SHORT FORM ORDER

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NASSAU

Present: **HON. RANDY SUE MARBER**
JUSTICE TRIAL/IAS PART 23

X

MARLA R. PECKMAN, Individually and as Administratrix of the Estate of IAN PECKMAN, deceased,

Plaintiffs,

Index No.: 2070/05
Motion Sequence...02
Motion Date...06/12/09

-against-

MICHAEL ANDREW SAUL, M.D., GREAT NECK MEDICAL ASSOCIATES, LLP, JALAN MARSHALL BULBIN, M.D., DAVID B. BRIEFF, M.D., NORTH SHORE INFECTIOUS DISEASE CONSULTANTS, P.C., JAY STEVEN BERLAND, M.D., JEFFREY LEWIS SIEGEL, M.D., JEFFREY SIEGEL, M.D., P.C., DAVID EDWARD BRENNER, M.D., NORTH SHORE PULMONARY ASSOCIATES, P.C., DANA LUSTBADER, M.D., NORTH SHORE UNIVERSITY HOSPITAL, PAUL T. SMITH, M.D., JOEL GREENSPAN, M.D., ANDREW PUMERANTZ, M.D. and ERFAN HUSSAIN, M.D.,

Defendants.

X

Papers Submitted:
Notice of Motion.....x
Affirmation in Opposition.....x
Reply Affirmation.....x

This motion by the Defendants, Michael Andrew Saul, M.D., David Edward Brenner, M.D., Great Neck Medical Associates, LLP, Jay Steven Berland, M.D., Jeffrey

Lewis Siegel, M.D., Jeffrey Siegel, M.D., P.C., North Shore Pulmonary Associates, P.C., North Shore University Hospital, Dana Lustbader, M.D. and Erfan Hussain, M.D., for an order pursuant to CPLR 3212 granting them summary judgment dismissing the complaint against them is determined as provided herein.

In this action, the Plaintiff, Marla R. Peckman seeks to recover as administratrix of her husband, Ian Peckman's estate, for alleged medical malpractice and his wrongful death. After conferring with Dr. Saul the previous night and being seen by Dr. Brenner at Great Neck Medical Associates that morning, Mr. Peckman was admitted to North Shore University Hospital on January 23, 2003, with symptoms of an infection that the Defendants encountered difficulty diagnosing as viral, bacterial or both. The gravamen of the Plaintiff's claims is that the Defendants failed to timely and properly treat Mr. Peckman's systemic infection and bilateral pneumonia, including, among other things, improperly failing to obtain proper and necessary outside consultations, failing to timely and properly administer antiviral and antibiotic therapies and negligently and improperly discontinuing antiviral and antibiotic therapies. According to Mr. Peckman's death certificate, he ultimately died on February 10, 2003 of cardiopulmonary arrest due to bilateral pneumonia.

The moving Defendants seek summary judgment dismissing the complaint against them.

"On a motion for summary judgment pursuant to CPLR 3212, the proponent must make a *prima facie* showing of entitlement to judgment as a matter of law, tendering

sufficient evidence to demonstrate the absence of any material issues of fact." *Sheppard-Mobley v King*, 10 A.D.3d 70, 74 (2d Dept. 2004), aff'd. as mod., 4 N.Y.3d 627 (2005), citing *Alvarez v Prospect Hosp.*, 68 N.Y.2d 320, 324 (1986); *Winegrad v New York Univ. Med. Ctr.*, 64 N.Y.2d 851, 853 (1985). "Failure to make such *prima facie* showing requires a denial of the motion, regardless of the sufficiency of the opposing papers." *Sheppard-Mobley v King, supra*, at p. 74; *Alvarez v Prospect Hosp., supra*; *Winegrad v New York Univ. Med. Ctr., supra*. Once the movant's burden is met, the burden shifts to the opposing party to establish the existence of a material issue of fact. *Alvarez v Prospect Hosp., supra*, at p. 324. The evidence presented by the opponents of summary judgment must be accepted as true and they must be given the benefit of every reasonable inference. *See, Demishick v Community Housing Management Corp.*, 34 A.D.3d 518, 521 (2d Dept. 2006), citing *Secof v Greens Condominium*, 158 A.D.2d 591 (2d Dept. 1990).

The pertinent facts are as follows:

Mr. Peckman was seen and treated at North Shore University Hospital from November 17, 2002 through November 19, 2002 by the Defendant, Dr. Saul, an associate at Great Neck Medical Associates, most likely for viral meningitis. Thereafter, he consulted with Dr. Saul regarding a lap band procedure for weight loss purposes and he saw Dr. Saul's associate, Dr. Brenner, to obtain medical clearance for that procedure on January 20, 2003.

In the evening of January 22, 2003, Mr. Peckman's wife called Dr. Saul because he was suffering from a fever, sweating and a cough which produced green sputum

with slight blood tinging. Dr. Saul called in a prescription for the antibiotic Levaquin and told Mrs. Peckman to have her husband seen by a doctor in the morning, but if he got really sick during the night, to take him to the emergency room. At his examination before trial, Dr. Saul testified that he prescribed the antibiotic "to cover [Mr. Peckman] for the evening. . . ."

When Dr. Brenner, who is also an associate of Great Neck Medical Associates, saw Mr. Peckman the next morning, his temperature was 103.4°, he had a sore throat and a cough with blood being coughed up. He had bilateral back pain and a stiff neck. He also was photophobic, i.e., sensitive to light. He showed positive signs of meningitis, i.e., Kernig and Brudzinski. Dr. Brenner suspected acute viral illness, possible meningitis and/or early pneumonia. Mr. Peckman was immediately sent to the North Shore University Hospital Emergency Room for admission and for a consult with a neurologist, an infectious disease doctor and a lumbar puncture and blood tests. Mr. Peckman was triaged at 11:39 a.m., put on an intravenous antibiotic at 12:50 p.m. to cover the possibility of bacterial pneumonia and meningitis and blood cultures were drawn at 12:58 p.m. That day, he was admitted by an infectious disease doctor, the Defendant, Dr. Smith. Dr. Smith ordered a nasopharyngeal swab (nasal swab) to test for viral pathogens, i.e., the flu. Dr. Smith's differential diagnosis was viral illness, adenovirus (upper respiratory infection), possible mycoplasma which causes nonbacterial pneumonia and influenza. Mr. Peckman was promptly seen by the neurology department. Mr. Peckman's chest x-ray revealed a left lower lobe infiltrate so antibiotics

were continued and intravenous fluids were given to cover Mr. Peckman for typical and atypical pneumonias.

The day after his admission, January 24, 2003, Mr. Peckman still had a severe headache, fever and his photophobia had worsened. His lumbar puncture was found to be of a non-bacterial etiology. The nasopharyngeal swab had not been done but other blood cultures were negative. A neurologist examined Mr. Peckman and concurred with the differential diagnosis of viral syndrome. Upon Dr. Smith's suggestion, after examining Mr. Peckman, Dr. Saul discontinued antibiotics and ordered isolation.

The next day, January 25, 2003, Mr. Peckman was started on Tamiflu. He suffered respiratory difficulty, oxygen desaturation and tachycardia and was transferred to the Medical Intensive Care Unit and treated by Dr. Saul with oxygen and respiratory medicine and a pulmonary care consult was ordered. The antibiotics Zosyn and Zithromax were given. Dr. Bulbin, another infectious disease doctor, speculated that Mr. Peckman was suffering from a viral process, possibly mycoplasma or chlamydia, because nothing suggested a bacterial source. He started Mr. Peckman on intravenous Solu-Medrol for possible vasculitis or pneumocystitis pneumonia because he thought Mr. Peckman was suffering from a viral illness. In the Medical Intensive Care Unit, Mr. Peckman suffered breathing difficulties and he was sedated and intubated. Dr. Siegel felt that Mr. Peckman was suffering from Influenza pneumonia which may have caused Acute Respiratory Distress syndrome, but it remained unclear whether he also had a bacterial infection.

The next day, on January 26, 2003, Dr. Brenner diagnosed Mr. Peckman with Acute Respiratory Distress Syndrome secondary to an underlying infection process. Dr. Brenner noted that pulmonologist, Dr. Siegel and the Intensive Care Unit team all concurred with antibiotic and oxygen therapy. Dr. Siegel's consult that day concurred with Dr. Brenner's diagnosis of Acute Respiratory Distress Syndrome and his differential diagnosis was atypical pneumonia due to a viral process possibly superimposed by bacterial pneumonia. Dr. Bulbin, also an infectious disease doctor, declared that the diagnosis was difficult. He believed that with an elevated white blood count but negative blood cultures and normal chest x-rays and the development of Acute Respiratory Distress Syndrome, a viral process, an atypical bacterial infection or an inflammatory disease such as vasculitis or lupus all had to be considered. A lung biopsy was considered.

The next day, January 27, 2003, Dr. Saul ordered continued medication and oxygen therapy. Dr. Siegel ordered a bronchoscopy and ventilation therapy and his partner, Dr. Berland, performed the bronchoscopy removing fluid from Mr. Peckman's right lower lobe for testing. Pulmonary embolus, a blocked lung artery, had been ruled out by radiology done on January 25, 2003. Lovenox for DVT (deep vein thrombosis) prophylaxis was ordered.

On January 28, 2003, due to Mr. Peckman's agitation, in addition to other sedatives, a paralytic agent was added to his medication. A medical work-up was performed. Antibiotics were continued even though there were no significant findings with Mr.

Peckman's blood, sputum, urine, cerebral spine fluid or bronchial fluid. In fact, Mr. Peckman had tested negative for a number of viral illnesses, i.e., mycoplasma, legionella, parainflu, RSV (respiratory syncytial virus) and CMV (cytomegalovirus). Dr. Saul recommended blood cultures be drawn and Dr. Siegel recommended that Mr. Peckman be weaned from the respirator. A bronchoscopy was done and Mr. Peckman's chest x-ray showed an improvement. Lung fluid was drawn for cultures and studies. The lung biopsy was not done because of safety concerns.

The next day on January 29, 2003, Mr. Peckman's viral and rheumatoid panels came back negative. Mr. Peckman seemed to be feeling better although diagnosis or etiology findings still had not been made.

On January 30, 2003, the viral culture from the bronchoscopy revealed Influenza A. Dr. Saul prescribed a new drug for superimposed pneumonia and continued Tamiflu, Zosyn and Zithromax. Pneumocystitis pneumonia was ruled out and Dr. Siegel discontinued Solu-Medrol. Dr. Siegel continued to wonder whether Mr. Peckman was suffering from bacterial pneumonia too. However, since there was little to suggest a bacterial superinfection, Dr. Bulbin recommended that antibiotics be discontinued in light of the Influenza A finding to limit the potential development of drug-resistant flora. He also recommended discontinuing Tamiflu as its benefit was limited.

Despite Drs. Siegel and Saul's concerns, on January 31, 2003, antibiotic and antiviral medications were discontinued. Mr. Peckman remained stable and orders to

decrease sedation and continue weaning from the ventilator were given.

On February 1, 2003, Dr. Siegel noted Mr. Peckman was afebrile and stable. He did begin to run a low-grade fever with temperature spikes.

On February 2, 2003, both Dr. Siegel and Dr. Brenner found Mr. Peckman to be essentially afebrile and stable. Dr. Siegel noted Mr. Peckman was doing well without antibiotics and recommended weaning him from the respirator if he remained afebrile.

On February 3, 2003, Dr. Siegel believed that Mr. Peckman was continuing to improve. Influenza pneumonia was certain and there was no evidence of a bacterial superinfection, and if there had been a bacterial infection, it had been treated and his Acute Respiratory Distress Syndrome had resolved.

On February 4, 2003, Mr. Peckman's low grade fever continued. Dr. Saul concurred with Dr. Siegel's recommendation to wean Mr. Peckman from the respirator. Dr. Berland recommended how to decrease sedation, wean and extubate Mr. Peckman and recommended deep vein thrombosis and gastroenterological prophylaxis. Although Mr. Peckman was extubated that day, he could not sustain his breathing and he experienced mental problems and elevated blood pressure and so he had to be reintubated. He was seen by the Renal Department because of occasional high blood pressure.

On February 5, 2003, Dr. Berland saw Mr. Peckman and noted he was easily arousable. His impression was Influenza pneumonia and respiratory failure. He thought that it was unclear why reintubation was required. Dr. Brieff from Infectious Diseases

recommended that Mr. Peckman be tested for C. difficile toxins on account of the diarrhea which he had developed. That test as well as blood, urine and septum species all came back negative. A neurology consult recommended an MRI and MRV of Mr. Peckman's brain when he was stable enough. Mr. Peckman was experiencing delirium and was agitated and was given the anti-psychotics Ativan and Haldol.

Mr. Peckman was successfully extubated on February 6, 2003 and he remained easily arousable.

A full medical examination was done by a resident on February 7, 2003. While he was physically and neurologically stable, Mr. Peckman remained with a fever. Blood and urine cultures drawn on February 5, 2003 came back negative. A psychological consult was ordered.

On February 7, 2003, Drs. Berland and Saul found Mr. Peckman more alert, slow to respond, with a continued low grade fever and agitated. Additional cultures were ordered to further try to identify the temperature's source. Dr. Brieff of Infectious Diseases noted that Mr. Peckman's Acute Respiratory Distress Syndrome was improving but that further testing was required. A renal consult found him stable but in need of better blood pressure control.

On February 8, 2003, Mr. Peckman experienced significant temperature spikes and his clinical condition deteriorated. Dr. Berland recommended that the MRI and MRV of Mr. Peckman's brain be done, which came back normal, as well as other consults. Dr.

Brieff saw no role for antibiotics.

On February 9, 2003, Dr. Berland found Mr. Peckman febrile and still slow to respond. He questioned whether he was suffering from encephalopathy in addition to Influenza A. A renal consult found his blood pressure to be more under control. Dr. Brieff found Mr. Peckman's escalating fever to be puzzling because his white blood cell count was within normal range, atypical for a bacterial infection. A full spectrum of blood and urine tets and x-rays were ordered. Dr. Brieff saw no need for antibiotics but because of the genuine concern for a superinfection, Infectious Disease was to watch Mr. Peckman closely and use Vancomycin and Ceftazadin **if** needed. Dr. Brieff wanted him out of bed.

On February 10, 2003, Drs. Saul and Berland again found Mr. Peckman to be awake, febrile and slow to respond. Dr. Berland questioned the presence of a neurological inflammatory process and recommended an EEG and lumbar puncture. Dr. Bulbin of Infectious Disease found Mr. Peckman febrile which was difficult to explain in light of his stable respiratory status and unremarkable culture data. He questioned the presence of an underlying undeclared immunodeficiency syndrome, in light of the elevated white blood count. Like Dr. Brieff, Dr. Bulbin ordered the administration of the blockbuster antibiotics Vancomycin and Ceftazadin for any change in Mr. Peckman's clinical status. The medical attending and renal consult noted Mr. Peckman's slow mental state. An abdominal CAT scan and a repeat lumbar puncture were recommended due to Mr. Peckman's neurological status. Dr. Balin recommended that "nonessential medications" be discontinued to better

assess Mr. Peckman's mental status. That afternoon, Mr. Peckman was evaluated by physical therapy for possible acute rehabilitation. A swallowing evaluation revealed that Mr. Peckman was a significant candidate at risk for aspiration. Dr. Bulbin saw Mr. Peckman and wanted rheumatology to see him because his erythrocyte sedimentation rate was elevated. From 5:00 p.m. to 8:00 p.m., Mr. Peckman's heart rate ranged from 140 to 144 and his respiratory rate ranged from 27 to 34. While a lumbar puncture was performed at 8:45 p.m. and Lopressor was given, neither Vancomycin nor Ceftazidin were ever given. At 11:00 p.m., a nurse's note indicates that Mr. Peckman was very lethargic and unable to follow simple commands, febrile and tachycardic at 140 beats per minute. At 11:15 p.m. while a cooling blanket was being applied, the nurses observed Mr. Peckman foaming at the mouth, becoming cyanotic and without respirations. The Medical Intensive Care Unit attending, Defendant, Dr. Dana Lustbader, responded. Mr. Peckman was intubated and cardiac life support measures were employed, but after 30 minutes, Mr. Peckman's heart rhythm could not be restored. An autopsy was refused. The death certificate identifies the cause of death as cardiopulmonary arrest due to bilateral pneumonia.

"To establish a prima facie case of liability in a medical malpractice action, a plaintiff must prove (1) the standard of care in the locality where the treatment occurred, (2) that the defendant breached that standard of care, and (3) that the breach of the standard was the proximate cause of injury (quotations omitted)." *Sampson v Contillo*, 55 A.D.3d 588, (2nd Dept. 2008), citing *Nichols v Stamer*, 49 A.D.3d 832 (2nd Dept. 2008), quoting *Berger v*

Becker, 272 A.D.2d 565, 565 (2nd Dept. 2000). "In a medical malpractice action, the party moving for summary judgment must make a *prima facie* showing of entitlement to judgment as a matter of law by showing the absence of a triable issue of fact as to whether the defendant physician [and/or hospital were] negligent." *Taylor v Nyack Hospital*, 18 A.D.3d 537 (2d Dept. 2005) citing *Alvarez v Prospect Hosp., supra.* Thus, a moving defendant doctor and/or hospital has " 'the initial burden of establishing the absence of any departure from good and accepted medical malpractice or that the plaintiff was not injured thereby.'" *Chance v Felder*, 33 A.D.3d 645 (2nd Dept. 2006) quoting *Williams v Sahay*, 12 A.D.3d 366, 368 (2d Dept. 2004), citing *Alvarez v Prospect Hosp., supra; Johnson v Queens-Long Island Medical Group, P.C.*, 23 A.D.3d 525, 526 (2nd Dept. 2005); *Taylor v Nyack Hospital, supra; see also, Thompson v Orner*, 36 A.D.3d 791 (2nd Dept. 2007).

A moving defendant must address the specific factual allegations set forth in the complaint and the Bill of Particulars. *Terranova v Finklea*, 45 A.D.3d 572 (2nd Dept. 2007); *Hutchinson v Berenstein*, 22 A.D.3d 527 (2nd Dept. 2005); citing *Seefeldt v Johnson*, 13 A.D.3d 1203 (4th Dept. 2004); *Vincini v Insel*, 1 A.D.3d 351(2nd Dept. 2003); *Muscatello v City of New York*, 215 A.D.2d 463 (2nd Dept. 1995); *Ritt v Lenox Hill Hosp.*, 182 A.D.2d 560 (1st Dept. 1992]). "[B]are allegations which do not refute the specific factual allegations of medical malpractice in the bill of particulars are insufficient to establish entitlement to judgment as a matter of law." *Grant v Hudson Valley Hosp. Center*, 55 A.D.3d 874 (2nd Dept. 2008), citing *Berkey v Emma*, 291 A.D.2d 517, 518 (2nd Dept. 2002); *Drago v King*, 283

A.D.2d 603, 604 (2nd Dept. 2001); *Terranova v Finklea, supra; Kuri v Bhattachorya*, 44 A.D.3d 718 (2nd Dept. 2007). And, an expert may not make conclusions which are based on facts not in evidence or are directly contradicted by the evidence. *See, Holbrook v United Hosp. Medical Center*, 248 A.D.2d 358 (2nd Dept. 1998); *see also, Kaplan v Hamilton Medical Associates, P.C.*, 262 AD2d 609, 610 (2nd Dept. 1999).

If the moving party meets his burden, in opposition, "a plaintiff must submit a physician's affidavit of merit attesting to a departure from accepted practice and containing the attesting doctor's opinion that the defendant's omissions or departures were a competent producing cause of the injury." *Domaradzki v Glen Cove Ob/Gyn Assocs.*, 242 A.D.2d 282 (2d Dept. 1997) *citing Cerkvenik v County of Westchester*, 200 A.D.2d 703 (2nd Dept. 1994); *Caggiano v Ross*, 130 A.D.2d 538 (2nd Dept. 1987); *Amsler v Verrilli*, 119 A.D.2d 786 (2nd Dept. 1986); *see also, Mosezhnik v Berenstein*, 33 A.D.3d 895 (2d Dept. 2006). "To establish proximate cause, the plaintiff must present 'sufficient evidence from which a reasonable person might conclude that it was more probable than not that' the defendant's deviation was a substantial factor in causing the injury." *Alice v Liguori*, 54 A.D.3d 784 (2nd Dept. 2008), *quoting Johnson v Jamaica Hosp. Med. Ctr.*, 21 A.D.3d 881, 883 (2nd Dept. 2005) and *citing Holton v Sprain Brook Manor Nursing Home*, 253 A.D.2d 852 (2nd Dept. 1998); *see also, Zak v Brookhaven Memorial Hosp. Medical Center*, 54 A.D.3d 852 (2nd Dept. 2008), *citing Lyons v McCauley*, 252 A.D.2d 516 (2nd Dept. 1998), *lv den.* 92 N.Y.2d 814 (1998). " 'The plaintiff's evidence may be deemed legally sufficient even if his expert

cannot quantify the extent to which the defendant's act or omission decreased the plaintiff's chance of a better outcome or increased [the] injury, 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 his injury.' " *Alicea v Liguori, supra*, at p. 464-465, quoting *Flaherty v Fromberg*, 46 A.D.3d 743 (2nd Dept. 2007) and *citing Barbuto v Winthrop University Hosp.*, 305 A.D.2d 623, 624 (2nd Dept. 2003); *Wong v Tang*, 2 A.D.3d 840 (2nd Dept. 2003); *Jump v Facelle*, 275 A.D.2d 346 (2nd Dept. 2000), lv den., 98 N.Y.2d 612 (2002).

In support of their motion, the moving Defendants have submitted the affirmation of David Mark Nierman, a Diplomate of the American Board of Internal Medicine with subspecialty certifications in Pulmonary Disease and Critical Care Medicine. Having reviewed the records regarding the medical care and treatment, the moving Defendants provided Mr. Peckman as well as Mr. Peckman's other medical records which pre-date the case at issue in this case, the pleadings, the Bills of Particulars and deposition testimony of the Plaintiff and the physician Defendants, he opines to a reasonable degree of medical certainty that the medical care and treatment provided to Mr. Peckman by the moving Defendants was appropriate and consistent with good and accepted standards of medical care. Dr. Nierman opines that upon Mr. Peckman's admission to North Shore University Hospital with acute viral illness and possible early pneumonia, his attending doctors, Drs. Brenner and Saul, correctly promptly called for consults by specialists including

neurology, infectious disease and pulmonology and thereafter saw Mr. Peckman "virtually daily" and worked with those specialists and relied on them in formulating Mr. Peckman's treatment plan. It is also Dr. Nierman's opinion that the pulmonary-critical care consultants who were called in to address Mr. Peckman's pulmonary issues, including lung infiltrates, pneumonia, hypoxia, respiratory failure and Acute Respiratory Distress Syndrome, Drs. Siegel and Berland's recommendations were at all times appropriate and consistent with good and accepted standards of care.

Dr. Nierman opines that "all of the care rendered" by the moving Defendants "demonstrated thoughtfulness and willingness . . . to interact and explore virtually every potential diagnosis and underlying etiology for [Mr. Peckman's] condition utilizing all medical means and diagnostic modalities available." Thus, he notes that Mr. Peckman was intensively worked up. As for the non-moving infectious disease doctors, Drs. Bulbin and Brieff, Dr. Nierman saw nothing that suggests that their recommendations were incorrect or should not have been followed. He saw nothing wrong with the timing of the administration of Tamiflu or the adequacy of its course or the decision to discontinue antibiotics when all bacterial cultures proved negative and remained negative, particularly in view of the possible side effects of unnecessary antibiotics like the development of C. difficile bowel infection or some other super infection. Dr. Nierman also found that the Defendants' failure to reinstate antibiotics when Mr. Peckman became feverish was appropriate. He does not specifically address Drs. Brieff and Bulbin's prescription of Vancomycin and Ceftazadin, if

needed or the Defendants' failure to give it. He opines that the administration of the intravenous steroid, Solumedrol, was appropriate in view of the possible diagnosis of pneumocystitis carinii pneumonia and opines that its discontinuance on January 30, 2003 establishes that it played no part in Mr. Peckman's demise which did not occur until ten days later. Dr. Nierman opines that Dr. Siegel fully and properly assessed Mr. Peckman on January 25, 2003, ruled out a pulmonary embolus and intubated and transferred him to the Medical Intensive Care Unit where his Acute Respiratory Distress Syndrome was effectively and properly managed. He believes that Dr. Siegel properly considered all the possible etiologies of Mr. Peckman's illness and properly medicated him for all contingencies. Dr. Nierman opines that "Drs. Siegel and Berland, as pulmonologists, continued to render appropriate care to Mr. Peckman throughout his presence in the Medical Intensive Care Unit." He opines that Dr. Hussain and the entire Medical Intensive Care Unit's "day to day management was entirely appropriate and consistently met the standards of care for critical care physicians managing patients in the Intensive Care Unit." Dr. Nierman opines that Dr. Hussain and the Medical Intensive Care Unit properly interacted with the specialists and allowed them to chart Mr. Peckman's course. As for Dr. Lustbader, Dr. Nierman notes that her only involvement with Mr. Peckman occurred at 11:15 p.m. on February 10, 2003 in response to his sudden decompensation and cardiopulmonary arrest and he opines that she did nothing that could be considered substandard care. In conclusion, Dr. Nierman opines that Mr. Peckman's proven viral and likely bacterial pneumonia (bilateral) was properly

managed and addressed by the moving Defendants during the course of the subject care and treatment. As for proximate cause, he opines that he can "identify no action that was taken, or which these defendants allegedly failed to take, that can in any way be considered to be causes or contributing factor to Mr. Peckman's sudden demise." In his opinion, "absent an autopsy [there is] no way that the cause of Mr. Peckman's death can be established with any degree of certainty."

With the exception of Dr. Lustbarder, the Defendants have not met their burden. The expert's affirmation is unacceptably conclusory. *See, Hutchinson v Bernstein*, 22 A.D.3d 527 (2nd Dept. 2005); *Nwabude v Sisters of Charity Health Care Sys. Corp.*, 309 A.D.2d 909, 910 (2nd Dept. 2003). More importantly, Dr. Nierman fails to specifically address a key allegation in the Plaintiffs' Bill of Particulars, to wit, the effect that the timing of the administration of antibiotics and Tamiflu had on the moving Defendants' ability to identify, diagnose and treat Mr. Peckman's condition. That is, antibiotics were administered both orally and intravenously before blood or other cultures were drawn, thereby possibly skewing the results of the tests conducted to determine whether Mr. Peckman's infection was viral or bacterial. Furthermore, Dr. Nierman has not addressed the fact that Tamiflu, which must be given ASAP for optimal effectiveness, was withheld for several days early in Mr. Peckman's treatment. Nor has he addressed the Defendants' failure to give Vancomycin or Ceftazadin. *See, Terranova v Finklea, supra; Kuri v Bhattacharya, supra.* As for Dr. Nierman's conclusion that the cause of death cannot be determined because there was no

autopsy and so there is no evidence that the Defendants' acts or omissions caused Mr. Peckman's death, that is contradicted by the death certificate as well as Dr. Brenner's testimony, at his examination before trial, that Influenza A was probably a contributing cause of his death and Dr. Hussain's testimony, at his examination before trial, that the pneumonia had progressed to Acute Respiratory Distress Syndrome and contributed to his death as well.

The Plaintiff has failed to meet her burden of establishing the existence of a material issue of fact with respect to Dr. Lustbader. The Plaintiff's expert's "affirmation" is from a Connecticut doctor, which is not permitted (CPLR 2106). Furthermore, his allegation that he is "familiar with the standards of accepted medical practice pertaining to internal medicine and pulmonary/critical care in New York" is devoid of facts supporting that representation and, more importantly, he limits his knowledge to standards "as they existed in **2004**" and the care and treatment in question here as well as Mr. Peckman's demise occurred in **2003**.

The Defendants' motion is granted to the extent that the complaint against the Defendant, Dr. Lustbader, is **DISMISSED**.

This constitutes the decision and order of the Court.

DATED: Mineola, New York
July 30, 2009

Hon. Randy Sue Marber, J.S.C.