Part 63

At ~~MMTRP~~ of the Supreme Court of the State of New York, held in and for the County of Kings, at the Courthouse located at 360 Adams Street, Brooklyn, New York, on the 26 day of ~~April~~, 2023.

PRESENT:

HON. ELLEN M. SPODEK,
Justice

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF KINGS

Index No.: 501173/2018

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MALVINA VAYNER, As Administrator of the Estate of AVRAM VAYNER, Deceased, and MALVINA VAYNER, Individually,

DECISION AND ORDER

MS#8

Plaintiff,

-against-

VLADIMIR KRICHEVSKY, MD, VLADIMIR KRICHEVSKY, MD, PC, SERGEY TERUSHKIN, MD, CAMILLE ARMAND, MD and NEW YORK COMMUNITY HOSPITAL,

Defendants.

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Defendant The New York Community Hospital of Brooklyn, Inc. (hereinafter NYCH) moves pursuant to CPLR 3212 for Summary Judgment dismissing plaintiff's Complaint in its entirety with prejudice and all crossclaims and counter claims. Plaintiff opposes.

Background

This cause of action arises out of alleged medical malpractice involving treatment received by the decedent, Avram Vayner, a 73-year-old man, at NYCH in August of 2016. Prior to the decedent's

admission to NYCH in August of 2016, defendant Dr. Krichevsky had been treating the decedent since 2008. From 2013 through 2016, Dr. Krichevsky primarily treated Mr. Vayner for an enlarged prostate, benign prostatic hypertrophy, bladder stones, and a penile mass.

Mr. Vayner visited Dr. Krichevsky's office on July 18, 2016. During that visit they discussed Mr. Vayner's hematuria (blood in the urine), its possible etiologies, and possible courses of treatment. Dr. Krichevsky diagnosed Mr. Vayner with bladder stones. Dr. Krichevsky suggested proceeding with a cystoscopy and possible bladder biopsy. Mr. Vayner agreed to this plan.

Dr. Krichevsky made arrangements to perform the surgery at NYCH. On August 1, 2016, Mr. Vayner executed an informed consent form authorizing Dr. Krichevsky to perform a cystoscopy and laser guided lithotripsy of the bladder stones. That day, Dr. Krichevsky performed the laser lithotripsy of multiple bladder stones in Mr. Vayner's bladder. Dr. Krichevsky had no surgical assistance during this operation.

Immediately following the cystoscopy and laser lithotripsy, Mr. Vayner had hematuria and was placed on continuous bladder irrigation (CBI) postoperatively. The plan was to continue the CBI for 1-2 hours and then discontinue it when the bloody urine cleared.

At approximately 12:22 a.m. on August 1st, Mr. Vayner was admitted to NYCH through the emergency department, due to continued bloody urine. He was transferred from PACU to a Med-Surg floor at approximately 3:00 a.m. At approximately 3:40 a.m., Mr. Vayner had shortness of breath and was given supplemental oxygen.

Registered Nurse Linda Voight was assigned to care for Mr. Vayner during her shift on August 1, 2016, which started at 7:00 pm and ended at 7:30 am, on August 2, 2016. Nurse Voight is an employee of NYCH.

Nurse Voight did not contact Dr. Krichevsky during her overnight shift to inform him that Mr. Vayner was vomiting, had increased pain despite the administration of morphine, had abdominal

distension, had shortness of breath, or that his bleeding was continuing. Neither Nurse Voight nor anyone else at NYCH documented any vital signs for Mr. Vayner between 7:16 p.m. on August 1st and 08:59 a.m. on August 2nd.

Dr. Krichevsky examined Mr. Vayner at 7:20 am on August 2, 2016. At that time, Mr. Vayner had a distended bladder, moderate tenderness, and mild to moderate hematuria. Dr. Krichevsky notes that the bladder was irrigated by NYCH staff a few times overnight, and that there were some clots that staff were unable to irrigate.

On August 2, 2016, at approximately 6:30 p.m., Dr. Krichevsky performed a cystoscopy, attempted bladder irrigation with clot evacuation, intraoperative cystogram, exploratory laparotomy, bladder exploration, repair of bladder tear/perforation, suprapubic cystostomy placement, and closure of peritoneal tear. Mr. Vayner's vitals dropped and he had to be intubated, and central and arterial lines were placed. He also received a blood transfusion. General surgeon Dr. Terushkin was called in to assist. An exploratory laparotomy was done and a 5-6 cm bladder tear in the right posterior wall was found. Bleeding from the bladder perforation was cauterized and the defect was repaired in 2 layers with 2-0 Vicryl stitches.

Postoperatively, on August 3rd, Mr. Vayner was transferred to the ICU. He was further resuscitated and transfused but remained hypotensive with BPs of 78/27 at 12:47 a.m., 49/16 at 03:05 a.m. and 100/43 at 03:55 a.m. Mr. Vayner went into cardiac arrest twice, at approximately 03:10 a.m., and died at 04:40 a.m. on August 3rd, 2016.

Discussion

On a motion for summary judgment dismissing a medical malpractice cause of action, a defendant has the prima facie burden of establishing that there was no departure from good and accepted medical practice, or, if there was a departure, the departure was not the proximate cause of

the alleged injuries. *Brinkley v. Nassau Health Care Corp., 120 A.D.3d 1287 (2d Dept. 2014); Stukas v. Streiter, 83 AD3d 18, 24-26 (2d Dept. 2011).*

Once the defendant has made such a showing, the burden shifts to the plaintiff to submit evidentiary facts or materials to rebut the prima facie showing made by the defendant, so as to demonstrate the existence of a triable issue of fact. *Alvarez v. Prospect Hosp., 68 NY2d 320, 324 (1986); Brinkley v. Nassau Health Care Corp., supra; Fritz v. Burman, 107 A.D.3d 936, 940 (2d Dept. 2013); Lingfei Sun v. City of New York, 99 AD3d 673, 675 (2d Dept. 2012); Bezerman v. Bailine, 95 AD3d 1153, 1154 (2d Dept. 2012); Stukas v. Streiter, at 24.* A plaintiff succeeds in a medical malpractice action by showing that a defendant deviated from accepted standards of medical practice and that this deviation proximately caused plaintiff's injury. *Contreras v. Adeyemi, 102 AD3d 720, 721 (2d Dept. 2013); Gillespie v. New York Hosp. Queens, 96 A.D.3d 901, 902 (2d Dept. 2012); Semel v. Guzman, 84 AD3d 1054, 1055-56 (2d Dept. 2011).* The plaintiff opposing a defendant's motion for summary judgment must only submit evidentiary facts or materials to rebut the defendant's prima facie showing. *Stukas, at 24.*

A hospital is normally protected from tort liability if its staff follows the orders of the patient's private physician. The only exception is where the staff knows that the doctor's orders are so clearly contraindicated by normal practice that ordinary prudence requires inquiry into the correctness of the orders. *Cook v. Reisner, 295 A.D.2d 466 (2d Dept. 2002).*

In support of its motion, defendant NYCH submits the affirmation of Dr. Reza Mehrazin, a board-certified Urologist. Dr. Mehrazin opines that nothing in the record suggests the hospital staff failed to timely follow the orders and instructions of the attending physician, Dr. Krichevsky, and that any claimed actions or inactions by the staff of NYCH were not the proximate cause of plaintiff's injuries *Def. Exp. Aff. Para. 4.* Dr. Mehrazin states that he believes to a reasonable degree of medical certainty that Mr. Vayner sustained a perforation of the bladder as a result of Dr. Krichevsky's

performance of the laser lithotripsy and cystoscopy on August 1, 2016. De*f. Exp. Aff. Para. 12.* Dr. Mehrazin additionally states that he believes that if the second operation, in which an NYCH surgeon assisted, had been performed earlier in the day on August 2, 2016, that "would not have made a difference in the outcome of this matter." *Id.*

In support of its opposition, plaintiff submits the affirmation of a board-certified surgeon. Plaintiff's expert opines that NYCH departed from good and accepted standards of medical practice in several ways with respect to Mr. Vayner's treatment. Firstly, plaintiff's expert opines that it was a departure for NYCH to grant Dr. Krichevsky privileges despite the fact that he lost his board certification in urology. *Pltf. Exp. Aff. Para. 9.* Plaintiff's expert explains that, "The Joint Commission for Accreditation of Healthcare Facilities (JCAHO) has pointed to board certification and maintenance of certification as excellent benchmark for the delineation of clinical privileges," and that NYCH therefore departed from good and accepted standards by not discovering that Dr. Krichevsky was not board certified in urology, or in not revoking his privileges despite having that knowledge *Id. Para. 8.*

Plaintiff's expert additionally points to the conduct of Nurse Voight, a NYCH employee, as a departure. Plaintiff's expert claims that it is standard for a nurse to inform an operating surgeon of significant changes in a post-operative patient and points out that Dr. Krichevsky had explicitly instructed Nurse Voight to call him if there were changes in Mr. Vayner's condition overnight. Plaintiff's expert also points to Nurse Voight's failure to document Mr. Vayner's vitals for approximately 12 hours the night of August 1, 2016 as a departure, emphasizing that her failure to document Mr. Vayner's blood pressure was particularly "egregious," given that Mr. Vayner was bleeding. *Id. Paras. 15-17.* This expert opines that Nurse Voight failed to contact Dr. Krichevsky despite the fact that Mr. Vayner was in "horrific" pain, was vomiting and short of breath on the night of August 1, 2016, into the morning of August 2, 2016. *Id. Para. 14.* Plaintiff's expert states that

"Voight violated all prevailing standards of care and was a substantial factor and competent producing cause of a gross delay in the treatment of Mr. Vayner's ongoing bleeding and bladder perforation, and of his wrongful death," *Id.* Plaintiff's expert claims that each of these departures is indicative of a failure on the part of NYCH to train and supervise its nurses.

Plaintiff's expert also points to the fact that Dr. Krichevsky booked an Operating Room (OR) for Mr. Vayner's second surgery at 8:30 in the morning and one was not available until 6:30 that evening as a departure. Defendant repeatedly asserts in its expert affirmation as well as its other supporting papers that Dr. Krichevsky did not book this OR on an emergency basis and that if he had, one might have been available sooner. However, plaintiff's expert points out that a case note from NYCH's records entered at 4:35 p.m. on August 2, 2016 lists Mr. Vayner's case status as "emergency." *Id. Para 20.* Additionally, Dr. Krichevsky testified at his deposition that he booked this second OR on an emergency basis. *Id.* Plaintiff's expert states that the 10-hour delay before the second surgery was a "substantial factor" in Mr. Vayner's death. *Id.*

"Summary judgment is not appropriate in a medical malpractice action where the parties adduce conflicting medical expert opinions since such conflicting expert opinions will raise credibility issues which can only be resolved by a jury. However, expert opinions that are conclusory, speculative, or unsupported by the record are insufficient to raise triable issues of fact. In order not to be considered speculative or conclusory, expert opinions in opposition should address specific assertions made by the movant's experts, setting forth an explanation of the reasoning and relying on specifically cited evidence in the record." *Lowe v. Japal, 170 AD3d 701, 702-703, 95 N.Y.S.3d 363 (2d Dept 2019) (internal quotation marks, brackets, and citations omitted).* "An expert opinion that is contradicted by the record cannot defeat summary judgment." *Schwartz v. Partridge, 179 AD3d 963, 964, 117 N.Y.S.3d 300 (2d Dept 2020).*

In this case, plaintiff's expert addresses and refutes each point made by Defendant's expert. Defendant's expert does not address the conduct or involvement of Nurse Voight, a hospital employee, at any point in his affirmation. He simply states that "the care rendered to Mr. Vayner by the staff of NYCH was within the standard of care." *Def. Exp Aff. Para. 3*. Defendant's expert does not lay out with specificity what the standard of care would have been for NYCH staff under these circumstances. He points to Dr. Krichevsky's alleged departures, but he bypasses the claims that NYCH staff including Nurse Voight violated their duties of care.

With respect to the long wait time for the second OR, Plaintiff's and Defendant's experts are again in conflict. Defendant's expert claims that if Dr. Krichevsky had requested an emergency OR, one would have been available within 30 minutes. *Id. Para 9*. He does not point to any hospital policy that substantiates this timeframe. Whereas Plaintiff's expert cites portions of the record including NYCH's own notes where it appears Dr. Krichenvky did request an emergency OR. *Pltf. Exp. Para. 20*. Plaintiff's expert concludes that the 10 hour wait time was due to a failure of organization on the part of NYCH and amounts to a departure from good and accepted standards of practice.

Defendant's expert's statements are conclusory and lack specificity. He does not lay out what the standard of care would have been for NYCH's staff in observing and caring for Mr. Vayner post-operatively. He simply repeats that nothing NYCH did or did not do had any impact on Mr. Vayner's condition or his ultimate death. Plaintiff's expert clearly creates issues of fact when it comes to the alleged negligence of NYCH's staff and the appropriateness of its procedures.

As to the informed consent claims, it is well settled that the responsibility of obtaining informed consent lies with the treating physician. *Beard v. Brunswick Hospital Center, 220 AD2d 550 (2nd Dept 1995)*; *Culkin v. Nassau Hospital Association, 143 AD2d 973 (2nd Dept 1988)*. Here, it was Dr. Krichevsky's responsibility as the attending physician and as Mr. Vayner's surgeon to

obtain informed consent. Therefore, the claims of lack of informed consent against NYCH must be dismissed.

Conclusion

Defendant's motion is granted as to the claims of lack of informed consent against NYCH. The remainder of the defendant's motion is denied.

ENTER:

J.S.C.
HON. ELLEN M. SPODEK