SUPREME COURT OF THE STATE OF NEW YORK
NEW YORK COUNTY

PRESENT: HON. JUDITH MCMAHON **PART** 30M

Justice

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KAREN MURPHY, KAREN MURPHY,

Plaintiff,

- v -

CHINATOWN CARDIOLOGY, P.C.,RAVI DIWAN, TAK KWAN

Defendant.

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INDEX NO. 805038/2016

MOTION DATE 10/19/2022

MOTION SEQ. NO. 003

DECISION + ORDER ON MOTION

The following e-filed documents, listed by NYSCEF document number (Motion 003) 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140

were read on this motion to/for JUDGMENT - SUMMARY.

Upon the foregoing documents, it is ordered that the motion of defendants Chinatown Cardiology, P.C., Ravi Diwan, M.D. and Tak Wai Kwan, M.D. for summary judgment pursuant to CPLR §3212 is granted and the complaint is dismissed.

This matter arises out of the medical malpractice rendered to plaintiff's decedent, Francis Murphy, who was 54 years old when he underwent a percutaneous transluminal intervention of the common iliac artery and placement of stents, performed by defendants on March 27, 2014. Plaintiff also claims that her late husband's May 25, 2021 death from COVID-19 was a direct result of defendants' negligent performance of this procedure seven years earlier.

Plaintiffs filed this action on January 26, 2016. On January 28, 2022, after obtaining leave of court, plaintiffs filed an amended complaint (*see* NYSCEF Doc. No. 128) which contains four causes of action: medical malpractice, lack of informed consent, loss of consortium, and wrongful death.

FACTUAL BACKGROUND

Decedent first presented to Dr. Ravi Diwan on March 18, 2014 for an evaluation of his severe leg pain. At that time Mr. Murphy was an overweight two to three pack a day smoker for thirty years and had a history of angina. He had passed a stress test in January of 2012.

Dr. Diwan documented that decedent suffered from severe bilateral claudication, pain, and severe cramping at rest with exertion, and had an exertion tolerance of less than a half block. He noted that decedent's symptoms were most likely secondary to severe peripheral artery disease and prescribed Pletal (a medication used to improve blood flow in the legs), Lipitor and aspirin. A carotid duplex scan revealed decreasing filling times peripherally and occlusions of calcifications in both legs near the common femoral artery. Dr. Diwan counseled decedent on two treatment options: surgical revascularization, or the less invasive catheterization (*i.e.*, placement of a catheter in the leg to identify the blockage). Decedent refused the surgical option, so a plan was made to evaluate his peripheral artery disease with a lower extremity angiogram.

On March 27, 2014 decedent presented to Chinatown Cardiology for peripheral catheterization with possible intervention. Mr. Murphy consented to a diagnostic bilateral lower extremity angiogram and possible intervention and a peripheral catheterization with possible intervention. He signed the consent form for an abdominal aortogram, bilateral leg angiogram, left leg balloon angioplasty, atherectomy and possible stenting.

The procedure, performed by both Dr. Diwan and Dr. Kwan, began at 1:00 p.m. and lasted for forty minutes. The arteriogram report noted that decedent's iliac artery was completely occluded on both the right and the left from the common to the external iliac vessel. The left common iliac artery and the left external iliac artery were successfully ballooned and stented.

The procedure concluded with no reports of complications, and decedent remained in recovery until his discharge at 5:15 p.m.

While in recovery, Mr. Murphy complained of lower back and flank pain. Dr. Diwan and Dr. Kwan evaluated his complaints by checking the femoral artery access site in the groin, to ensure there was no bleeding and that there were adequate pulses. The pain improved with palpation and Dr. Diwan testified that the cause of the pain was questionable, because decedent's vital signs were stable for several hours post-operatively and he had no fever, chills, or abdominal pain. The doctor's differential diagnosis was musculoskeletal, back spasm, referred pain from the stent insertion, bleeding and infection.

Although Dr. Diwan testified that he recommended that plaintiffs go directly to Beth Israel Hospital for further study (*i.e.*, CT scan) as to the etiology of the flank pain, this was disputed by Mrs. Murphy.[1]

Dr. Kwan ordered Tylenol 3 at 3:40 p.m. along with 1 mg Versed and 25 mg fentanyl via IV at 4:26 p.m. The IV was removed at 4:50 p.m. and Mr. Murphy was discharged home at 5:15 p.m. with instructions to call 911 if his symptoms worsened, and to follow up with his primary care doctor on April 1, 2014.

Dr. Diwan testified that at 7:30 p.m. he spoke to Mrs. Murphy on her cellphone. She informed that her husband was "in pain," and Dr. Diwan instructed the Murphys to go straight to the emergency room (*see* NYSCEF Doc. No. 124, pp 163-164). Dr. Diwan further testified that he called Valley Hospital himself to inform them of Mr. Murphy's condition and his need for a CT scan to evaluate the source of back pain.

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[1] Decedent's cardiologist, John E. Strobeck, M.D. also recorded that Mr. Murphy "was offered transportation to the Beth Israel Medical Center ER using EMS but he refused indicating he would rather go to his home and ultimately to the Valley Hospital ER if his symptoms worsened or persisted" (*see* NYSCEF Doc. No. 133, Valley Hospital Records, p. 171).

At 9:00 p.m. decedent presented to Valley Hospital's emergency department with a chief complaint of severe right flank pain and diffuse back discomfort. Dr. Strobeck noted that Mr. Murphy's discomfort began to increase in severity while driving home from Chinatown Cardiology, that it had become progressively worse and was now severe. The plan was for immediate line placement, CT angiogram and monitoring as well as aggressive hydration to reduce the risk of acute kidney injury from dye.

The CT angiogram of the abdomen and pelvis revealed "intrascapular hematoma with a contrast blush lateral to the right kidney, mass effect upon the right kidney, **no active bleeding nidus is seen**. The right main renal artery appears intact. Right renal vein is compressed but patent…no evidence of vascular dissection in the aorta or great vessels" (*see* NYSCEF Doc. No. 133, pp 351-352). Decedent's bloodwork results at 10:30 p.m. (*i.e.*, over nine hours after his procedure at Chinatown Cardiology) revealed that his hemoglobin, hematocrit, and platelet counts were normal.

A vascular consult with Valley Hospital's emergency medicine attending noted that acute vascular intervention was not necessary as decedent was unlikely to bleed further due to capsule. The plan was to admit him for pain control and monitoring, including serial blood testing to evaluate for hemoglobin and hematocrit levels, and to gauge blood loss. IV fluid hydration was continued given the renal injury and hematoma.

At 4:51 a.m. on March 28, 2014 (12 hours after discharge from Chinatown Cardiology) decedent's hemoglobin and hematocrit began to drop. By 12:38 p.m. the levels had dropped further, and by 4:23 p.m. decedent's hemoglobin fell to 9.2 (normal is 14.0-18) and hematocrit to 27 (normal is 42-54).

A March 28, 2014 renal consult indicated an acute renal injury (*see* report of Alexander M. Vitievsky, M.D.; NYSCEF Doc. No. 133, p. 174-175). Dr. Vitievsky noted "possible double hit from right hematoma pressing on some renal tissue, possible intravascular volume depletion due to ongoing bleeding, as well as contrast exposure" (*id.*, at p. 175). Further hydration and a Foley were recommended, as well as possible embolization of the renal artery if there were signs of ongoing bleeding.

By late afternoon of March 28th, decedent had a persistent elevated heart rate, falling hematocrit, and trouble breathing. He was seen by vascular surgeon Dr. Joshua Bernheim, who discussed the risks of angiographic intervention including the need for contrast dye which could worsen renal function. Dr. Bernheim took decedent to the operating room emergently to perform a coil embolization at 5:20 p.m. (*i.e.*, 20 hours after his admission to Valley Hospital, and 24 hours after his discharge from Chinatown Cardiology). Dr. Bernheim's operative findings noted that the superior renal artery demonstrated active extravasation and that after coil embolization there was no further bleeding.

Decedent developed respiratory distress after the IV sedation was turned off. Anesthesia attempted to place a laryngeal mask airway but was unsuccessful, and decedent was then intubated with difficulty. His heart rate dropped, he suffered cardiac arrest, and CPR was performed for twelve minutes. Decedent was successfully resuscitated and brought to recovery in guarded condition (*see* Dr. Bernheim's operative report; NYSCEF Doc. No. 133, pp. 178-179).

Mr. Murphy experienced a tonic-clonic seizure while in the PACU and was started on anti-seizure medication. A further work-up including an EEG was negative for seizure activity, and an MRI of the brain revealed a lacunar infarct involving decedent's deep right cerebrum. He had episodes of agitation requiring sedation. Gradually, as Mr. Murphy's behavior began to

improve, he was weaned off sedation. He opened his eyes on April 5, 2014 at which time he was able to follow simple commands. On April 8, 2014 Mr. Murphy was able to eat without a feeding tube. He was treated for pneumonia during this hospitalization.

Decedent was discharged from Valley Hospital in stable condition on April 9, 2014 and was admitted to Kessler Institute, where he remained until April 21 2014. He ultimately returned to work full time.

Seven years later, on April 24, 2021, Mr. Murphy presented to the emergency department at Holy Name Medical Center with a complaint of worsening shortness of breath for three days. He had a fever, high blood pressure, elevated heart rate, and was hypoxic. Decedent was unvaccinated and had tested positive for COVID-19 three days earlier. His medical history at that time included treatment for hypertension, high cholesterol, and diabetes. Decedent was obese and had quit smoking in 2014.

Mr. Murphy was admitted to the ICU. He died on May 25, 2021. No autopsy was performed.

EXPERT OPINIONS AND SUMMARY JUDGMENT

In support of their motion for summary judgment, the defendants attach the expert affidavit of Robert Attaran, M.D., who is board certified in cardiovascular disease and interventional cardiology (*see* NYSCEF Doc. No. 116). Dr. Attaran opines, within a reasonable degree of medical certainty, that the treatment rendered to Mr. Murphy by defendants was consistent with the standards of good and accepted medical practice, and that decedent did not have a significant capsular bleed while being monitored at Chinatown Cardiology, because if he had, he would have appeared sicker, his vital signs would have been abnormal, and his pain would not have abated with analgesics or massage. Dr. Attaran concludes that decedent was

appropriately discharged from Chinatown Cardiology with the proper follow up instructions, given his refusal to obtain a CT scan at nearby Beth Israel for further evaluation.

Critically, Dr. Attaran opines that it was Valley Hospital's delay in performing surgery, twenty hours after his admission to that facility, that was the primary cause of decedent's decompensation, respiratory distress and hypoxia following the embolization. In this regard, the doctor points out that the treating physicians at Valley Hospital diagnosed the bleed and decided not to address the hematoma until twenty hours after decedent had been under their care, after the lab values showed steadily decreasing hematocrit and hemoglobin levels and worsening vital signs which, by that point, indicated an active bleed. In fact, the hospital's decision to wait nearly twelve hours after discovering the bleed (the lab values first reflected a drop in decedent's hemoglobin and hematocrit in the early morning of March 28, 2014) to perform the embolization was, according to defendants' expert, a cause of decedent's acute respiratory distress stemming from poor blood oxygenation from active blood loss for several hours: "It was this nearly twelve-hour delay by Valley Hospital and not the defendants' alleged negligence that was the proximate cause of his injuries" (*id.*, para 59). Finally, Dr. Attaran contributes decedent's refusal to undergo diagnostic imaging at Beth Israel Hospital as a possible factor in causing or contributing to the delay in his diagnosis and treatment.

Specifically, Dr. Attaran finds that (1) the planned performance of angioplasty with stenting was indicated due to decedent's significant claudication, and the recommendation by Dr. Diwan of the less invasive angioplasty with stenting, when decedent refused revascularization surgery, was an effective alternative to widen decedent's artery at the site of the blockage to increase blood flow; (2) Dr. Diwan appropriately counseled decedent on the risks, benefits and alternatives of proceeding with angioplasty, and decedent provided informed consent and agreed

to the proposed diagnostic angiogram, angioplasty and possible stenting procedure; (3) the performance of the angioplasty with stenting was appropriately done within the standard of care as documented in the procedure notes; defendants successfully performed the balloon angioplasty and stented the left common iliac artery and left external iliac artery to open the occlusion, and decedent remained stable throughout the procedure with no reports of complications or issues during the procedure; (4) the subsequent development of a subcapsular hematoma did not result from a departure from the standard of care, but rather occurred due to the inadvertent passing of a wire through the renal artery, puncturing the kidney ("[a] bleed from an inadvertent wire puncture is not a departure from the standard of care and can occur in the absence of negligence" [*id.*, para 49]), and this bleed was insignificant at that time, based on later studies; (5) Dr. Diwan appropriately appreciated decedent's complaints of backpain after the procedure and evaluated him to identify the cause; (6) it was appropriate and within the standard of care to discharge decedent three hours after the procedure, based on his vital signs and the fact that the pain had abated; (7) Dr. Diwan appropriately recommended that decedent have a CT scan at Beth Israel to identify the cause of his pain, but since decedent refused, and since his vital signs were stable and the pain was positional in nature and did not radiate, then it was appropriate to advise him to continue to monitor his symptoms and call 911 to undergo a CT scan at a nearby hospital; (8) Dr. Diwan demonstrated further competence by calling decedent two hours after his discharge and, upon learning that he still had backpain, instructing him to go to the nearest emergency room, and by calling ahead to Valley Hospital to advise them that decedent would need a CT scan.

Dr. Attaran is emphatic that there was no evidence of a significant bleed until twelve hours after Mr. Murphy's discharge from Chinatown Cardiology, and the fact that he did not

have surgery until twelve hours after discovering that bleed was a proximate cause of his injuries. Finally, the expert concludes that there is no evidence that defendants' alleged malpractice caused or contributed to decedent's death seven years later from COVID-19; rather, that it was Mr. Murphy's comorbidities and unvaccinated status that may have contributed to his death. Dr. Attaran opines, based on the medical records which are *silent as to decedent's neurologic status,* that it is "nothing more than speculation" that any alleged residual neurological deficits contributed to Mr. Murphy's susceptibility to becoming infected with or succumbing to COVID-19.

In opposition to the motion, plaintiff attaches the affidavit of Carlos Mena-Hurtado, M.D., who is board certified in internal medicine, cardiovascular medicine, and interventional cardiology (*see* NYSCEF Doc. No. 137). Dr. Mena-Hurtado sets forth that the defendants departed from the accepted standard of medical care in two ways: first, by perforating decedent's right renal artery while performing a lower extremity peripheral vascular intervention, and second, by failing to recognize the nature of the iatrogenic injury, leading to a significant delay in Mr. Murphy's treatment. The doctor attests that these departures resulted in Mr. Murphy suffering significant injuries including cardiac arrest and a traumatic brain injury and were a direct and proximate cause of his death seven years later.

According to plaintiff's expert, an individual with significant neurological deficits has a greatly compromised immune system, since the body does not properly respond to outside agents. For example, an individual who sustains a traumatic brain injury does not secrete mucus and other necessary fluids in the same manner as a person without a brain injury, making him more susceptible to respiratory infections: "[a] traumatic brain injury is a predisposing condition that made an individual, such as decedent, not only more vulnerable to being infected with

COVID-19, but also reduced his body's ability to fight the virus" (*id.*, paras 30-32). In Dr. Mena-Hurtado's opinion within a reasonable degree of medical certainty, the injuries suffered by Mr. Murphy because of defendants' malpractice significantly increased his chances of contracting and dying from COVID-19 and were a proximate cause of his death on May 25, 2021. The expert entirely disagrees with Dr. Attaran's opinion that perforation of the right renal artery is a recognized and accepted risk of the procedure that may occur in the absence of negligence. In fact, according to Dr. Mena-Hurtado, defendants' tacit admission that they perforated the artery is itself, an indication of a "quintessential and clear departure" from the accepted standard of care.

Dr. Mena-Hurtado emphasizes that where, as in this case, the patient is in significant pain immediately after a procedure (as testified to by Mrs. Murphy, who stated that her husband looked "horrible" and was "moaning and groaning" on the way home), and where the doctor cannot determine the etiology of the pain, the appropriate standard of medical care requires that the patient not be discharged without determining the etiology of the pain.

Finally, based on his review of the hospital record, Dr. Mena-Hurtado finds no departures from the standard of medical care on the part of non-party Valley Hospital. He finds that Dr. Attaran's opinion ignores the reality that the traumatic brain injury caused by defendants' malpractice, made decedent more susceptible to being infected by COVID-19, which is a proximate cause of his untimely death.

LEGAL STANDARD AND DISCUSSION

The standards for summary judgment are well settled. The proponent "must make a *prima facie* showing of entitlement to judgment as a matter of law, tendering sufficient evidence to eliminate any material issues of fact from the case" (*Winegrad v. New York Univ. Med. Ctr.,*

64 NY2d 851, 853 [1985]; [internal citations omitted]). The motion must be supported by evidence in admissible form (*see Zuckerman v. City of New York,* 49 NY2d 557, 562 [1980]), and the facts must be viewed in the light most favorable to the nonmoving party (*see Vega v. Restani Constr. Corp.,* 18 NY3d 499, 503 [2012]). "In determining whether summary judgment is appropriate, the motion court should draw all reasonable inferences in favor of the nonmoving party and should not pass on the issue of credibility" (*Garcia v. J.D. Duggan, Inc.*, 180 AD2d 579, 580 [1st Dept. 1992]).

Once the movant has met his or her burden on the motion, the nonmoving party must establish the existence of a material issue of fact (*Vega v. Restani Constr. Corp.,* 18 NY3d 499, 503 [2012]). A movant's failure to make a *prima facie* showing requires denial of the motion, regardless of the sufficiency of the opposing papers (*Winegrad v. New York Univ. Med. Ctr.,* 64 NY2d 851 [1985]; [internal citations omitted]). It has been held that merely "pointing to gaps in an opponent's evidence is insufficient to demonstrate a movant's entitlement to summary judgment" (*Koulermos v. A.O. Smith Water Prods.*, 137 AD3d 575, 576 [1st Dept. 2016]). "The drastic remedy of summary judgment, which deprives a party of his day in court, should not be granted where there is any doubt as to the existence of triable issues or the issue is even 'arguable'" (*DeParis v. Women's Natl. Republican Club, Inc.,* 148 AD3d 401 [1st Dept. 2017]; [internal citations omitted]).

To sustain a cause of action for medical malpractice, the plaintiff must prove two essential elements: (1) a deviation or departure from accepted practice, and (2) evidence that such departure was a proximate cause of the claimed injury. A medical provider moving for summary judgment, therefore, must make a *prima facie* showing of entitlement to judgment as a matter of law by establishing the absence of a triable issue of fact as to his or her alleged

departure from accepted standards of medical practice (*Frye v. Montefiore Med. Ctr.*, 70 AD3d 15 [1st Dept. 2009]; [internal citations omitted], or by establishing that the plaintiff was not injured by such treatment (*see Stukas v. Streiter,* 83 AD3d 18 [2d Dept. 2011]).

To satisfy the burden on the motion, a defendant must present expert opinion testimony that is supported by the facts in the record, addresses the essential allegations in the complaint or the bill of particulars, and is detailed, specific, and factual in nature (*see Roques v. Noble,* 73 AD3d 204, 206 [1st Dept. 2010]). If the expert's opinion is not based on facts in the record, the facts must be personally known to the expert and the opinion should specify "in what way" the plaintiff's treatment was improper and "elucidate the standard of care" (*Ocasio-Gary v. Lawrence Hospital*, 69 AD3d 403, 404 [1st Dept. 2010]). Once a defendant has made such a showing the burden shifts to the plaintiff to "submit evidentiary facts or materials to rebut the *prima facie* showing by the defendant" (*Alvarez v. Prospect Hosp.,* 68 NY2d 320, 324 [1986]), but only as to those elements on which the defendant met the burden (*see Gillespie v. New York Hosp. Queens,* 96 AD3d 901 [2d Dept. 2012]). Accordingly, a plaintiff must produce expert testimony regarding the specific acts of malpractice, and not just testimony that alleges "[g]eneral allegations of medical malpractice, merely conclusory and unsupported by competent evidence" (*Alvarez v. Prospect Hosp.*, 68 NY2d at 325). In most instances, the opinion of a qualified expert that the plaintiff's injuries resulted from a deviation from relevant industry or medical standards is sufficient to defeat summary judgment (*Frye v. Montefiore Med. Ctr.*, 70 AD3d 15, 24). Where the expert's "ultimate assertions are speculative or unsupported by any evidentiary foundation, however, the opinion should be given no probative force and is insufficient to withstand summary judgment" (*Diaz v. New York Downtown Hosp.,* 99 NY2d 542, 544 [2002]). The plaintiff's expert must address the specific assertions of the defendant's

expert with respect to negligence and causation (*see Foster-Sturrup v. Long,* 95 AD3d 726, 728-729 [1st Dept. 2012]).

A "mere possibility" of causation is insufficient to create a jury issue (*Mortensen v. Memorial Hospital,* 105 AD2d 151 [1st Dept. 1984]).

The focal issue in this matter is whether the defendants' conduct was a proximate cause of plaintiff's decedent's injuries while at Valley Hospital and subsequent death on May 25, 2021 death. Assuming, *arguendo,* that the defendants deviated from the accepted standard of care by perforating decedent's right renal artery and/or by improperly discharging the decedent from Chinatown Cardiology despite his continuing complaints of back and flank pain, the plaintiff has failed to offer any evidence--other than conclusory assertions and speculation--that these deviations were a proximate cause of decedent's cardiac arrest, stroke, and subsequent death from COVID-19 seven years later.

This Court finds that defendants have established entitlement to judgment as a matter of law dismissing plaintiffs' complaint through the factually based and detailed affirmation of Dr. Attaran, who set forth that a proximate and intervening cause of decedent's injuries was Valley Hospital's twelve-hour delay before surgically repairing the perforation.

In opposition, plaintiffs have failed to meet their burden in rebutting defendants' *prima facie* showing. While the affirmation of Dr. Mena-Hurtado asserts that decedent's neurological deficits may have contributed to his susceptibility to a COVID-19 infection, there is no evidence in the medical records that decedent had any ongoing neurological issues, much less whether alleged neurological deficits impacted his health. Moreover, plaintiff's expert is silent in response to Dr. Attaran's explanation that Valley Hospital's delay in surgically stopping the bleed was a proximate cause of decedent's injuries and sequalae herein.

Accordingly, it is

ORDERED that the defendants' motion for summary judgment dismissing plaintiffs' complaint is granted; and it is further

ORDERED that the Clerk enter judgment dismissing the complaint of Karen L. Murphy as Administratrix of the Estate of Francis Murphy, Deceased and Karen L. Murphy, individually.

10/21/2022
DATE

JUDITH MCMAHON, J.S.C.

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

Hon. Judith N. McMahon
J.S.C.