SUPREME COURT : STATE OF NEW YORK
IAS PART WESTCHESTER COUNTY
PRESENT: HON. JOAN B. LEFKOWITZ, J.S.C.

To commence the statutory time period for appeals as of right (CPLR 5513[a]), you are advised to serve a copy of this order, with notice of entry, upon all parties.

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CHRISTINE COSTOSO-MILLER, as Administratrix of the Estate of ROBERT MILLER, Deceased, and CHRISTINE COSTOSO-MILLER, Individually,

Plaintiffs,

-against-

WESTCHESTER COUNTY HEALTHCARE CORPORATION (MIDHUDSON REGIONAL HOSPITAL OF WESTCHESTER COUNTY MEDICAL CENTER), WILLIAM BARRACK, M.D., ORTHOPEDIC ASSOCIATES OF DUTCHESS COUNTY, P.C., FAIZAN ARSHAD, M.D., and LORETTA OBI, M.D.,

Defendants.

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DECISION & ORDER

Index No: 69729/2015

Motion Return Date:
December 8, 2017
Motion Seq. #2

The following papers (e-filed documents 33-45; 111-128; 133-135) were read on the motion by the defendants, William Barrack, M.D., and his employer, Orthopedic Associates of Dutchess County, PC., for an order granting summary judgment dismissing the complaint insofar as it asserts a cause of action against them.

Notice of Motion, Affirmation, Affidavit (Exhibits A-J)
Affirmation in Opposition (Exhibits A-Q)
Reply Affirmation (Exhibits I-J [sic])

Upon reading the foregoing papers it is

ORDERED the motion is denied; and it is further

ORDERED the parties are directed to appear on July 31, 2018, at 9:15 a.m. in the Settlement Conference Part, Courtroom 1600, Westchester County Supreme Court, 111 Martin Luther King Boulevard, White Plains, New York, prepared to conduct a settlement conference.

On October 23, 2014, Robert Miller consulted with Dr. William Barrack concerning his neck, back and shoulder pain. Eventually Dr. Barrick recommended surgery to remove a disc in Mr. Miller's neck and fuse the spine there. Mr. Miller consulted with his primary care physician, Dr. Fontanez, who cleared him for the surgery. Dr. Fontanez instructed Miller to discontinue all anti-inflammatory products such aspirin or Aleve for one week prior to surgery.

On December 1, 2014, Miller met with Dr. Barrack. At that time it was agreed to go ahead with the elective surgery. The surgery was then scheduled for December 17, 2014, at Mid-Hudson Regional Hospital. Miller received written instructions from Mid-Hudson Regional Hospital to stop anti-inflammatory medicines, including Aleve, one week before surgery.

On the day of surgery, December 17, 2014, Mr. Miller advised the anesthesiologist that he had taken Aleve within the past 48 hours. Dr. Barrack's notes state, "Had Aleve. Increased risks of surgical bleeding discussed with patient and daughter. Patient declines cancellation of surgery despite increased risks." Mr. Miller's daughter has a different recollection. At deposition, the daughter testified Dr. Barrack was hesitant to go forward with the surgery and her father stated I am already on disability and am already here, do you think we should go forward with it, and that Dr. Barrack responded yes, it was a quick surgery and everything would be fine.

Dr. Barrack performed the surgery. His post-operative report indicates a loss of 50 ccs of blood and states the inferior thyroidal artery was not in the operative field. At deposition and in an affidavit he denied the artery could have been injured since he did not see it in the operative field and that if it were injured there would have been the loss of more blood.

Mr. Miller was admitted to the Post Anesthesia Care Unit (PACU) at approximately 6:57 p.m. He had a slight temperature, elevated blood pressure and a pain score of 0/10. Dr. Barrack's post operative orders included orders that Mr. Miller's head be elevated to reduce airway swelling and prevent aspiration and that a Miami J collar be worn out of bed, but not in bed. No orders were issued regarding the increased risk of bleeding due Miller's ingestion of Aleve within 48 hours of the surgery. Prior to leaving Miller in the recovery room at 7:44 p.m. Dr. Barrack noted that Mr. Miller's voice was normal and that he observed no swelling of the neck.

Mr. Miller's family then visited him in the PACU. His daughter recalled that Mr. Miller was wearing a big collar, did not speak and appeared to be in pain. At 7:25 p.m. morphine was administered when Mr. Miller reported his pain level at 5/10. Additional medications were administered for elevated blood pressure and for nausea.

Miller was transferred from PACU to the total joint center at 9:35 p.m. His pain score was 3/10 and his blood pressure was lower.

At 10:45 p.m. Dr. Obi examined Miller at Dr. Barrack's request for management of his diabetes. Dr. Obi testified that Miller complained of neck pain and tightness of the collar. Dr. Obi made no inquiry as to the reason for the tightness and asked a nurse to remove it. Dr. Obi testified that she thought the collar might be tight because she thought Miller's neck was bigger than normal. After dictating her notes Dr. Obi again observed Miller. She observed the neck was swollen but attributed this to normal swelling after surgery. She only observed the neck and did not palpate the neck or press on the swelling. She testified that she was consulted only for medical issues and not surgical issues. During Dr. Obi's consultation Miller's pain level increased from 4/10 to 8/10 and he was given oxycodone.

Mr. Miller was noted to be sleeping at midnight, one a.m. and two a.m. He was given medication for nausea, vomiting, anxiety and itching. At 2:03 a.m. a note was entered that indicated swelling around Miller's eye, and "tenderness, redness and swelling" were noted in Miller's neck, but that no drainage, redness or swelling were noted around the incision. The note indicates Miller was wearing the collar. The 2:03 a.m. note does not indicate when these observations were made.

More Ativan, an anti-anxiety drug, and oxycodone were administered at 3:26 a.m. when Mr. Miller reported a pain level of 9/10. A 3:47 a.m. note documents Mr. Miller had reported "discomfort" in his throat. The nurse at deposition stated that Miller told her his throat "still hurt" but she attributed this to Miller having been intubated during surgery.

There are no nursing notes which document any interaction between the nursing staff and Mr. Miller between 3:47 a.m. and 5:15 a.m., a span of one hour and a half hours.

A nursing note relates the following occurring at 5:15 a.m.:

> "Pt received in asleep [sic] in bed, easily aroused to name. Speech clear. Pt states surgical pain level has improved. However, throat still uncomfortable, Pt stated 'I feel like I am having a hard time breathing.' RR easy and unlabored at 22. Pulse OX 94%Ra. 2LNC applied. Asked to open mouth to assess airway. Mild swelling to tongue. Mild swelling noted to lateral neck bilaterally. DRSG remains CDI. Charge nurse called to room to assess patient. Charge nurse left room to call Dr. Barrack to report findings of assessment. Pt quickly sat up and stated 'I can't breathe.' Rapid response called. In less than one minute pt color went to blue. Code blue activated. ICU RN x2 and RRT arrived. Refer to code blue flowsheet for code events."

Dr. Arshad, who is trained in emergency medicine, responded to the code blue. According to Dr. Arshad, when he arrived Miller was in full cardiac arrest. According to the code blue flowsheet, the code blue was activated at 5:33 a.m., the monitor was applied at 5:34 and the initial rhythm was noted as "sinus bradycardia with weak pulse." CPR was immediately administered. Dr. Ashad attempted to intubate Mr. Miller with a Glidescope, but could not since he could not adequately see the vocal chords. Next Dr. Ashad unsuccessfully attempted intubation with a conventional layryngoscope equipped with a "Miller" blade. Dr. Ashad claims he was then able to successfully place a laryngeal mask airway (LMA) device. Dr. Ashad claims normal CO2 and SaOs2 levels were maintained after placement of the LMA, although Mr. Miller remained pulseless. Dr. Arshad testified three minutes passed between his arrival and the successful placement of the LMA. Twenty minutes into the code Dr. Arshad and staff discussed possibility of a hematoma in the neck causing the cardiac arrest and considered performing surgery to create an airway but would only do so if Mr. Miller regained spontaneous circulation of his blood. However, Mr. Miller never regained spontaneous circulation. He was pronounced dead at 6:10 a.m.

The autopsy report indicates a cause of Mr. Miller's death as "cardio pulmonary arrest associated with hematoma formation in the neck." The report noted a 9 x 3 x 1.5 inch purple hematoma overlying the right side of the larynx, thyroid gland and upper trachea with hemorrhage noted throughout the neck. The report also states, "[u]pon postmortem perfusion of the vessels of the neck there appears to be leakage from a branch of the inferior thyroidal artery."

This action was commenced in August 2015. Following completion of discovery, Dr. Barrack and Orthopedic Associates of Dutchess County, PC., move for an order granting summary judgment dismissing the complaint insofar as it asserts a cause of action against them.

In support of the motion defendants submit the affidavit of Dr. Barrack who states that he did not deviate from good and accepted medical and surgical practice during his treatment of Mr. Miller. Dr. Barrack asserts that he informed Mr. Miller of the increased risks of bleeding if Aleve is ingested within a week of surgery, that he performed the surgery because Mr. Miller directed him to proceed after being informed of the increased risk of bleeding, that he did not injure the inferior thyroidal artery during the surgery because the artery was not in the operative field and there was minimal bleeding during the surgery, and that both his post-operative orders and post-operative care were in all ways proper.

In opposition, plaintiff submitted the affirmation of its expert. Plaintiff's expert, based upon the review of the medical record and relevant depositions, stated his opinion that Dr. Barrack deviated from good and accepted medical practice by proceeding with the elective surgery knowing that Mr. Miller was exposed to an increased risk of bleeding due to his ingestion of Aleve within 48 hours of the surgery, by injuring the inferior thyroidal artery during surgery and failing to ensure the integrity of the artery prior to closing the surgical incision which caused the post-operative bleeding leading to the hematoma which cut off Mr. Miller's airway causing his asphyxiation, cardiac arrest and eventual death, and by failing to issue appropriate post-operative orders for closer monitoring of Mr. Miller to guard against the increased risk of bleeding due to Mr. Miller's recent ingestion of Aleve.

Plaintiff's expert notes that the surgery was elective, not an emergency, and Dr. Barrack's failure to postpone the surgery to avoid the risk of bleeding deviated from accepted surgical practice. The expert also disputes Dr. Barrack's claim that the inferior thyroidal artery was not in the operative field. The expert states it is "anatomically impossible for Dr. Barrack not to visualize the inferior thyroidal artery" because in his post-operative report, Dr. Barrack notes that he had a difficult dissection of the longus colli muscle due to "a deep neck with tight soft tissues and low lying C7-T1," and, according to plaintiff's expert, the inferior thyroidal artery must have been visible since it runs in front of the longus colli muscle. The expert also disputes Dr. Barrack's claim that he did not injure the inferior thyroidal artery. The expert asserts "[i]t is physiologically impossible for leaking [as described in the autopsy report] to form from a branch of the inferior thyroidal artery without some form of injury to it."

"Summary judgment is not appropriate in a medical malpractice action where the parties adduce conflicting medical expert opinions. Such conflicting expert opinions . . . raise credibility

issues which can only be resolved by a jury" (*Barrocales v. New York Methodist Hosp.*, 122 AD3d 648, 649 [2d Dept 2014] [internal quotations and citations omitted]).

Here, the papers submitted raise a triable issue of fact whether Dr. Barrack deviated from good and accepted medical and surgical practice in his treatment of Mr. Miller, and whether that deviation was a proximate cause of his asphyxiation, cardiac arrest and death.

ENTER,

Dated: White Plains, New York
July 3, 2018

HON. JOAN B. LEFKOWITZ, J.S.C.