach's EBT tr at page 45, line 15 to page 46, line 7.

[13] Dr. Mardach's EBT tr at page 30, line 16 to page 31, line 6; at page 43, lines 17-25.

[14] Dr. Mardach's EBT tr at page 54, lines 7-20.

[15] Although Dr. Mardach testified (at page 49, lines 16-17) that she ordered the initial CT scan with oral contrast, the initial CT scan report states that it was performed without either oral or IV contrast.

but before the radiologist's report was ready, Dr. Mardach, according to her pretrial testimony (at page 53, lines 2-16), reviewed the films at her computer station in the ER. Dr. Mardach, upon her review of the initial CT scan films, documented her findings of two interrelated events: (1) "obstruction" or "wall thickening" of a portion of the patient's colon, and (2) "dilatation of [the remaining portion of her] colon" (Wyckoff's Chart at 11). Dr. Mardach's first finding – an "obstruction" or "wall thickening" – indicated an increase in the thickness of the lumen of the colon, meaning that the caliber of the colon decreased or narrowed to the point of an LBO as the result of diverticulosis.[16] Dr. Mardach's second finding – "dilatation" – indicated an increase in the caliber of the colon which was proximal to (or above) the LBO. Dr. Mardach's "final clinical impression" was that the patient was suffering from the LBO. [17]

According to plaintiff, Dr. Mardach reviewed the initial CT scan films with him in the ER and pointed to him on the films his mother's colon blockage, describing it as being "the size of a grapefruit."[18] Further according to plaintiff, Dr. Mardach initially told him that his mother needed surgery which, if performed, would result in his mother wearing a colostomy bag for the remainder of her life.[19] Either in the same conversation or on the following day, however, Dr. Mardach informed plaintiff that she wanted to

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[16] Dr. Mardach's EBT tr at page 55, lines 13-16.

[17] Dr. Mardach's EBT tr at page 54, lines 4-6.

[18] Plaintiff's July 16, 2019 EBT tr at page 57, line 21 to page 58, line 5; page 192, lines 3-8.

[19] Plaintiff's June 14, 2013 EBT tr at page 30, lines 2-12; page 31, lines 6-16.

avoid surgery and, instead, "want[ed] to give [the patient] medication to see if the medication works" – a recommendation which plaintiff accepted.[20]

The radiologist's report of the initial CT scan, dictated at 1:37 p.m. on April 5th, found, as to the GI section of the patient's abdomen, the following:

> "Evaluation of the stomach is limited due to underdistention and underopacification. *The small bowel is normal in caliber. The large bowel is markedly distended to the level of the transition zone in the mid-sigmoid colon . . . where there is extensive diverticulosis. This may be due to wall thickening from diverticular disease*; however, the exact etiology is unclear. No contrast is seen at this level. *The sigmoid colon and rectum [are] decompressed. There is no sign of diverticulitis.*
>
> *There is no free intraperitoneal air.* There is no abdominal or pelvic ascites.
>
> . . . *There is no significant retriperitoneal, pelvic, or inguinal lymphadenopathy.*
>
> Impression: The colon is dilated to the level of a transition zone in the mid sigmoid colon where there is extensive diverticulosis. Possible etiologies include wall thickening from diverticular disease; however, the exact etiology is unclear.
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> Recommendation: GI consult is recommended."[21]

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[20] Plaintiff's June 14, 2013 EBT tr at page 36, lines 4-20; page 68, lines 4-18; Plaintiff's July 16, 2019 EBT tr at page 55, lines 10-13 ("Dr. [Mardach] said, most likely, your mother needs surgery. We are going to try medication first. She recommended medication."); page 59, lines 10-11 ("The topic of medication came up after [the initial CT scan review.])"; page 59, lines 18-24 ("She [Dr. Mardach] recommended the medication before surgery."]; page 60, lines 22-23 ("Dr. [Mardach] recommended medication first.").

[21] Final Report, Non-Contrast Enhanced CT of Abdomen and Pelvis, at 2 (capitalization omitted; emphasis added). The initial CT scan report is included in Wyckoff's Chart which was filed at NYSCEF #5 and in Wyckoff's Chart filed at NYSCEF #74 at AC0001307-AC0001308 (rather than in Wyckoff's Chart which was filed at NYSCEF #28).

The initial CT scan report, as amplified by pretrial testimony, is significant for the following:

(1) "[T]he transition zone in the [patient's] mid-sigmoid colon" was obstructed or narrowed (an LBO), which, in the radiologist's view, may have been due to extensive *diverticulosis* (herniations or protrusions of mucosa through the muscular wall of the colon) but without *diverticulitis* (without an inflammation superimposed on diverticulosis).

(2) The area that was *distal* to (or below) the LBO was "decompressed."

(3) The *entire* area of the colon which was *proximal* to (or above) the LBO – the area starting at the cecum in the right colon, continuing to the transverse colon, and concluding at the transition zone in the mid-sigmoid of the left colon – was "markedly distended" (or dilated).[22]

(4) The diameter of the patient's cecum – the widest section of the colon in diameter[23] – was dilated. The diameter of the cecal dilation at that time varied between the separate estimations made by Dr. Mardach and Dr. Chendrasekhar. According to Dr. Mardach, the cecal dilation at the time was at 9 cm in diameter, which, in her opinion, was a medium to large enlargement and, thus, at risk of perforation (Wyckoff's Chart at 75).[24] According to Dr. Chendrasekhar, however, the diameter of the cecal dilation at the time was at "about 8 cm" (Wyckoff's Chart at 305 (Operative Report at 1), which (in his

[22] Dr. Chendrasekhar's EBT tr at page 104, lines 10-24; page 105, line 6 to page 106, line 3.

[23] Dr. Chendrasekhar's EBT tr at page 136, lines 2-3.

[24] Dr. Mardach's EBT tr at page 93, line 24 to page 94, line 4.

pretrial testimony in which he failed to fully address the risk of cecal perforation) was "not at a critical level where the blood supply cutoff might start occurring."[25]

(5) The dilation of the colon proximal to (or above) the LBO did not extend to the small bowel because the latter's radiographic appearance on the initial CT scan was normal in caliber. This means that the patient's ileocecal valve was competent in precluding the dilation from moving up the colon and entering the small bowel through the ileocecal valve.[26] In sum, the patient's LBO was in the nature of a closed loop confined to the colon (also known as the large bowel).

(6) There was no radiographic evidence of colonic (and, in particular, no cecal) perforation because "[t]here [was] no free intraperitoneal air" at the time.[27]

(7) Subject to a GI consultation, no malignancy, as a likely alternative cause of the LBO, was detected on the initial CT scan because there were no enlarged lymph nodes, nor any local/regional metastases.

At 1:30 p.m. by telephone, and at 2 p.m. in writing, Dr. Mardach requested from nonparty surgical attending Ramon Benedicto, M.D. (Dr. Benedicto), a consultation to evaluate the surgical treatment of the LBO (Wyckoff's Chart at 291 [Consultation Request]).

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[25] Dr. Chendrasekhar's EBT tr at page 131, line 21 to page 132, line 18.

[26] Dr. Chendrasekhar's EBT tr at page 137, line 24 to page 138, line 4; page 152, lines 4-5.

[27] Dr. Arya's EBT tr at page 40, lines 15-16 ("The [initial] CAT scan did not show any sign of perforation.").

Between 2 p.m. and 2:30 p.m., a junior member of the surgical team, fourth-year surgical resident nonparty Misuko Takahashi, D.O. (Dr. Takahashi), provided a surgical consultation to Dr. Mardach in the latter's presence, and some time thereafter relayed her findings to a surgical attending by telephone.[28] According to Dr. Takahashi's consultation note, timed at 2 p.m., the patient was found, based on the initial CT scan report, to have: (1) an LBO in the mid-sigmoid transition; (2) diverticulosis; and (3) diverticular disease with fibrosis and thickened wall, albeit without free air or pneumatosis (the presence of gas within the wall of the colon) (Wyckoff's Chart at 291). Dr. Takahashi noted that the patient had a "bowel movement times 1 today (small)" (*id.*). Further, Dr. Takahashi, based on her physical examination, found that the patient's abdomen was distended, positive for bowel sounds, with diffuse tenderness, but without rebound or guarding (*id.*).

Dr. Takahashi's assessment and plan, as per the 2 p.m. note, were as follows: (1) the patient was suffering from an LBO; (2) she needed a nasogastric decompression; (3) she could not take anything by mouth (no oral intake); (4) she needed IV fluids; (5) the GI service should be consulted about performing a colonoscopy on the patient; and (6) the patient would need surgery in the form of a "diverting ostomy versus resection"; and (7) the patient should be optimized for the operating room (Wyckoff's Chart at 291). Dr. Takahashi's plan, at 2 p.m. on April 5th, was essentially a two-step approach to

[28] Dr. Mardach's EBT tr at page 61, lines 20-22 ("Q. Was [the patient] evaluated for a surgical consultation in your presence? A. Yes."); page 64, lines 12-14 ("[The] [f]emale physician (Dr. Takahashi) evaluated the patient, who (Dr. Takahashi) was a resident, then she had called the attending."]).

surgical management of the patient's LBO: (1) a diagnostic colonoscopy to corroborate the radiographic finding of the LBO; and (2) a surgical resection of the LBO with the creation of an ostomy.[29]

Dr. Takahashi, as a junior member of the surgery team, could not provide any surgical consultation, without having her assessment/plan cosigned and approved by her surgical attending. At the time, the four-person surgical practice at Wyckoff included, among others: (1) the above-noted surgical attending Dr. Benedicto to whom Dr. Mardach initially had directed the surgical consultation note regarding the patient, and (2) Dr. Chendrasekhar, then a director of trauma and surgical critical care at Wyckoff with a double board certification in surgery and surgical critical care. According to Wyckoff's Chart (at 291), Dr. Chendrasekhar manually cosigned Dr. Takahashi's 2 p.m. note, with his handwritten addition that the "patient [was] seen and reviewed," with the addition of a stamp bearing his name/medical license number.[30] Dr. Chendrasekhar's cosigning and approval of Dr. Takahashi's 2 p.m. note, as it appears in Wyckoff's Chart, is undated and untimed. According to Dr. Chendrasekhar, he signed, added to, and

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[29] According to Dr. Mardach, Dr. Takahashi, in contradiction of the consultation note, told her that the patient needed *immediate surgery*, albeit to be preceded by a colonoscopy (Dr. Mardach's EBT tr at page 68, lines 11-27 ["Q. What was the sum and substance of the conversation that you had with Dr. Tak(a)hashi with respect to the surgical consultation that you ordered on (the patient)? A. That the patient will need *immediate surgery* and she needs to have a colonoscopy prior."] [emphasis added]). This is consistent with plaintiff's pretrial testimony that an unidentified female (possibly Dr. Takahashi) told him at approximately 3 p.m. on April 5th that his mother needed surgery (Plaintiff's June 14, 2013 EBT tr at page 32, line 2 to page 33, line 20 ["She said (that) *later in the day we're going to bring your mother up because your mother's going to need surgery.*"] [emphasis added]).

[30] Dr. Chendrasekhar's EBT tr at page 82, line 10 to page 83, line 14.

stamped Dr. Takahashi's 2 p.m. note *after* the patient's discharge (here, death) *without* reviewing that note for accuracy, explaining, at his pretrial deposition, that he did so because he needed to "process" or complete the patient's chart for administrative reasons.[31] Dr. Chendrasekhar testified that he did not see the patient, nor was he involved in her care, until two days later in the evening of Tuesday, April 7th.[32] According to Dr. Chendrasekhar, it was Dr. Benedicto, not he, who was the attending in charge of the surgical aspects of the patient's care and who approved, albeit not in writing, Dr. Takahashi's plan of care for the patient.[33] Dr. Chendrasekhar's deposition testimony is at odds with that of Dr. Mardach who testified that Dr. Benedicto never evaluated the patient, and that Dr. Chendrasekhar, in place of Dr. Benedicto, responded to her request for a surgical consultation,[34] although she could not recall whether Dr. Chendrasekhar saw the patient in person at the time.[35]

At 3 p.m., a junior member of Dr. Mardach's medical team, nonparty medical resident Ramandeep S. Banga, M.D. (Dr. Banga), admitted the patient to the medical

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[31] Dr. Chendrasekhar's EBT tr at page 50, line 17 to page 51, line 3; page 52, line 19; page 53, lines 18-22; page 54, line 18 to page 55, line 15; page 56, lines 8-10; page 60, lines 3-8; page 61, lines 4-7; page 63, lines 3-7; page 67, line 25 to page 68, line 7; page 68, lines 18-24; page 83, line 23 to page 84, line 3; page 95, lines 3-8.

[32] Dr. Chendrasekhar's EBT tr at page 44, line 9; page 50, lines 8-13; page 83, lines 15-18.

[33] Dr. Chendrasekhar's EBT tr at page 51, lines 4-5; page 59, line 23 to page 60, line 2.

[34] Dr. Mardach's EBT tr at page 71, lines 12-14 ("Q. To your knowledge, did Dr. Benedicto ever evaluate [the patient]? A. No."); at page 63, lines 6-15 ("Q. Who responded to [Dr. Mardach's] surgical consultation request? A. Dr. Chendrasekhar. Q. Dr. Chendrasekhar was a resident at that time? A. He was an attending. Q. He was an attending? A. Yes. Q. Surgical attending? A. Surgical attending.").

[35] Dr. Mardach's EBT tr at page 64, line 25 to page 65, line 4 ["Q. Did Dr. Chendrasekhar also evaluate physically (the patient) as per this consultation request? A. I cannot recall."]).

service under Dr. Mardach's name and that of her partner, nonparty Vanna Morero, M.D. (Dr. Morero) (Wyckoff's Chart at 13).[36] That was an unusual course of action because "[t]ypically, a patient admitted from the emergency department is admitted to the service of a physician *other than* the ER doctor."[37] Despite the "paper" admission to the medical floor, the patient physically remained stationed in her cubicle in the ER until she was transferred to the medical-service floor the following day.[38]

At 4 p.m., Dr. Banga (rather than the surgical team) requested a GI consultation under the names of his medical attendings, Dr. Mardach and Dr. Morero, from a GI attending, nonparty Yashpal Arya, M.D., who is the father of defendant Dr. Arya (Wyckoff's Chart [Consultation Request] at 292).[39] The request for a GI consultation did *not* indicate that it was STAT or urgent (*id.*).

Between 5:00 p.m. and 5:30 p.m., Dr. Banga ordered for the patient two antibiotics as prophylaxis (Wyckoff's Chart at 385).

Between 5:50 p.m. and 6 p.m., Dr. Banga, on two separate occasions, ordered Morphine for the patient to control the patient's pain (Wyckoff's Chart at 382).

Dr. Banga, in his note timed at 6 p.m. but reflecting his rounding on the patient earlier in the day, described the patient's history of presenting illness as follows:

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[36] Dr. Mardach's EBT tr at page 76, lines 6-7.

[37] Affirmation of Dr. Mardach's expert, Mark S. Silberman, M.D. (NYSCEF #26), ¶¶ 20, 59 (emphasis added).

[38] Plaintiff's June 14, 2013 EBT tr at page 34, lines 7 to 23; Plaintiff's July 16, 2019 EBT tr at page 65, line 25 to page 66, line 16; page 68, lines 20-21; page 76, line 25 to page 77, line 4.

[39] The request for a GI consultation came from the medical team of Dr. Mardach, rather than from the surgical team.

> "ER with complaints of abdominal pain . . . 5 of 10 in severity in left lower abdomen, with constipation aggravated with oral intake[,] with multiple episodes of vomiting which were more [in number] since last night. No feculent type [of] vomitus. . ." (Wyckoff's Chart at 17).

In his 6 p.m. note, Dr. Banga indicated that the patient's appetite was poor (Wyckoff's Chart at 18). On physical examination, Dr. Banga noted that the patient's abdomen was distended on her left side (the side of the sigmoid colon) and that she had positive bowel sounds (Wyckoff's Chart at 20). Dr. Banga further noted that the initial CT scan showed an LBO with "obstruction at . . . sigmoid with diverticulum" (Wyckoff's Chart at 21). Dr. Banga's plan was to:

> "admit [the patient] on regular floor *under Dr. [Mardach's] . . . team. Private patient. . . .* [40].
> Follow up [on] GI and surgery consults.
>
> Discussed with attending [Dr. Mardach] and agreed on management.
>
> Patient [was] explained about management and diagnosis"

(Wyckoff's Chart at 22 [emphasis added]).

Dr. Banga's 6 p.m. note further reflected the results of the urine test which showed elevated Ketones at > 80, a sign of dehydration (Wyckoff's Chart at 21).[41] In addition, it appears that Dr. Banga was the first healthcare provider at Wyckoff to measure and weigh the patient. The patient's height and weight, at the time, were 4'11" and 176

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[40] Dr. Banga indicated in the same note that the patient's primary care physicians were Dr. Morero/Dr. Mardach (Wyckoff's Chart at 17). Dr. Mardach discounted as lacking any significance Dr. Banga's characterization of the admission as a "private patient" (Dr. Mardach EBT tr at page 87, lines 7-10 ["Q. What is the significance of (the patient) being admitted as a private patient of yours and Dr. Morero? A. No significance."]).

[41] Dr. Mardach's EBT tr at page 83, lines 8-12.

pounds, respectively, with the BMI of 35.5 indicating that she was obese (Wyckoff's Chart at 19).

Dr. Mardach cosigned Dr. Banga's note with the words "agree with above" (Wyckoff's Chart at 22).[42] At 5:30 p.m., Dr. Mardach ordered an echocardiogram for the patient.[43]

At 8:15 p.m. on Sunday, April 5th, the patient signed a consent to surgery in the form of exploratory laparotomy, possible bowel resection, and possible ostomy (Wyckoff's Chart at 48). Two days later, in the late evening of Tuesday, April 7th, Dr. Chendrasekhar cosigned the patient's surgery-consent form, with his signature retroactively dated to April 5th. Dr. Chendrasekhar is steadfast in his insistence at his pretrial deposition that he did not see the patient for the first time until 11:40 p.m. on Tuesday, April 7th.[44]

Dr. Mardach testified (at page 88, lines 10-12) that the decision to defer surgical intervention was made by surgery.

As of 5 p.m. on Sunday, April 5th, Dr. Mardach made no treatment recommendations to the patient or to plaintiff who remained at his mother's bedside

[42] Dr. Mardach's EBT tr at page 88, lines 2-9.

[43] Dr. Mardach's EBT tr at page 117, lines 15-17.

[44] Dr. Chendrasekhar's EBT tr at page 162, lines 20-22; page 163, lines 4-9 and 12-15; page 164, line 21 to page 165, line 16.

during the visiting hours. At that time, the only plan in place was the one recommended by surgery: colonoscopy to be followed by surgery.[45]

B. Monday, April 6, 2009

Sometime in the morning before 6:45 a.m. on Monday, April 6th, the patient was rounded on by a surgical attending whose name and signature in the chart is not legible but who, according to Dr. Chendrasekhar, was Dr. Benedicto (Wyckoff's Chart at 73 [Progress Notes]).[46] The unidentified surgical attending indicated that the patient had an LBO in the mid-sigmoid section – "possible stricture for diverticulitis but cannot rule out malignancy" (Wyckoff's Chart at 73). On physical examination, the patient's bowel sounds were hypoactive (indicative of the cessation of peristalsis) (*id.*). The patient's complaint of pain was documented to be at the maximum of "10 out of 10" (*id.*). The surgical attending's plan was: (1) "to monitor output from NG tube"; (2) follow up with a two-position abdominal X-ray for any further distension; (3) "*may need either a diverting colostomy or a bowel resection*"; (4) "*[we] will operate if we can get cardiac workup and optimize [the] patient for surgery*"; (5) "conservative [non-operative] treatment at this time with hydration and nasogastric tube . . . and potassium replacement"; and (6) "start with peripheral parenteral nutrition" (*id.* [emphasis added]).

At approximately 6:45 a.m. (or 25 minutes after Morphine, once again, had been re-ordered for the patient [Wyckoff's Chart at 383]), Dr. Mardach rounded on the patient.

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[45] Dr. Mardach's EBT tr at page 88, line 25 to page 89, line 3; page 89, lines 4-11.

[46] Dr. Chendrasekhar's EBT tr at page 51, line 22 to page 52, line 7; page 56, lines 6-8; page 74, lines 11-16; page 75, lines 16-17.

Dr. Mardach, in her "medical attending (admitting note),"[47] documented that: (1) the patient's abdomen was soft and distended (or dilated) with the right lower quadrant being tender (on the right side of the colon); and (2) patient's cecum (which is also on the right side of the colon) was distended (or dilated) to 9 cm in diameter, which, in Dr. Mardach's view, was a medium to large enlargement (Wyckoff's Chart at 75).[48] As the cecum anatomically possesses the largest diameter of the length of its colon, the "medium to large" enlargement of the patient's cecum to 9 cm in diameter, as Dr. Mardach so documented, made it the most vulnerable site of the patient's colon to perforate. The site of the *largest* diameter in the colon (or, for that matter, any other long pliable tube) requires the *least* pressure to distend.[49] As Dr. Mardach's 6:45 a.m. note makes it clear, she did not (then or at any time thereafter) appreciate the risk of cecal perforation, notwithstanding the then-ominous sign of distention (or dilatation) of the patient's cecum to 9 cm in diameter. Moreover, Dr. Mardach, in her 6:45 a.m. note, confused "obstruction" with "distention," by erroneously attributing the location of the LBO as being near the cecum.[50] Dr. Mardach's attribution was contrary to the radiologic finding on the initial CT scan that the *obstruction* was at the sigmoid junction level in the left

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[47] Dr. Mardach confirmed (at page 91, lines 11-12 of her pretrial deposition) that she, in fact, was the medical attending for the patient.

[48] Dr. Mardach's EBT tr at page 93, line 24 to page 94, line 4.

[49] Dr. Chendrasekhar's EBT tr at page 136, lines 3-7 ("[B]ecause the cecum has the widest diameter [of the entire colon], therefore [, it is subject to] the greatest pressure on the [colon] wall. Basic physics."); page 136, lines 10-12 ("As the [cecal] diameter is greater [than the remainder of the colon], if it [the area below the cecum, as was the instance with the patient's sigmoid colon here] is obstructed[,] the pressure on the [cecal] wall gets to be greater.").

[50] Dr. Mardach's EBT tr at page 93, lines 10-19.

colon, whereas the *dilation* was proximal (or above) the LBO and extending all the way up to the cecum in the right colon.[51]

Dr. Mardach's assessment and plan, as documented in her 6:45 a.m. note, were, as follows:

> "Large bowel obstruction, electrolyte imbalance, hypokalemia, hyponatremia. . . . Admit to private service. Surgery/GI consults. Electrolyte supplement. *Prognosis guarded*."

(Wyckoff's Chart at 75 [emphasis added]).

It appears that April 6th at 6:45 a.m. was the last time Dr. Mardach rounded on the patient before surgery. Thereafter, Dr. Mardach's partner, nonparty Dr. Morero, rounded on the patient between April 7th and April 13th.[52] Nevertheless, Dr. Mardach conceded at her pretrial deposition that: (1) she, along with her partner, Dr. Morero, was responsible for coordination of the patient's care, including discussing with her resident the latter's subsequent assessment and plan for the patient; and (2) her custom and practice was to discuss with Dr. Morero their patients at the end of the workday.[53]

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[51] Contrary to the contention of Dr. Mardach's counsel (in ¶ 73 of the opening affirmation), the patient never had a bowel *obstruction* near the cecum; rather, the patient had a bowel *distention or dilation* at, and near, the cecum.

[52] Dr. Mardach's EBT tr at page 95, line 22 to page 96, line 8.

[53] Dr. Mardach's EBT tr at page 99, lines 9-11 ("Q. Who was in charge of the coordination of [the patient's] care as of April the 6th? A. Me, Dr. Morero."); page 104, lines 14-19 ("Q. Would a post grad year-one resident have been communicating with you with respect to [the patient]? A. Yes. Q. Either you or Dr. Morero? A. Yes."); page 126, lines 8-13 ("We [Dr. Morero and I] have a custom to discuss the patients at the end of the day. We always do discuss our patients, . . . the ones that are in the hospital when we summarize everything in the evening up to this day.").

At approximately 9:45 a.m., another order of Morphine for the patient was placed by the medical service team (Wyckoff's Chart at 386).

At 10:00 a.m., a junior member of the surgical team, nonparty surgical resident Matthew Cheung, D.O. (Dr. Cheung), rounded on the patient (Wyckoff's Chart at 78 [Progress Note: Surgery Attending]). Dr. Cheung, on examining the patient, noted that: (1) the patient's umbilicus was *inverted* (a sign of increased intraluminal pressure); (2) her abdomen was *tympanic* (drum-like) on percussion (another sign of increased intraluminal pressure); (3) her abdomen exhibited an increase in the tenderness of the left (sigmoid) side; (4) her bowel sounds were again hypoactive; and (5) the patient's pain score remained at the maximum level of 10 out of 10, despite prior Morphine administrations (Wyckoff's Chart at 78). Dr. Cheung's plan/comments were: (1) rehydration, (2) no oral intake, (3) nasogastric decompression, (4) potassium supplementation, and (5) *discussion with the surgical "attending regarding possible operation*" (*id.* [emphasis added]). It is unclear from the medical record who cosigned Dr. Cheung's note.

According to plaintiff, during the visiting hours on Monday, April 6th, he spoke to a doctor who identified himself and his colleague then-present at bedside as surgeons, and who told him that they were "going to take [his] mother to surgery, but we [surgeons]

are *backlogged* right now and we have *higher priorities* and we will get to [his] mother up there as soon as we can."[54]

At 11:30 a.m., an unnamed GI fellow as a junior member of the GI team provided a consultation in response to Dr. Banga's prior day's request (Wyckoff's Chart at 292). By that time, the patient's sodium, at 134, and potassium, at 3.4, were closer to the lower range of the normal limits than the day prior (*id.*). The GI fellow, after reiterating that the patient's cecum was dilated to 9 cm in diameter, planned for "colonoscopy [later] today to assess [the] length of stricture" (*id.*). The GI fellow noted, in contradiction to Dr. Takahashi's prior day's note, that the patient did *not* have a single bowel movement in the past three days (*id.* ["last bowel movement 3 days ago"]).

GI attending defendant Dr. Arya, in lieu of his father, nonparty Yashpal Arya, M.D., to whom Dr. Banga's consultation note was directed, approved the GI fellow's assessment/plan and, according to him, also performed a colonoscopy on the patient.[55] As a board-certified gastroenterologist working in the title of an associate director of therapeutic endoscopy at Wyckoff. Dr. Arya reviewed the initial CT scan report, the

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[54] Plaintiff's July 16, 2019 EBT tr page 70, lines 18-23 (emphasis added). *See also* Plaintiff's June 14, 2013 EBT tr at page 38, line 22 to page 39, line 9 (" He said they're the surgeons and there's been *backlog in the surgery*, as soon as they have a chance they'll bring my mother up into surgery.") (emphasis added).

[55] Dr. Arya's EBT tr at page 9, lines 16-23. Although Dr. Arya claims to have performed the colonoscopy on the patient, his father, Yashpal Arya, M.D., signed the accompanying Procedure Form (Wyckoff's Chart at 311) (Dr. Arya's EBT tr at page 58, line 10 to page 59, line 9 ["I did not do this procedure form. I have no involvement with this [Procedure] [F]orm."). Further, Dr. Arya testified (at page 58, lines 10-17) that he had "no idea" who filled out the Procedure Form and that the handwriting therein was not his. Coincidentally, the same handwriting as in the Procedure Form appears on the "physician" line at the bottom of the patient's signed consent form for colonoscopy to be performed by Dr. Arya (Wyckoff's Chart at 42).

surgical consult report, and the patient's latest blood work, all in preparation for the patient's colonoscopy.[56] According to Dr. Arya, the purpose of the patient's colonoscopy was twofold: (1) to determine the exact etiology of the LBO (whether its cause was benign, meaning that it was diverticular in nature, or whether it was due to malignancy); and (2) to decompress (or reduce the diameter of) the colon proximal to (or above) the LBO.[57] In addition, Dr. Arya was hoping to be able to examine the remainder of the colon proximal to (or above) the LBO.[58] Nevertheless, Dr. Arya "felt that *this was eventually going to be a surgical case* and [that the colonoscopy] would definitely [a]ffect and impact the surgical management if there were pathology in other parts of the colon."[59] In other words, if a suspicion of malignancy was found on colonoscopy, the patient, instead of a traditional bowel resection, would undergo a radical bowel resection that is appropriate for oncology cases. Although Dr. Arya did not know at the time whether he was dealing with "[e]ither diverticular strictures or malignancy," it appeared to him, from the nature of the patient's disease, that the patient would be a surgical candidate in any event.[60]

Between 1:30 p.m. and 2:00 p.m. on Monday, April 6th, Dr. Arya allegedly performed a colonoscopy on the patient. Because of a significant amount of liquid stool

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[56] Dr. Arya's EBT tr at page 26, lines 14-22; page 27, lines 3-7; page 28, lines 11-15.

[57] Dr. Arya's EBT tr at page 29, line 21 to page 30, line 6; page 66, lines 16-25.

[58] Dr. Arya's EBT tr at page 30, lines 10-17.

[59] Dr. Arya's EBT tr at page 30, lines 18-23 (emphasis added).

[60] Dr. Arya's EBT tr at page 30, line 24 to page 31, line 11.

in the patient's colon at the time (there had been no colon prep), the endoscope could not advance beyond the junction of the sigmoid colon and the descending colon.[61] The relevant endoscopic findings, as set forth in the Colonoscopy Report, dated April 6, 2009, were, as follows:

> "Stricture/Stenosis: Sigmoid Colon. Comments: There was marked narrowing of the lumen with edema at the junction of the sigmoid and descending colon measuring about 10 cm in length which was unable to be stented. *The colonoscope was able to pass[ ] the stenosed area with some difficulty and the colon above the area [i.e., in the descending colon] was decompressed endoscopically. The above findings are most likely due to extensive diverticular disease. No mass lesions noted. . . .*
>
> Diverticulosis: Sigmoid colon. Comments: Extensive diverticulosis in the sigmoid and descending colon. No mass lesions seen. . . .
>
> Diagnosis: Diverticulosis.
>
> *Plans. Comments: Full colonoscopy in [am] [on the following day] with a colon prep.*
>
> Disposition: After procedure[,] patient sent back to hospital ward."

(Wyckoff's Chart at 310 [emphasis added]).

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[61] Dr. Arya's pretrial testimony that he was unable to advance the endoscope beyond the patient's "splenic flexure" contradicts the Colonoscopy Report. The "splenic flexure," as Dr. Robbins clarifies in ¶ 9 of his reply affirmation, lies at the junction of the transverse colon and the descending colon near the spleen. As the Colonoscopy Report makes it clear, the endoscope could not advance beyond the distal (or toward the rectum) end of the descending colon; hence, the endoscope never reached anywhere near the splenic flexure (Wyckoff's Chart at 310; Dr. Arya's EBT tr at page 41, line 7 to page 43, line 4).

The colonoscopy report, as amplified by pretrial testimony, is significant for the following findings:

(1) The LBO was approximately 10 cm in length. The LBO could not be endoscopically "stented" because Wyckoff lacked the mechanical stents of that length.[62]

(2) The colonoscopy, like the initial CT scan preceding it, confirmed that the LBO was "most likely due to extensive diverticular disease."[63] In particular, the endoscopist, on visual examination, determined that the LBO was not of malignant origin.

(3) To the extent that the endoscope could reach up the colon, the endoscopist decompressed the area proximal to (or above) the LBO.[64] Dr. Arya conceded (at page 36, line 15, and at page 66, lines 21-22, of his pretrial deposition) that decompression of the

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[62] Dr. Arya's EBT tr at page 46, line 16 to page 47, line 12. According to Dr. Arya's expert, David H. Robbins, M.D. (Dr. Robbins), the maximum length of the then-available stents was 8 cm (Dr. Robbins' Opening Affirmation, dated June 2, 2020 [NYSCEF #4], ¶ 31).

[63] Dr. Arya explained that the diverticular strictures are "usually due to underlying diverticulosis with recurrent bouts of diverticulitis which may be clinical or subclinical" (Dr. Arya's EBT tr at page 34, lines 16-21). Dr. Arya indicated that, at the time of colonoscopy, he was aware that the patient had a history of diverticulosis (*id.* at page 34, lines 22-24). As Dr. Arya further explained, "[w]hen you have a distended lumen [of the colon], . . . , you can see the colon wall very clearly [through the endoscope]. When you have a strictured narrow segment [, however], all of that [lumen] is completely collapsed and your view and visualization is compromised" (*id.* at page 35, lines 20-24). In Dr. Arya's view which had remained unchanged throughout his treatment of the patient, her strictures ultimately caused her LBO (*id.* at page 35, line 25 to page 36, line 6).

[64] Dr. Arya's EBT tr at page 36, lines 13-22; page 66, lines 16-25. Dr. Arya explained that the endoscopic decompression was performed, as follows:

> "The scope has a suction valve that allows us to suck both air, bowel gas, liquids, things like that. There is a channel for suction within the scope."

(Dr. Arya's EBT tr at page 47, lines 21-24). As he further explained, the air, gas, etc. were causing distension, not obstruction (*id.* at page 47, line 25 to page 48, line 7).

colon is "only temporary," meaning that decompression was akin to a "bridge to surgery."[65]

Although the colonoscopy found that the LBO was due to diverticulosis (rather than to malignancy), Dr. Arya ordered *a repeat colonoscopy for the following morning with a colon prep*. At his pretrial deposition, however, Dr. Arya downplayed the effect of his order for the repeat colonoscopy, testifying (in plain contradiction to the Colonoscopy Report which he signed) that the repeat colonoscopy "*was never supposed to be intended to be done in the morning.*"[66] According to Dr. Arya's pretrial testimony (at page 53, line 13 to page 54, line 17), the patient would be receiving a "gentle," 24-to-48-hour colon prep via her then-in-place nasogastric tube.

Wyckoff's chart reflects that the patient was receiving the colon prep for her repeat colonoscopy until 6 p.m. on Monday, April 6th, when the remainder of the colon prep to be administered on the following day was canceled.[67] Dr. Arya's expert, David H. Robbins, M.D., is of the same view.[68]

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[65] Whether the endoscopic decompression of the area *above the stricture* relieved *the stricture itself* cannot be answered on the record (Dr. Chendrasekhar's EBT tr at page 142, lines 9-11 ["It depends on the tissue and the elasticity of the tissue and the elasticity of the area of stricture."]).

[66] Dr. Arya's EBT tr at page 49, lines 13-15 (emphasis added).

[67] The nursing records, dated and timed Monday, April 6th, at 6 p.m., confirm that the colon-prep order for Tuesday, April 7th, was discontinued (Wyckoff's Chart at 389).

[68] Dr. Robbins, in reviewing the patient's medical chart, noted (in ¶ 38 of his Opening Affirmation) that:

> "In anticipation of a repeat colonoscopy, [the patient] had been given a slow dose of [the colon prep], 250 ml/hour, over the course of 8 hours that day. It was to

Post-colonoscopy on Monday, April 6th, Dr. Banga, a junior member of Dr. Mardach's medical team, returned to round on the patient. Dr. Banga, on physical examination of the patient, found her abdomen to be soft, non-tender (with positive, though sluggish) bowel sounds. Dr. Banga noted that the patient had undergone a colonoscopy which found: (1) multiple diverticulosis in sigmoid and descending colon, and (2) an LBO at the sigmoid-descending colon junction (Wyckoff's Chart at 76). Dr. Banga's plan was: (1) to repeat a colonoscopy the following morning; (2) to follow up on the surgery/GI plan; (3) to keep the patient's family updated; and (4) to replace potassium and to repeat labs the following morning (*id.*).

Although Dr. Mardach could not specifically recall having a conversation with her partner, Dr. Morero, about the patient on Monday, April 6th, it was Dr. Mardach's custom and practice to have had that conversation.[69] Dr. Mardach acknowledged her participation in the decision-making regarding the patient's treatment plan on (and as of)

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begin at around 3:00 p.m. via the nasogastric tube; however, by 6:00 p.m. [on Monday, April 6th], [the patient] had reportedly received that day's dose."

Whereas Dr. Robbins initially asserted (in ¶ 43 of his Opening Affirmation) that the patient "was drinking [the colon prep] on examination that morning [*i.e.*, on Tuesday, April 7th] in preparation for a repeat colonoscopy," he has made a complete about-face (¶ 13 of his reply affirmation) that the patient "did not receive any bowel prep past 6:00 p.m. on the evening of [Monday,] April 6, 2009."

[69] Dr. Mardach's EBT tr at page 109, lines 13-19 ("Q. Had you any conversation with Dr. Morero with respect to [the patient] as of April the 6th? A. I do not recall. Q. Is that a conversation that you would have had *as per your custom and practice*? A. *Yes.*"); at page 111, lines 9-17 ("Q. Did you participate in discussions with the other treating physicians with respect to [the patient], *regarding the modality of treatment that would be provided to [the patient] with respect to the blockage*? . . . Q. *As of the 6th of April*? A. I do not remember, but *as a custom and practice I always do.*") (emphasis added).

Monday, April 6th.[70] In her view, three treatment modalities were then available to treat the patient's LBO: (1) nasogastric decompression, (2) a colonoscopy, and (3) surgery as the last option to be undertaken "[o]nce everything else had failed."[71]

C. Tuesday, April 7, 2009

At 6:00 a.m., on Tuesday, April 7th , the patient was rounded on by Dr. Mardach's partner, Dr. Morero, when Dr. Mardach was allegedly off-service (Wyckoff's Chart at 80). Dr. Morero's plan for the patient was: (1) to have surgery on Friday, April 10th; (2) to continue pain medications; (3) to continue IV hydration; and (4) to discharge her home when stable (Wyckoff's Chart at 80). Although Dr. Mardach did not see the patient between April 7th and April 12th because she was then allegedly off-service, she confirmed at her pretrial deposition that she, together with her partner, Dr. Morero, remained responsible for the patient's care until surgery.[72]

At 9:40 a.m., a junior member of the surgical team, nonparty surgical resident Charily E. Hamilton, D.O. (Dr. Hamilton), rounded on the patient (Wyckoff's Chart at 85 [Progress Note: Surgery Attending]). Dr. Hamilton, on examining the patient, noted that: (1) the patient's umbilicus continued to be inverted; (2) her abdomen continued to

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[70] Dr. Mardach's EBT tr at page 112, lines 16-20 ("Q. Did you participate in the decision as to what treatment plan would be pursued with respect to [the patient] as of April the 6th? A. Yes.").

[71] Dr. Mardach's EBT tr at page 111, line 18-22; at page 113, lines 9-17.

[72] Dr. Mardach's EBT tr at page 132, line 22 to page 133, line 5 ("Q. Did you participate at all in [the patient's] care and treatment from the time that you saw her on April 6th up until April the 13th? A. *I guess I was.* Q. When you say you guess you were – A. *If Dr. Morero is seeing the patient, we are partners. . . .*") (emphasis added).

be tympanic on percussion; and (3) she had "right lower quadrant pain" (near the area of her cecum[73]) on the scale of six, accompanied by "guarding." Dr. Hamilton's plan/comments were, as follows:

> "Operating room planning for exploratory laparotomy, bowel resection. *Follow GI plan [for] approximately 2-day bowel preparation.* Monitor output. Will get cardiac workup and clearance. Start bowel preparation slowly. . . ."

(Wyckoff's Chart at 85 [emphasis added]).

Dr. Hamilton's 9:40 a.m. note was cosigned by Dr. Benedicto.

At 11:40 a.m., a junior member of the medical team, after evaluating the patient at bedside, entered the following plan of action: (1) possible bowel resection and colostomy on Friday, April 10th; (2) potassium supplementation; and (3) cardiology evaluation for medical clearance (Wyckoff's Chart at 81-82).

At 12:20 p.m., at the medical-service resident's request, the patient was cleared for surgery by the cardiac service (Wyckoff's Chart at 293).

Four hours elapsed before Dr. Morero returned to the patient's bedside at 4:45 p.m. on April 7th – approximately 15 minutes after an order for additional Morphine had been placed by the medical service team (Wyckoff's Chart at 393).[74] By 4:45 p.m. on April 7th, Dr. Morero's (as well as Dr. Hamilton's) original plan to have the patient

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[73] The cecum is anatomically located in the lower right quadrant of the abdomen (Dr. Chendrasekhar's EBT tr at page 137, lines 8-9).

[74] Wyckoff's Chart at 84; Dr. Mardach's EBT tr at page 125, line 25 to page 126, line 4.

undergo surgery on April 10th (following a two-day colon prep), went awry when Dr. Morero, on re-examining the patient, documented that the latter was in extremis:

> "Abdomen positive for distention and tenderness.
> Decreased bowel sounds.
> *Possible perforation.*
> Small bowel obstruction.
> IV hydration.
> IV antibiotics.
> *Surgery STAT* [as soon as possible].
> Repeat CT scan.
> Patient education done."

Wyckoff's Chart at 84 (emphasis added).[75]

As of 5:30 p.m., April 7th, a repeat colonoscopy was canceled (Wyckoff's Chart at 389 and at 82-83).[76] At that time, an unnamed GI fellow as a junior member of the GI team rounded on the patient. On physical examination, the GI fellow noted a few ominous signs of the progression of the patient's LBO: (1) no passing of flatus or gas (indicating that the LBO had become complete[77]); (2) minimal bowel sounds; and (3) a distended, tympanic abdomen, tender to touch (Wyckoff's Chart at 82). The GI fellow's recommendations, subject to Dr. Arya's approval, were: (1) a flat-plate X-ray of

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[75] Dr. Silberman's contention that "it is not the job of an internist . . . to *determine* if emergency surgery is required" (Reply Affirmation, ¶ 12 [emphasis added]) confuses decision-making with performance. Although no internist is qualified of *performing* the surgeon's job of emergency surgery, any internist (including Dr. Morero and Dr. Mardach) is obviously qualified of *determining* whether the patient needs it in the first place.

[76] As noted, the colon prep for Tuesday, April 7th, was discontinued at 6 p.m. on Monday, April 6th.

[77] Dr. Chendrasekhar's EBT tr at page 155, lines 10-16 ("If the stricture is tight enough to cause a complete obstruction . . . then you will get dilation of the rest of . . . the colon. If it does not cause a complete obstruction, gas [flatus] is passing through, you will not get a progressive dilatation of the colon.").

the abdomen; (2) follow-up with surgery and, separately with the medical team, regarding the IV antibiotics; and (3) *no endoscopic intervention* (Wyckoff's Chart at 83). Dr. Arya noted at his pretrial deposition that the minimal bowel sounds indicated that the motility of the patient's colon had diminished – a potential sign of an impending perforation.[78] As Dr. Arya explained, the colon in the setting of an LBO becomes perforated by "[d]istension, gaseous distension, bowel wall ischemia."[79] In Dr. Arya's words, "it was looking like [the patient] was heading in . . . [surgical] direction."[80]

A repeat non-contrast CT scan of abdomen and pelvis, performed at 7:10 p.m. at Dr. Morero's order, but dictated the following morning at 9:10 a.m. (the repeat CT scan), stated, in relevant part, that:

> "There is marked distention of the colon with an abrupt transition point at the descending sigmoid junction. There is thickening and diverticulum through the remaining sigmoid segment distally. There could be tumor at the transition point. *There is now fluid in the right upper quadrant.*
>
> * * *
>
> The case reviewed with senior surgical team. The patient has already gone to the OR at the time of this dictation."[81]

The appearance of the fluid in the right upper quadrant of the patient's abdomen indicated that her LBO had become more acute or, in the words of Dr. Chendrasekhar, that she was progressing (if she had not progressed already) toward "ischemia and

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[78] Dr. Arya's EBT tr at page 51, lines 14-22; page 52, lines 16-24.

[79] Dr. Arya's EBT tr at page 53, lines 6-9.

[80] Dr. Arya's EBT tr at page 57, lines 24-25.

[81] Final Report of CT Pelvis Without Contrast and CT Abdomen Without Contrast (emphasis added). The repeat CT scan report is included in Wyckoff's Chart which was filed at NYSCEF #5.

possible gangrene."[82] In Dr. Chendrasekhar's opinion, the fluid in the right *upper* quadrant was located near the cecum, despite the latter's anatomical location in the right *lower* quadrant, because of the supine position in which the patient had been positioned on the CT scan table for her repeat CT scan.[83]

At 8 p.m., surgical resident, nonparty Michael Betler, D.O. (Dr. Betler), evaluated the patient at bedside (Wyckoff's Chart at 83). Dr. Betler documented the patient's cecal distension at 8.3 cm in diameter.[84] Dr. Betler's notation with respect to the patient's cecal distension is at odds with: (1) Dr. Chendrasekhar's operative note indicating that the repeat CT scan showed the cecal distention at 9.5 cm in diameter (Wyckoff's Chart at 305 [Dr. Chendrasekhar's Operative Report at 1]; and (2) Dr. Mardach's note dated and timed on April 6th at 6:45 a.m., that the initial CT scan showed the cecal distention at 9 cm in diameter (Wyckoff's Chart at 75).

The medical record suggests that: (1) the cecum is *at risk* of perforation once its diameter reaches 9 cm; (2) the "outer limits" of "permissible cecal dilation" is at "approximately 12 cm" in diameter;[85] and (3) the cecum *definitely* perforates when its diameter reaches 14 cm.

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[82] Dr. Chendrasekhar's EBT tr at page 134, lines 4-25.

[83] Dr. Chendrasekhar's EBT tr at page 137, lines 8-12.

[84] *Compare* Wyckoff's Chart at 83 (apparently referring to the *repeat* CT scan) *with* Dr. Chendrasekhar's operative report which indicated that the cecal distention on the *initial* CT scan was "about 8 cm" in diameter (Wyckoff's Chart at 305).

[85] Dr. Robbins' Opening Affirmation, ¶ 78.

At 11:40 p.m. on Tuesday, April 7th, Dr. Chendrasekhar appeared at the patient's bedside and examined her (Wyckoff's Chart at 83). He explained to the patient that she had a surgical emergency and urgently needed to go to the operating room. Although, as noted, the patient had signed – and Dr. Chendrasekhar had acknowledged (at least retroactively) – her *written* consent to surgery two days prior in the evening of Sunday, April 5th, he additionally obtained her *oral* consent to surgery (*id.*).

Dr. Mardach testified (at page 127, lines 10-13 of her pretrial deposition) that she was not involved in Dr. Chendrasekhar's decision to operate on the patient in the early morning of April 8th. Her understanding of the need for surgery (at page 127, lines 21-23 of her pretrial deposition) was that "[the patient] was perforated, her condition deteriorated, and decision was made by surgery to take her" to the operating room. Dr. Mardach (at page 125, lines 16-24; page 156, lines 8-12) could not recall having any discussion with Dr. Chendrasekhar.

To check on the patient's condition, Dr. Mardach (at page 127, lines 7-9; page 128, lines 18-20; page 129, lines 11-14) next examined the patient in the ICU on April 13th when she entered an untimed note reflecting that the patient was in respiratory failure, whereas Dr. Morero had examined the patient in the ICU four days prior on April 9th. Dr. Mardach's and Dr. Morero's post-surgical rounding on the patient in the ICU was, according to Dr. Mardach (at page 133, line 5 to page 134, line 21), merely to check on the patient's status, inasmuch as the primary healthcare teams for the patient in the ICU were comprised of surgeons and intensivists.

D. Wednesday, April 8, 2009

Between 12:40 a.m. and 3:20 a.m. on Wednesday, April 8th, the patient underwent explorative laparotomy, subtotal colectomy for perforated viscus, and ileostomy.[86] The intra-operative findings included a gangrenous cecum, caused by the colon distention which, in turn, had been caused by the LBO in the sigmoid colon,[87] with multiple cecal perforations and a large amount of stool in the peritoneal cavity, which necessitated a subtotal colectomy (the excision of the entire colon), Hartman's Procedure, and ileostomy.

The excised colon and omentum were submitted to pathology for analysis. The pathology report revealed that the sigmoid portion of the colon contained severe (and, in some places, impassable) strictures:

> "[The specimen] consists of dilated colon measuring 89 cm long. The proximal end [*i.e.*, toward the small intestine] discloses 3 cm ileum by 3 cm in circumference . . . and a veriform appendix attached in the cecum measuring 7 x 0.5 cm, normal. *[The] cecum is dilated 14 cm wide*, and 14 cm from the ileocecal valve[,] the dilatation [extends] to 16 cm dilatation with a thin wall. Distally [*i.e.*, toward the rectum,] the colon narrows to 12, 10 and 9 cm. A detached segment of dilated colon with narrowed stricture segment measures 14 cm long with *a circumference of 9 cm but as it goes down to the fibrotic stricture[,] the entire external diameter is 3.5 cm. Serial cut of the stricture discloses a series of 1.8 cm complete stricture[s]. The mucosal lumen averages only 0.7 cm diameter with a fibrotic wall of 0.5 cm.*"[88]

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[86] Wyckoff's Chart at 305-307 (Operative Report) and at 317 (Anesthesia Record). Dr. Robbins' statement (in ¶ 48 of his Opening Affirmation) that "Dr. Chendrasekhar's surgery began on 4/8/09 at approximately 3:25 a.m. and ended at approximately 7:00 a.m." is contradicted by the Anesthesia Record (Wyckoff's Chart at 317).

[87] Dr. Chendrasekhar's EBT tr at page 148, lines 22-24; page 151, lines 10-12.

[88] Wyckoff's Chart at 321 (Surgical Pathology Report) (emphasis added).

There are three takeaways from the pathology report. The first is that the cecal diameter of 14 cm, as was noted in the April 8th pathology report, is significantly wider than: (1) the cecal diameter of 9 cm which Dr. Mardach noted two days prior on Monday, April 6th; and (2) the cecal diameter of 9.5 cm which the repeat CT scan (as interpreted by Dr. Chendrasekhar in his operating report) showed. There was an interim increase in the diameter of the cecum by approximately 5 cm (which is equivalent to a 50% increase) between 6:45 a.m. on April 6th when Dr. Mardach documented the initial CT scan findings and shortly after midnight on April 8th when surgery was performed. Concurrently, the intraluminal pressure in the colon increased, as evidenced by: (1) the inversion of the patient's umbilicus as was first noted by surgical resident Dr. Cheung in the morning of April 6th; and (2) an increase in the patient's pain level up to the maximum level of 10 out of 10 despite Morphine administrations.

The second takeaway from the pathology report is the tightness of the stricture at 0.2 cm in diameter at the time of surgery (*i.e.*, 0.7 cm in diameter of the mucosal lumen, less the diameter of the fibrotic wall of 0.5 cm). Granted that the endoscopist had been able to pass the stricture with an endoscope during the April 6th colonoscopy 1½ day prior, the pathology report indicates that the stricture became impassable by the time of surgery, *as well as* prior to surgery when the patient had stopped passing gas and experienced a further bowel distension.

The third and final takeaway from the pathology report is that the patient's appendix had "fecalith and intraluminal abscesses," and that the pathology specimen of

the patient's omentum had "diffuse peritonitis with small abscesses" (Wyckoff's Chart at 321). Stated otherwise, the patient's cecum had perforated and leaked feces into her peritoneum *either* before surgery (a scenario which is propounded by Wyckoff's expert based on the radiologic finding of fluid in the right side of the patient's abdomen on the repeat CT scan), *or* during surgery, *or* both before and during surgery.

An infection disease consultant's note, dated and timed April 14, 2009 at 11:39 a.m., stated that the patient had enterococcus faecalis with peritonitis (Wyckoff's Chart at 125).

III. The Aftermath

Post-operatively, the patient could not be weaned off the ventilator. She underwent multiple procedures, including a surgical drainage of an intra-abdominal abscess wound. The patient never recovered from her systemic infection. Her condition continued to deteriorate until she died on May 1, 2009 at 11:59 p.m. The immediate cause of the patient's death was septicemia (sepsis) due to (or as a consequence of) her multi-organ failure as a result (or as a consequence) of her perforated colon (Wyckoff's Chart at 67).

Litigation

In April 2011, plaintiff commenced this action against, among others, Wyckoff, Dr. Mardach, and Dr. Chendrasekhar for medical malpractice, lack of informed consent, and wrongful death. Wyckoff, Dr. Mardach, and Dr. Chendrasekhar, by separate answers, joined issue. In November 2014, Wyckoff commenced a third-party action

against Dr. Arya, Theopine Abakporo, M.D. (Dr. Abakporo), Bhakti Patel, P.A. (PA Patel), and Wyckoff Emergency Medicine Services, P.C. (the latter entity being the alleged provider of the ER services at Wyckoff) (Wyckoff ER) for indemnification and contribution. The third-party defendants, by separate answers, joined issue in the third-party action. In May 2015, plaintiff moved for leave to amend his complaint to add Dr. Arya, Dr. Abakporo, PA Patel, and Wyckoff ER as direct defendants. By decision and order, dated March 8, 2016, the Court (Dabiri, J.), over Dr. Arya's objection, granted plaintiff's motion in its entirety (the prior order), and the proposed amended complaint was deemed served. In June 2016, Dr. Arya appealed the prior order to the Second Judicial Department. By decision and order, dated August 7, 2019, the Second Judicial Department affirmed the prior order insofar as appealed from by Dr. Arya (*see Rivera v Wyckoff Heights Med. Ctr.*, 175 AD3d 522 [2d Dept 2019], *lv to reargue, lv to appeal denied*, 2020 NY Slip Op 62118[U] [2d Dept 2020]).

While his appeal from the prior order was pending, Dr. Arya moved for leave to reargue/renew the underlying motion. By order, dated January 5, 2017, the Court (Dabiri, J.) "held in abeyance [Dr. Arya's motion for leave to reargue/renew] pending the completion of discovery, including all relevant depositions with respect to the defendant's Wyckoff['s] vicarious. liability, if any, for the acts or omissions of Dr. Arya" (NYSCEF #12). After the pretrial depositions (with the exception of defendant Wyckoff ER) were held, the instant motions followed.

Standard of Review

"To prevail on a motion for summary judgment in a medical malpractice action, the defendant must make a prima facie showing either that there was no departure from accepted medical practice, or that any departure was not a proximate cause of the patient's injuries" (*McCarthy v Northern Westchester Hosp.*, 139 AD3d 825, 826-827 [2d Dept 2016] [internal quotation marks omitted]). "[T]o sustain this burden, the defendant is only required to address and rebut the specific allegations of malpractice set forth in the plaintiffs complaint and bill of particulars" (*Schuck v Stony Brook Surgical Assoc.*, 140 AD3d 725, 726 [2d Dept 2016]).

"In opposition, a plaintiff . . . must submit material or evidentiary facts to rebut the defendant's prima facie showing that he or she was not negligent in treating the plaintiff" (*Dolan v Halpern*, 73 AD3d 1117, 1118 [2d Dept 2010] [internal quotation marks omitted]). "[P]laintiff need only raise a triable issue of fact regarding the element or elements on which the defendant has made its prima facie showing" (*McCarthy*, 139 AD3d at 826-827 [internal quotation marks omitted]). Further, "general allegations of medical malpractice that are conclusory and unsupported by competent evidence tending to establish the essential elements of medical malpractice are insufficient to defeat a defendant's motion for summary dismissal" (*Melendez v Parkchester Med. Servs.*, P.C., 76 AD3d 927, 927 [1st Dept 2010]).

"[T]o establish proximate causation, a plaintiff must present sufficient medical evidence from which a reasonable person might conclude that it was more probable than

not that the defendant's departure was a substantial factor in causing the plaintiff's injury" (*Bacchus-Sirju v Hollis Women's Ctr.*, ___ AD3d ___, 2021 NY Slip Op 04538 [2d Dept 2021]). "A plaintiff's evidence of proximate causation may be found legally sufficient . . . as long as evidence is presented from which the jury may infer that the defendant's conduct diminished the plaintiff's chance of a better outcome or increased the injury" (*id.* [internal quotation marks and citations omitted]).

"The elements of a cause of action to recover damages for wrongful death are (1) the death of a human being, (2) the wrongful act, neglect or default of the defendant by which the decedent's death was caused, (3) the survival of distributees who suffered pecuniary loss by reason of the death of decedent, and (4) the appointment of a personal representative of the decedent" (*Chong v New York City Tr. Auth.*, 83 AD2d 546, 547 [2d Dept 1981]). Only the second element of the wrongful death claim – the alleged medical malpractice – is at issue at this stage of litigation.

Discussion

I. Dr. Mardach (Motion Seq. No. 6)

In support of her summary judgment motion, Dr. Mardach relies on the expert affirmation of Mark S. Silberman, M.D. (Dr. Silberman), a New York state-licensed and board-certified physician in the separate fields of Emergency, Critical Care, Pulmonary, and Internal Medicine. Dr. Silberman opines, "based upon [his] review of the relevant medical and hospital records, laboratory and diagnostic, studies, [and] deposition testimony," that within a reasonable degree of medical certainty: (1) the care and

treatment rendered to the patient by Dr. Mardach, from the time that she became Dr. Mardach's patient on April 5, 2009 through the time of her death on May 1, 2009, at all times comported with the standard of good and accepted medical practice; (2) Dr. Mardach never committed any act of malpractice at any time during her treatment of the patient; and (3) no act or alleged omission by Dr. Mardach proximately caused any injury, harm, or the death of the patient (Dr. Silberman's Affirmation, dated July 27, 2020 [NYSCEF #26], ¶¶ 3, 6). Dr. Silberman's opinions are premised on his factual mischaracterization of Dr. Mardach as a relatively passive observer who was specifically chosen by plaintiff as his mother's physician and whose only obligation, after obtaining the initial CT scan (together with the surgical and GI consultations) was to defer to, and to follow, the consultants' recommendations; namely, to administer the IV fluids and antibiotics; to have the patient undergo a colonoscopy as recommended by surgery; and, if all those preliminary measures failed, to optimize the patient for surgery. Dr. Silberman's position is refuted by the facts of this case.

The medical record (as supplemented and amplified by Dr. Mardach's and plaintiff's respective pretrial depositions which were concurrently submitted with Dr. Silberman's expert affirmation) undermines Dr. Silberman's charitable view of Dr. Mardach's purportedly limited involvement in the patient's care both as her ER attending and as her medical service attending. The facts and reasonable inferences from those facts (when construed in plaintiff's favor) show that:

(1) Dr. Mardach, as the physician in charge of the patient's ER care, admitted the patient to her own medical service *without* any request (or involvement) from plaintiff;

(2) Dr. Mardach reviewed the patient's initial CT scan films *on her own*;

(3) Dr. Mardach determined, *again on her own*, that the patient had an LBO; and

(4) Dr. Mardach *reviewed the patient's initial CT scan films with plaintiff* and informed him that his mother's LBO was the size of a "grapefruit."

Furthermore, although Dr. Mardach knew from the initial CT scan films that the cecal diameter was enlarged to 9 cm (a moderate-to-large enlargement, in her opinion, and, thus, at risk of perforation), and although she was present during Dr. Takahashi's surgical consultation when the latter, according to Dr. Mardach, recommended *immediate* surgery, Dr. Mardach did *not* defer to the surgical team but instead played an active role – if plaintiff's pretrial testimony is credited – in selecting non-surgical treatment for the patient in the form of medications (including Morphine which her resident, Dr. Banga, repeatedly ordered for the patient) to avoid what she believed (without any foundation in the record) would be a permanent colostomy for the patient as a consequence of surgery. Compounding the error, Dr. Mardach took no steps to expedite a GI consultation which she caused to be placed (via Dr. Banga) as a routine, non-urgent request.

Dr. Silberman's concept of "the coordinated management decisions of the appropriate specialists" (¶ 75), not only did not exist, but could not have existed, in this peculiar case which – when all inferences are drawn in plaintiff's favor at this stage of

litigation – evolved into an uninterrupted stream of alleged medical errors.[89] As soon as the patient signed her consent to surgery at 8:15 p.m. on Sunday, April 5th, Dr. Mardach's obligation, when she rounded on the patient at 6:45 a.m. the following morning, was to expedite surgery, *irrespective* of her personal (and factually unfounded) belief which she gratuitously shared with plaintiff that surgery would result in the patient being burdened with a permanent colostomy.

Contrary to Dr. Silberman's forgiving view of the record, Dr. Mardach's responsibilities to the patient did not end when she rounded on the patient at 6:45 a.m. on Monday, April 6th. As Dr. Mardach confirmed at her pretrial deposition, she, together with her partner, Dr. Morero, remained jointly responsible for the patient's care until surgery. This means that Dr. Mardach was responsible for her partner's (Dr. Morero's) seven-hour delay in having surgery performed on the patient between: (1) 4:45 p.m. on April 7th when Dr. Morero explicitly documented that the patient was in extremis and required immediate surgery, and (2) 11:40 p.m. on April 7th when Dr. Chendrasekhar in person (rather than "on paper" as was the case in the evening of April 5th when the patient signed the surgery-consent form) signaled his readiness to proceed with surgery.

But even before Dr. Mardach's partner, Dr. Morero, became alarmed at the patient's extremely poor condition at 4:45 p.m. on Tuesday, April 7th, Dr. Mardach had

[89] Dr. Silberman's assertion (in ¶ 14 of his reply affirmation) that "two appropriate and distinct physician specialty teams (both surgery and GI) were acting in concert to determine the appropriate workup and timing of surgery," is belied by the record. The GI team, at a minimum, was stepping on the toes of the surgical team by scheduling a repeat colonoscopy and then canceling it, thus further contributing to the delay in the performance of what could have been life-saving surgery for the patient.

a duty to intervene one day earlier on Monday, April 6th, 6:45 a.m., when she documented the patient's enlarged cecum at 9 cm in diameter (and thus at risk for perforation), *and, in addition,* when, during the visiting hours later on the same day, the surgeons informed plaintiff that they were "backlogged" and had "higher priorities" than his mother. It may be true that Wyckoff's surgeons as consulting physicians to the patient's medical case had "higher priorities" than excising an LBO of a non-malignant (diverticular) nature in a 66-year-old obese female. Outside surgery, however, the patient, who was admitted to the medical service, remained Dr. Mardach and Dr. Morero's joint responsibility.[90] Even assuming (as Dr. Silberman does in his reply affirmation) that Dr. Mardach's responsibility for the patient had shifted to the surgical team at 2 p.m. on Sunday, April 5th, when surgical resident Dr. Takahashi directed that the patient be optimized for surgery,[91] that responsibility *re-vested* in Dr. Mardach the following day, Monday, April 6th, when surgeons in their face-to-face bedside meeting with plaintiff and the patient during the visiting hours declined to operate on her because they had more pressing priorities. While, as an abstract matter, "[t]here is no effective means for an internist to

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[90] Post-operatively, Dr. Mardach ordered X-rays and CT scans for the patient almost daily between April 8th and May 1st, although she was allegedly off-service until April 13th (Wyckoff's Chart [at NYSCEF #5]). In addition, a consultation request under Dr. Mardach's name is directed to the ICU on April 8th at 10:15 a.m. (Wyckoff's Chart at 289). Further, the patient, while in the ICU, was seen by Dr. Mardach on April 13th, April 17th, April 19th, April 24th, April 26th, April 27th, and May 1st (Wyckoff's Chart [at NYSCEF #5]).

[91] *See* Dr. Silberman's Reply Affirmation, dated April 22, 2021 (NYSCEF #101), ¶ 9 ("The surgical consultant [Dr. Takahashi] made the decision that patient-decedent would likely need surgery, but further decided that optimization was needed prior to performing surgery. *This was a key moment because it resulted in a change of responsibility.* When a surgical team decides that a patient needs surgery, they assume control and responsibility regarding the steps to be taken to prepare the patient for surgery.") (emphasis added).

force a surgeon to perform surgery *when the surgeon is not convinced [that] it is necessary or advisable*" (Dr. Silberman's Reply Affirmation, ¶ 12 [emphasis added]), this was *not* the reason which surgeons gave plaintiff for declining to operate on his mother when they met him at her bedside during the visiting hours on Monday, April 6th.[92] Although Dr. Morero, when rounding on the patient at 6 a.m., on Tuesday, April 7th, was planning for the patient to undergo surgery on Friday, April 10th, she abandoned her newly formulated medico-surgical plan approximately 11 hours later when, on re-examining the patient at 4:45 p.m. of the same day, she documented the patient's need for immediate surgery.

Inasmuch as Dr. Mardach has failed to make a prima facie showing of entitlement to summary judgment on the subject of departures underpinning plaintiff's medical malpractice claim (and, by extension, his wrongful death claim) *with respect to her and her partner's, Dr. Morero's, pre-surgical (April 5th through April 7th) care of the patient*, the branch of the motion for summary judgment dismissing the medical malpractice and wrongful death claims as against Dr. Mardach is denied, without regard to the sufficiency

[92] While "it is difficult [for Dr. Silberman] to see why [p]laintiff's expert thinks that there is anything Dr. Mardach could have done differently that would have affected the outcome in this case" (Dr. Silberman's Reply Affirmation, ¶ 14), one common-sense alternative would have been to transfer the patient to a hospital with sufficient operating capacity to immediately perform bowel-resection surgery. Nothing in particular tied the patient to Wyckoff. As plaintiff explained at his pretrial deposition, the patient "went to Wyckoff as opposed to anywhere else" because "[i]t's the closest hospital [to her residence]" (Plaintiff's June 14, 2013 EBT tr at page 21, lines 20-22).

of plaintiff's opposition papers (*see Winegrad v New York Univ. Med. Ctr.*, 64 NY2d 851, 853 [1985]; *Coller v Habib*, 185 AD3d 653, 654 [2d Dept 2020]).[93]

Further, plaintiff's expert's affidavit in opposition (in ¶¶ 50, 52-53), which is adequately supported by the record, has raised a triable issue of material fact as to whether, *at a minimum*, the approximately 50-hour delay in the performance of the bowel-resection surgery on the patient – counting from 8:15 p.m. on Sunday, April 5th, when the patient signed her consent to surgery, and up to 11:40 p.m. on Tuesday, April 7th, when Dr. Chendrasekhar ultimately expressed his willingness to operate on the patient – proximately caused or contributed to her sepsis, subsequent injuries, and death (*see e.g. Zabary v North Shore Hosp. in Plainview*, 190 AD3d 790 [2d Dept 2021]).[94]

On the other hand, Dr. Mardach has demonstrated prima facie, on the basis of Dr. Silberman's expert affirmation, that she is entitled to summary judgment as a matter of law with respect to: (1) her and her partner's, Dr. Morero's, post-surgical (April 8th through May 1st) care of the patient; and (2) the patient's April 2nd visit to Wyckoff's ER. In opposition, plaintiff has failed to raise a triable issue of fact, as his expert's affidavit does not address those periods of treatment (*see e.g. Messeroux v Maimonides Med. Ctr.*, 181 AD3d 583, 585 [2d Dept 2020]).

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[93] Defense counsel's analysis of plaintiff's expert's affidavit on the subject of Dr. Mardach's alleged departures in the pre-surgical period (as set forth in ¶¶ 8-30 of defense counsel's reply affirmation [NYSCEF #100]) is erroneously premised on Dr. Silberman's version of events which is heavily slanted in Dr. Mardach's favor.

[94] The moving defendants' reliance on *Derrick v North Star Orthopedics, PLLC*, 121 AD3d 741 (2d Dept 2014), is devoid of merit.

II. Dr. Arya (Motion Seq. No. 5)

A. Summary Judgment

Dr. Arya, in support of the initial branch of his motion which is for summary judgment, relies on the expert affirmation of David H. Robbins, M.D. (Dr. Robbins), a New York state-licensed and board-certified physician in the field of internal medicine with a sub-certification in gastroenterology. Dr. Robbins, based on his review of Wyckoff's chart and the parties' pretrial testimony, opines that: (1) "the treatment rendered by Dr. Arya [to the patient from 11:30 a.m. on Monday, April 6th, to 5:30 p.m. on Tuesday, April 7th] was in accordance with the standard of care as it pertained to the subspecialty of gastroenterology at the time," and (2) "none of the claimed departures, [insofar] as they pertain to the care and treatment by Dr. Arya [to the patient], were the proximate cause of [her] pain and suffering and death" (Dr. Robbins' Opening Affirmation, ¶¶ 4, 66). On the subject of departures, Dr. Robbins justifies Dr. Arya's decision to perform the colonoscopy as having been necessary to enhance the patient's diagnosis. On the subject of proximate cause, Dr. Robbins explains (in ¶¶ 96-97 of his opening affirmation) that Dr. Arya's involvement was specifically limited in the patient's case by the presence of the LBO, and further limited by a medical axiom that "[a] patient with a large bowel obstruction requires surgery" (Dr. Robbins' Opening Affirmation, ¶ 97). In that regard, Dr. Robbins defends Dr. Arya's directive for administering the colon prep to the patient for her subsequent (but never performed) colonoscopy as having been relatively harmless because, in his (Dr. Robbins') view, the patient tolerated it well

for the limited period of time in which it was administered to the patient (the late afternoon and early evening of Monday, April 6th). Lastly, Dr. Robbins denies that the colonoscopy caused colon perforation because, as he interprets the repeat CT scan, it showed no "evidence of a perforation due to the colonoscopy" (Dr. Robbins' Opening Affirmation, ¶¶ 73-75, 80, 84-90). The Court finds that Dr. Arya, by way of the medical records and Dr. Robbins' expert affirmation, has established entitlement to judgment as a matter of law as to both the departure and causation elements of the medical malpractice claim insofar as asserted against him. The burden now shifts to plaintiff and Wyckoff, as the objecting parties, to raise a triable issue of fact as to each of those elements.

In opposition, plaintiff's and Wyckoff's respective experts have raised triable issues of fact as to both elements of plaintiff's medical malpractice claim insofar as asserted against Dr. Arya. Plaintiff's expert (in ¶¶ 43-45 of his/her affidavit) discounts the colonoscopy as a time waster, considering that the initial CT scan attributed the LBO to the diverticulosis (rather than to malignancy) and revealed no malignancy in any portion of the patient's abdomen or pelvis. Plaintiff's expert (in ¶ 42 of his/her affidavit) brushes off the proximal colon decompression which Dr. Arya performed as part of the colonoscopy as "at best a temporary reprieve." In addition, Wyckoff's expert, Peter Geller, M.D. (Dr. Geller), a New York state-licensed and board-certified general

surgeon,[95] takes Dr. Arya to task for advancing the endoscope beyond the stenosed area during the colonoscopy (Dr. Geller's Affirmation, dated August 12, 2020 [NYSCEF #77], ¶ 9).

On the subject of proximate cause, plaintiff's expert and Dr. Geller unanimously criticize Dr. Arya's order for administering the colon prep to the patient for a subsequent (but never-performed) colonoscopy. Both plaintiff's expert and Dr. Geller opine that the colon prep either caused or contributed to one or more of the cecal perforations which the patient had experienced before surgery. As plaintiff's expert explains:

> "[T]he patient cannot get prepped for colonoscopy if the colon is obstructed because there is nowhere for the bowel content to evacuate. In fact, *administering bowel prep to the colon in the presence of an unresolved bowel obstruction, as was the case here, is contraindicated because it only served to increase the pressure within the lumen of the bowel [and thereby] exacerbate[d] the dilation of the colon, and the cecum in particular, ultimately causing the perforation. Also, the preparation medication is formulated to draw fluid into the bowel lumen and is therefore significantly more dangerous to administer in the setting of known bowel obstruction. . .* ."

(Plaintiff's Expert Affidavit, ¶ 45 [emphasis added]).

In addition, Dr. Geller opines (in ¶ 6 of his affirmation) that the repeat CT scans "showed fluid in the Right Upper Quadrant [of the patient's abdomen], which was from the bowel prep."

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[95] Wyckoff's general surgery expert, Dr. Geller, is competent to render an opinion as to whether Dr. Arya departed from the standard of care and proximately caused injuries to the patient's colon (*see Spilbor v Styles*, 191 AD3d 722 [2d Dept 2021]). Dr. Arya's objection to Dr. Geller's qualifications does not preclude the admission of his testimony, but only raises an issue of fact as to the weight to be accorded to it, which is for a jury to resolve (*see Lopez v Gem Gravure Co., Inc.*, 50 AD3d 1102, 1103 [2d Dept 2008]).

Dr. Robbins' reply affirmation fails to eliminate triable issues of fact regarding the elements of departures and causation. Dr. Robbins' disagreement with Dr. Geller's interpretation of the repeat CT scan raises a triable issue of fact as to the origin of the "fluid in the right upper quadrant" of the patient's abdomen. Dr. Robbins' general denial (in ¶ 19 of his reply affirmation) that "it can[not] be shown that Dr. Arya's actions in any way contributed to [the patient's] worsening condition" is insufficient to eliminate a triable issue of fact on the subject of proximate cause.

Accordingly, the initial branch of Dr. Arya's motion which is for summary judgment dismissing plaintiff's medical malpractice and wrongful death claims as against him is denied with respect to his (and his GI fellows') alleged GI-related involvement (or lack thereof) with the patient (including the colonoscopy) for the period from 11:30 a.m. on Monday, April 6th, to 5:30 p.m. on Tuesday, April 7th. *With the exception of the aforementioned treatment period*, however, the remaining branch of Dr. Arya's motion which is for summary judgment dismissing plaintiff's medical malpractice and wrongful death claims as against him is granted.

B. Leave to Renew/Reargue

The alternative branch of Dr. Arya's motion which is for leave to renew/reargue his prior motion must be denied. Dr. Arya's arguments in opposition to plaintiff's motion for leave to amend his complaint to add him, among others, as direct defendants were initially rejected by decision and order, dated March 8, 2016 (Dabiri, J.), and, on his direct appeal, were rejected by the Second Judicial Department by decision and order,

dated August 7, 2019. Since then, Dr. Arya has presented no new evidence which negates the Appellate Division's reasoning for affirming Justice Dabiri's order (*see e.g. Raghavendra v Stober*, 171 AD3d 814, 817 [2d Dept 2019]).

III. Dr. Chendrasekhar (Motion Seq. No. 7)

Dr. Chendrasekhar, in support of his motion, submits the expert affirmation of Jerald Wishner, M.D. (Dr. Wishner), a New York state-licensed and double board-certified physician in the fields of colon/rectal surgery and general surgery.[96] Dr. Wishner credits Dr. Chendrasekhar's testimony that the latter was not involved in the patient's care until 11:40 p.m. on Tuesday, April 7th. In contrast, however, Wyckoff's Chart for Sunday, April 5th, together with Dr. Mardach's pretrial testimony, place Dr. Chendrasekhar as having been involved in the patient's surgical care on Sunday, April 5th. Dr. Chendrasekhar's handwritten addendum to Dr. Takahashi's note, dated and timed Sunday, April 5th, 2 p.m., that the "patient [was] seen and reviewed" by him, followed by his signature, is particularly significant. It is for a trier of fact to determine whether Dr. Chendrasekhar's participation (or lack thereof) in connection with the patient's surgical consultation with Dr. Takahashi on Sunday, April 5th, diminished her chance of a better outcome or increased her injury (*see Bacchus-Sirju v Hollis Women's Ctr.*, ___ AD3d ___, 2021 NY Slip Op 04538 [2d Dept 2021]).

[96] The Court has disregarded, as duplicative of his pretrial testimony, Dr. Chendrasekhar's self-serving, post-deposition affidavit (NYSCEF #52) which he submitted in support of his motion (*see Mayancela v Almat Realty Dev.*, LLC, 303 AD2d 207, 208 [1st Dept 2003]).

Accordingly, the branch of Dr. Chendrasekhar's motion for summary judgment dismissing the medical malpractice and wrongful death claims against him is denied with respect to: (1) his and his resident's, Dr. Takahashi's, surgical consultation to the patient on Sunday, April 5th; and (2) the events surrounding the patient's execution of the surgery-consent form at 8:15 p.m. on Sunday, April 5th, inclusive of Dr. Chendrasekhar's retroactive signature and dating of the surgery-consent form on April 7th, regardless of the sufficiency of plaintiff's opposition (*see Winegrad*, 64 NY2d at 853).

On the other hand, Dr. Chendrasekhar has established, without opposition from plaintiff, that he was not involved in the patient's care on Monday, April 6th, and until 11:40 p.m. on Tuesday, April 7th. Further, plaintiff has not challenged, by way of his expert's affidavit, the propriety of Dr. Chendrasekhar's surgery on the patient in the early morning of Wednesday, April 8th. Nor has plaintiff questioned Dr. Chendrasekhar's post-operative care of the patient through the date of death on May 1st. Accordingly, the branch of Dr. Chendrasekhar's motion for summary judgment dismissing the remainder of the medical malpractice and wrongful death claims insofar as asserted against him is granted.

IV. Wyckoff (Motion Seq. No. 8)

The relief which is granted to Dr. Chendrasekhar with respect to his alleged direct liability to plaintiff applies equally to Wyckoff's alleged vicarious liability to plaintiff with respect to Dr. Chendrasekhar.

Conclusion

Accordingly, it is

ORDERED that Dr. Eichenstein and Dr. Mardach's joint motion for summary judgment in Seq. No. 6 is *granted to the extent* that:

(1) the amended complaint is dismissed as against Dr. Eichenstein in its entirety without costs and disbursements;

(2) the informed consent claim as against Dr. Mardach is dismissed; and

(3) the medical malpractice and wrongful death claims as against Dr. Mardach are dismissed *with the exception of her and her partner's, Dr. Morero's, pre-surgical (April 5, 2009 through April 7, 2009) care of the patient*; and the remainder of their motion is denied *pro tanto*; and it is further

ORDERED that the initial branch of Dr. Arya's motion in Seq. No. 5 which is for summary judgment is granted to the extent that:

(1) the informed consent claim as against Dr. Arya is dismissed; and

(2) the medical malpractice and wrongful death claims as against Dr. Arya are dismissed *with the exception of his (and his GI fellows') alleged GI-related involvement (or lack thereof) with the patient (including the colonoscopy) for the period from 11:30 a.m. on Monday, April 6, 2009, to 5:30 p.m. on Tuesday, April 7, 2009*; and the remainder of the initial branch of his motion is denied *pro tanto*; and it is further

ORDERED that the remaining branch of Dr. Arya's motion in Seq. No. 5 which is for leave, pursuant to CPLR 2221 (f), to renew and reargue his prior motion based on

allegedly new evidence and an alleged misapprehension of fact and law is *denied in its entirety*; and it is further

ORDERED that Dr. Chendrasekhar's motion in Seq. No. 7 for summary judgment is *granted to the extent* that:

(1) the informed consent claim as against Dr. Chendrasekhar is dismissed; and

(2) the medical malpractice and wrongful death claims as against Dr. Chendrasekhar are dismissed with the exception of: *(1) his and his resident's, Dr. Takahashi's, surgical consultation to the patient on Sunday, April 5, 2009; and (2) the events surrounding the patient's execution of the surgery-consent form at 8:15 p.m. on Sunday, April 5, 2009, inclusive of Dr. Chendrasekhar's retroactive signature and dating of the surgery consent form on Tuesday, April 7, 2009*; and the remainder of his motion is denied *pro tanto*; and it is further

ORDERED that Wyckoff's motion in Seq. No. 8 is granted *mutatis mutandis* with Dr. Chendrasekhar's motion in Seq. No. 7; and it is further

ORDERED that the principal action is severed as against Dr. Eichenstein and is continued as against the remaining defendants; and it is further

ORDERED that the caption of this action is amended to read in its entirety as follows:

----------X
LUIS RIVERA, as Administrator of the Estate of
CARMEN OTERO, Deceased,

Plaintiff,

-against- Index No. 9685/11

WYCKOFF HEIGHTS MEDICAL CENTER,
DALI CHAKHVASHVILI MARDACH, M.D.,
AKELLA CHENDRASEKHAR, M.D.,
MUKUL ARYA, M.D.,
THEOPINE ABAKPORO, M.D., BHAKTI PATEL, P.A.,
and WYCKOFF EMERGENCY MEDICINE SERVICES, P.C.,

Defendants.
----------X
WYCKOFF HEIGHTS MEDICAL CENTER,

Third-Party Plaintiff,

-against-

MUKUL ARYA, M.D.,
THEOPINE ABAKPORO, M.D., BHAKTI PATEL, P.A.,
and WYCKOFF EMERGENCY MEDICINE SERVICES, P.C.,

Third-Party Defendants.
----------X

; and it is further

ORDERED that plaintiff's counsel is directed to electronically serve a copy of this decision and order with notice of entry on defendants' respective counsel and to electronically file an affidavit of service thereof with the Kings County Clerk.

This constitutes the decision and order of the Court.

ENTER,

Bernard J. Graham

J. S. C.

HON. BERNARD J. GRAHAM

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