SHORT FORM ORDER

SUPREME COURT - STATE OF NEW YORK

Present:

HON. F. DANA WINSLOW,

Justice

TRIAL/IAS, PART 3

NASSAU COUNTY

GREG POPLARSKI, As Administrator of the Estate of ANNA POPLARSKI, Deceased, and EDWARD POPLARSKI, Individually,

Plaintiffs,

-against-

MOTION SEQ. NO.: 003, 004, 005

MOTION DATE: 4/5/12

WINTHROP UNIVERSITY HOSPITAL, JOHN ANTHONY GONCALVES, JR., M.D., STEVEN WAYNE SEIDEN, M.D., SOUTH SHORE HEART ASSOCIATES, P.C., NEW ISLAND HOSPITAL, WINTHROP CARDIOVASCULAR AND THORACIC SURGERY, P.C.,

INDEX NO.: 13711/09

Defendants.

The following papers having been read on the motion (numbered 1-8):

Notice of Motion Seq. No. 003.....1
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Notice of Cross Motion Seq. No. 005.....5
Affirmation in Opposition.....6
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These motions by the defendant New Island Hospital; Winthrop Cardiovascular and Thoracic Surgery, P.C., and John Anthony Goncalves, Jr., M.D.; and Winthrop University Hospital for an order pursuant to CPLR 3212 granting them summary judgment dismissing the complaint and any and all cross-claims against them are determined as provided herein.

The plaintiffs in this action seek to recover for medical malpractice and the wrongful death of Anna Poplarski. The plaintiffs also seek to recover for lack of informed consent, negligent hiring from both of the defendant hospitals and loss of services o/b/o plaintiff Edward Poplarski.

The defendants New Island Hospital, Winthrop Cardiovascular and Thoracic Surgery, P.C., John Anthony Goncalves, Jr., M.D., and Winthrop University Hospital seek summary judgment dismissing the complaint and any and all cross-claims against them.

"On a motion for summary judgment the facts must be viewed 'in the light most favorable to the non-moving party.' " Vega v Restani Constr. Corp., 18 NY3d 499 (2012), quoting Ortiz v Varsity Holdings, LLC, 18 NY3d 335, 339 (2011). Summary judgment is a drastic remedy, to be granted only where the moving party has " 'tender[ed] sufficient evidence to demonstrate the absence of any material issues of fact' . . . and then only if, upon the moving party's meeting of this burden, the non-moving party fails 'to establish the existence of material issues of fact which require a trial of the action.' " Vega v Restani Constr. Corp., supra, quoting Alarez v Prospect Hosp., supra, at p. 324. "The moving party's '[f]ailure to make [a] prima facie showing [of entitlement to summary judgment] requires a denial of the motion, regardless of the sufficiency of the opposing papers.' " Vega v Restani Constr. Corp., supra, quoting Alarez v Prospect Hosp., supra, at p. 324.

"[T]o succeed on an action to recover damages for wrongful death, the plaintiff must prove the following elements: (1) the death of a human being born alive; (2) a wrongful act, neglect or default of the defendant by which the decedent's death was caused, provided the defendant would have been liable to the deceased had death not ensued; (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." Slobin v Boasiako, 19 Misc 3d 1110(A) (Supreme Court Nassau County 2008), citing Chong v New York City Transit Authority, 83 AD2d 546 (2nd Dept 1981).

"The essential elements of medical malpractice are (1) a deviation or departure from accepted medical practice, and (2) evidence that such departure was a proximate cause of injury (quotations omitted)." Faicco v Golub, 91 AD3d 817 [2nd Dept 2012]; see also, Roca v Perel, 51 AD3d 757, 758 (2nd Dept 2008), quoting DiMitri v Monsouri, 302 AD2d 420, 421 (2nd Dept 2008); Flaherty v Fromberg, 46 AD3d 743, 745)2nd Dept 2007). "Thus, [o]n a motion for summary judgment dismissing the complaint in a medical malpractice action, the defendant doctor has the initial burden of establishing the absence of any departure from good and accepted medical practice or that the plaintiff was not injured thereby (quotations omitted)." Faicco v Golub, supra, at p. 817; see also, Roca v Perel, supra, at p. 458-579; Chance v Felder, 33 AD3d 645 (2nd Dept 2006); Stukas v Streiter, 83 AD3d 18, 24 (2nd Dept 2011). "In order to sustain this burden, the defendant must address and rebut any specific allegations of malpractice set forth in the plaintiff's

bill of particulars (citations omitted)." Wall v Flushing Hosp. Med. Ctr., 78 AD3d 1043 (2nd Dept 2010).

"Once a defendant physician 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 . . . so as to demonstrate the existence of a triable issue of fact.' " Savage v Quinn, 91 AD3d 748, 749 (2nd Dept 2012), quoting Alvarez v Prospect Hosp., 68 NY2d 320, 324 (1986) and citing Stukas v Streiter, supra, at p. 24. "The formulation of the applicable standard makes it evident that the nonmoving party is required only to 'rebut' the moving party's prima facie showing." Stukas v Streiter, supra, at p. 24. Thus, "where a defendant physician . . . demonstrates only that she or he did not depart from the relevant standard of care, there is no requirement that the plaintiff address the element of proximate cause in addition to the element of departure." Stukas v Streiter, supra, at p. 25. "Of course, where a defendant physician makes a prima facie showing that there was no departure from good and accepted medical practice, as well as an independent showing that any departure that may have occurred was not a proximate cause of the plaintiff's inquiries, the burden shifts to the plaintiff to rebut the defendant's showing by raising a triable issue of fact as to both the departure element and the causation element (citations omitted)." Stukas v Streiter, supra, at p. 25.

Moreover, " '[i]n a medical malpractice action, where causation is often a difficult issue, a plaintiff need do no more than offer sufficient evidence from which a reasonable person might conclude that it was more probably than not' that the defendant's deviation was a substantial factor in causing the injury." Goldberg v Horowitz, 73 AD3d 691, 694 (2nd Dept 2010), quoting Johnson v Jamaica Hosp. Med. Ctr., 21 AD3d 883 (2nd Dept 2005) and citing Alicea v Ligouri, 54 AD3d 784 (2nd Dept 2008); Flaherty v Fromberg, supra, at p. 745; Bunea v Cahaly, 37 AD3d 389, 390-391 (2nd Dept 2007); Holton v Sprain Brook Manor Nursing Home, 253 AD2d 852 (2nd Dept 1998), lv den., 92 NY2d 818 (1999). "A plaintiff's evidence of proximate cause may be found legally sufficient even if his or her expert is unable to 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 [the] injury.' " Goldberg v Horowitz, supra, at p. 694.

A hospital cannot ordinarily be held vicariously liable for the malpractice of a private attending doctor. Sita v Long Island Jewish-Hillside Med. Ctr, 22 AD3d 743 (2nd Dept 2005). That is, "[w]hen supervised medical personnel are not exercising their independent medical judgment, they cannot be held liable for medical malpractice unless

the directions from the supervising superior or doctor so greatly deviates from normal medical practice that they should be held liable for failing to intervene." Bellafiore v Ricotta, 83 AD3d 632, 633 (2nd Dept 2011), citing Soto v Andaz, 8 AD3d 470 (2nd Dept 2004); Costello v Kirmani, 54 AD3d 656 (2nd Dept 2008); Crawford v Sorkin, 41 AD3d 278 (2nd Dept 2007).

The facts pertinent to the determination of these motions are as follows:

Anna Poplarski was brought by ambulance to New Island Hospital on December 3, 2007. When the ambulance crew arrived, Mrs. Poplarski was pale and lethargic. Her presenting problem was chest and neck pain. She reported a history of a dissecting aortic aneurysm. Saline was administered via IV and atropine was administered. Her color and blood pressure normalized. Aspirin and nitroglycerin were also administered. Upon arrival at the hospital at 2:25 PM, she complained of having collapsed and experiencing chest pain radiating down her neck and shortness of breath which began 30 minutes prior to her arrival. Her medical history included hypertension, hypercholesterolemia and descending distal thoracic aortic aneurysm. Her recent medical history included dizziness and transient loss of vision for several weeks. Her son observed that she had drooping of face and some slurred speech after she collapsed. Mrs. Poplarski was admitted to the emergency room at 2:19 PM. An intravenous line was placed and she was placed on oxygen and placed on a monitor. Her labs were essentially normal including cardiac enzymes. An echocardiagram was performed at 2:30 PM which indicated a normal sinus rhythm, anteroseptal infarct, age undetermined, and abnormal EKG, unconfirmed. Pursuant to the direction of the emergency room attending physician Dr. Buri, 300 mg. of Plavix was administered at 2:40 PM, as well as one gram of Tylenol. At his examination-before-trial, Dr. Buri testified that Mrs. Poplarski's history of an aortic aneurysm did not dictate against administering Plavix because Mrs. Poplarski "presented like she was having an acute event consistent with acute coronary syndrome" or "unstable angina." A chest x-ray was performed at 2:44 PM which revealed a tortuous aorta and cardiomegaly. A CPK obtained at 2:45 PM was within normal range. Dr. Buri testified at his examination-before-trial that he was not happy with the chest x-ray and at that point he felt that Mrs. Poplarski might have had an aneurysm but did not know whether it was ruptured or dissected so he ordered a CAT scan, stat. After fluids were administered, her blood pressure was improved at 3:30 PM. Additional echocardiograms were performed at 2:48 PM and 3:30 PM. Those EKGs indicated normal sinus rhythm, anterior infarct, age undetermined, abnormal EKG, unconfirmed. Dr. Friedman's report of the third EKG indicates "sinus rhythm, old anteroseptal MI, age-indeterminate, non-specific St-T wave abnormalities." Dilandid and Phenegan were given at 3:40 PM.

Despite the "stat" order, Ms. Poplarski was not sent for the CT scan until 3:45 PM. It was performed at 3:56 PM. The results thereof became available at 4:11 PM and revealed a Type I thoracic and abdominal aortic dissection which originated in the ascending thoracic aorta to the descending aorta and extended through the renal arteries. A request for transfer to Winthrop University Hospital was immediately made. Her blood pressure was elevated at 4:00 PM and remained elevated at 4:15 PM and 4:30 PM at which time she was still in pain. While Intravenous Lopressor was ordered at 4:45 PM, it is not clear when the two doses were administered. There is a reference to Lopressor on the Vital Signs Flow Sheet at 4:30 PM and an IV push dose being given at 4:50 PM on the transfer form. She was discharged for transfer to Winthrop University Hospital at 5:00 PM.

Mrs. Poplarski's daughter, Ms. Petry, testified at her examination-before-trial that when she arrived at New Island Hospital, she found that the staff was attentive to her mother's blood pressure because they thought she had had a heart attack. She testified that she complained to hospital staff that they were treating her mother for the wrong thing and that her mother needed an immediate scan because she was having another dissection.

Mrs. Poplarski arrived at Winthrop University Hospital at 5:37 PM. She was admitted to the cardiothoracic intensive care unit at 5:41 PM, to the service of Dr. Goncalves, the attending cardiothorasic surgeon and an employee of the hospital. All decisions regarding Mrs. Poplarski's care thereafter were made by Dr. Goncalves. Her blood pressure was elevated. It was 192/83 at 5:37 PM and 200/110 when Dr. Goncalves saw her but she was alert, oriented and her speech was normal. Cardene was begun to control her blood pressure. She complained of chest and upper back pain. Upon examining Mrs. Poplarski, another hospital employee, P.A. Huggler, noted an absent right cartoid pulse. Dr. Goncalves evaluated her and learned that she had a long standing but nevertheless stable chronic dissection of her descending aorta, as well as hypertension and a recent history of transient visual blurriness and confusion. At Dr. Goncalves' first examination of Mrs. Poplarski, she denied substernal chest pressure, back pain, nausea, vomiting, diaphonesis, palpitations and shortness of breath. She was grossly intact neurologically without focal motor deficits. Dr. Goncalves wrote: "[w]ith aggressive blood pressure control, her pain has now subsided. She is resting comfortably and is in absolutely no distress. I therefore believe it is safer to proceed with surgery first thing tomorrow morning." He also wrote:

> "[p]atient is a very pleasant 77-year old female with a prior history of hypertension and Type B dissection. She now presents with a

> Type A component. This either represents retrograde dissection of her former dissection planes versus a new tear within the ascending aorta. I believe the process began in the patient approximately 1-1/2 weeks ago when she began having neurologic symptoms. Interestingly, her antihypertensives were lowered at that time, and therefore, her blood pressure has been higher than usual I am sure over the intervening time period.

Regarding the CT scan, he wrote "[t]he aortic arch on CAT scan shows multiple dissection planes and has the suggestion of chronicity."

Mrs. Poplarski's family members testified that Dr. Goncalves was concerned about the Plavix having been given. In fact, at this examination-before-trial, Dr. Goncalves testified: "[t]he fact that she was loaded with Plavix which, um, you could argue whether that should have been done or not, but she was so I had to deal with it. In the setting of a dissection, that placed her at very high risk for bleeding to death. . . . Typically when someone received Plavix we don't operate for five to seven days." His exam revealed an absent right carotid pulse and a discrepancy between the pulses in the upper extremities which, he believed coupled with his review of the New Island Hospital CT scan, suggested that Mrs. Poplarski was now also suffering from a chronic (more than two week process) dissection of the ascending aorta. Her ascending aorta was marked by numerous dissection planes which Dr. Goncalves thought was indicative of a chronic process and an unfortunate indicator of a poor prognosis. Her presentation was complicated by her earlier neurological state which was indicative of an evolving stroke, during which bypass surgery is contraindicated. Dr. Goncalves deferred surgery until the following morning because he believed that the safer course of treatment was monitoring and stabilizing Mrs. Poplarski before proceeding with a high risk procedure with a poor prognosis. In fact, Dr. Goncalves testified that this was a subacute situation, not an acute one which would have required immediate action.

Mrs. Poplarski's family members testified at their examinations-before-trial that Dr. Goncalves said he wanted to operate in the morning with a "fresh crew." They also testified that there were phone calls to Dr. Goncalves from his wife and daughter indicating that there was a personal problem at home. Dr. Goncalves denied ever saying he wanted a "fresh crew" and he denied that his family's situation entered into his decision on when to operate.

Pre-surgically Dr. Goncalves noted an intraoperative mortality rate of 30% and had concerns about the ability to perfuse Mrs. Poplarski during surgery to prevent hypoxia.

The risk of complications and death were high. Mrs. Poplarski's hospital chart indicates that her neurological state declined overnight. Her chart reads:

- "Cardene off to increase systolic blood pressure after Pt noted to have facial droop and unable to move L upper extremity."

At 4 AM, Dr. Goncalves' own progress note indicates:

- "Dynamic neurologic changes. Improved with increased systolic blood pressure. Facial droop almost gone."

At 6 AM, a nurse's note indicates:

- "Pt continues to move about aimlessly – restless & agitated; C/O back pain . .

The surgery was undertaken at 8:40 AM on December 4th by Dr. Goncalves with William Kokotus, M.D., Frank Rizutto, RPA-C and Steven Alper, RPAC. assisting. The surgery lasted seven hours. A re-suspension of the aortic valve, replacement of the ascending aorta, de-branching of the aortic arch, total aortic arch replacement, and "elephant trunk" procedure were performed. Dr. Goncalves was unable to re-establish blood flow to Mrs. Poplarski's brain due to the obliteration of her aortic arch. Dr. Goncalves' post-operative diagnosis reads "chronic Type B aortic dissection, acute and chronic dissection of the aortic arch, ascending aortic dissection with mild mitral regurgitation. While Mrs. Poplarski survived the surgery, she never regained consciousness. Mrs. Poplarski deteriorated overnight. A head CT scan indicates that she sustained a large right cerebral hemispheric infarction with mass effect and herniation. She died on December 8, 2007.

The plaintiffs maintain that the defendant Dr. Goncalves departed by delaying in diagnosing and appropriately treating Mrs. Poplarski. Additionally departed from accepted practice Dr. Goncalves and Winthrop University Hospital departed in not performing surgery. The plaintiffs also allege that both of the defendant hospitals were negligent in their hiring and supervision of their employees.

In support of its motion, the New Island Hospital has submitted the affirmation of Dr. Gregory Mazarin who opined that the care New Island Hospital provided to Mrs. Poplarski was at all times within the confines of good and accepted medical practice and did not proximately cause her injuries or death. He opines that she was properly evaluated

upon arrival. He opines that Plavix was properly administered despite the fact that it may increase the risks of bleeding associated with open heart surgery. Dr. Mazarin notes that the possibility of dissection was considered. He explains that although contrast is needed for this exam, the results of serum creatine must be obtained first and so completing the CT within one and one-half hours of Mrs. Poplarski's arrival was "extremely fast." He notes that she was properly diagnosed and transferred within two and one-half hours of her presentation which was "extremely impressive." He comments that the transfer was best made as soon as possible as opposed to keeping her at New Island Hospital to control her blood pressure. In conclusion he opines "the care provided to the plaintiff exceeded the expected standard." He states "aortic dissection is a condition with a very high morbidity and mortality [and that] [a]lthough Anna Poplarski subsequently expired, this does not in any way evidence that her care was managed inappropriately."

The defendant New Island has established its entitlement to summary judgment thereby shifting the burden to the plaintiffs of establishing a material issue of fact.

The Court finds that Winthrop University Hospital's motion is not untimely in view of its similarly to defendant Dr. Goncalves' timely motion. See, Alexander v Gordon, 95 AD3d 1245 (2nd Dept 2012), citing Grande v Peteroy, 39 AD3d 590, 591-592 (2nd Dept 2007). Denominating it as a cross-motion, while erroneous, is no more than a technical defect. Daramboukas v Samlidis, 84 AD3d 719, 721 (2nd Dept 2011).

The defendants Dr. Goncalves and his employer Winthrop Cardiovascular and Thoracic Surgery, P.C. have submitted an affidavit by Dr. Goncalves in support of their motion. Based on the CT scan, he opines that the ascending aorta was of a chronic nature and had been there for several weeks or as long as a month before her collapse. He notes that on examination a right carotid pulse was absent and there was a clear discrepancy between the pulses in the right and left upper extremities which findings are poor indicators for survival in dissection patients. He further notes that facial drooping and slurred speech had been reported earlier in the day, suggesting an evolving stroke. He opines that "bypass surgery while a patient is having a stroke in evolution is contraindicated: it is not survivable." He states that Mrs. Polarski presented with a chronic Type A aortic dissection with clear signs of neurologic involvement. Accordingly, the proposed surgery was technically very challenging and the risks were compounded by the number of dissection planes and the necessity to cannulate the femoral vessels. He represents that it was impossible to cannulate the axillary artery due to malperfusion from the aortic arch which raised significant concerns regarding the ability to perfuse Mrs. Poplarski while on bypass. He believed that neurologic impairment was a very high risk utilizing this procedure.

Dr. Goncalves opines that many surgeons would not have performed the surgery under the circumstances due to the risk of intra-operative mortality and post-operative morbidity. However, he concluded that surgery was Mrs. Poplarski's only hope. However, he opined that immediate surgery was not only not mandated, but was contraindicated because it was safer to stabilize Mrs. Poplarski's blood pressure and monitor her neurological status to insure that she had no fixed deficits. He noted that she was managed and monitored overnight and that he evaluated her at 4:00 AM and concluded that her neurologic status did not preclude the planned surgery. He stated that the surgery went as well as it could in the presence of the intra-operative confirmation that Mrs. Poplarski's total arch needed to be replaced and extensive vessel damage was encountered with the feared perfusion complications occurring. He opined that Mrs. Poplarski's prognosis was not altered by the delay in surgery nor was the delay a cause of the outcome.

The defendants Dr. Goncalves and Winthrop Cardiovascular and Thoracic Surgery, P.C., have thus established their entitlement to summary judgment thereby shifting the burden to the plaintiff to establish the existence of a material issue of fact.

In support of its motion, the defendant Winthrop University Hospital has submitted the affirmation of Charles M. Geller, M.D. a Board Certified Thoracic Surgeon. Having reviewed the pertinent medical records and legal documents, he opined to a reasonable degree of medical certainty, that the medical staff of the hospital properly carried out Dr. Goncalves' orders in monitoring and caring for Mrs. Poplarski, in particular her vital signs including her blood pressure prior to, during and subsequent to the surgery. He further opined that Dr. Goncalves' care and treatment of Mrs. Poplarski was medically appropriate, therefore the hospital's staff did not err in following his orders. He opines that Mrs. Poplarski died due to multi-organ system failure as a result of malperfusion syndrome secondary to her aortic pathology and through no fault of Dr. Goncalves or the Winthrop University Hospital staff.

Therefore, Winthrop University Hospital has also established its entitlement to summary judgment thereby shifting the burden to the plaintiff to establish the existence of a material issue of fact.

In opposition, the plaintiffs have submitted the affirmation of a Board Certified surgeon who was Chief of Thoracic Surgery at a metropolitan New York hospital and for years has evaluated patients in the emergency room who presented with signs and symptoms of aortic dissection. Having reviewed all of the pertinent medical records, legal documents and the moving papers, s/he opined to a reasonable degree of medical certainty, that New Island Hospital departed from good and accepted medical

practice by failing to adequately control Mrs. Poplarski's blood pressure during the time she was treated and evaluated there and that that failure which was manifested by significantly hypertensive values during the last hour of stay resulting in an exacerbation of her aortic dissection. S/he also opines that Winthrop University Hospital also departed from good and accepted medical practice by failing to timely and properly operate to repair Mrs. Poplarski's Type A aortic dissection. S/he assert that "the standard of care required immediate surgical repair on December 3, 2007 [and that] during the delay between December 3 and 4, Mrs. Poplarski developed neurological changes and became hemo- dynamically unstable." S/he believes that "[d]elaying operative repair of the dissection reduced the probability of recovery and was a substantial contributing factor to Mrs. Poplarski's neurological decompensation, which eventually caused her death on December 8, 2007."

The plaintiffs' expert explains that Type A aortic dissection which involves a tear in the ascending aorta and aortic arch is more common and dangerous and necessitates immediate surgery whereas Type B aortic dissection involves a tear in the descending aorta and does not. He explains that when dealing with an aortic dissection, a patient's blood pressure is very important because significant hypertension causes additional damage to a compromised aorta. In that regard, he tracks Mrs. Poplarski's blood pressure measurements while at New Island Hospital and takes particular note that her blood pressure went from 196/71 at 4:00 PM to 168/98 at 4:15 PM to 188/68 in her left arm and 177/96 in her right arm at 4:30 PM but Lopressor was not ordered until 4:45 PM and its administration is not documented in the Vital Signs Flow Sheet. He notes that at 4:55 PM, Mrs. Poplarski's blood pressure was 196/71. The plaintiffs' expert states that New Island Hospital's failure to control and treat Mrs. Poplarski's severe hypertension was a departure from good and accepted medical practice. S/he opines that Lopressor was called for at 4:00 PM with the alarmingly elevated reading and notes that antihypertensives can decrease the heart's work which is essential when a heart and circulatory system are being compromised by aortic dissection. His/her opinion is that the prolonged elevated blood pressure caused additional damage to Mrs. Poplarski's aorta.

The plaintiffs' expert also opines that Dr. Goncalves' post-operative diagnosis confirms that there was in fact a significant acute component, namely, the injury to the aortic arch, indicating the need for prompt surgical repair. More importantly, s/he notes that the CT scan done at New Island Hospital revealed damage to the ascending aorta thereby indicating the need for immediate surgical repair. S/he also notes that Mrs. Poplarski's chest, back and neck pain on December 3rd were indicative that an acute event was being superimposed on a chronic condition. S/he determined that Mrs. Poplarski's

complaints in conjunction with the radiological findings indicated that an acute component was present necessitating immediate surgery. As for her neurological state, the plaintiffs' expert notes that the Adult Triage form assessment sheet at Winthrop University Hospital noted her to be alert and oriented times three and she was a source of her medical history. Dr. Goncalves original examination found her okay, too. Thus, s/he opines that immediate surgery was appropriate and that a twelve hour delay was outside the standard of care. S/he notes that Dr. Goncalves performed surgery on another patient that morning at 5:00 AM before Mrs. Poplarski and opines that given Winthrop's status, no patient should have trumped Mrs. Poplarski's status in terms of need: Her case was no less emergent than the patient on whom Dr. Goncalves operated first. The Court notes that this determination was convincing conjecture, unable to support the plaintiff's claim.

As for causation, the plaintiffs' expert opines that "during the aforesaid delay in operating, Mrs. Poplarski sustained neurological deterioration, and, therefore, the failure to operate in a timely fashion was a substantial contributing factor to Mrs. Poplarski's neurological injuries and death." S/he notes that there were significant neurological changes during the overnight period which were not present when Mrs. Poplarski was initially assessed by Dr. Goncalves, which is evidence of the need and opportunity to have operated immediately. S/he opines that Mrs. Poplarski's complex injury continued to evolve and exacerbate over the course of the 12 hour delay to the point that disintegration of the aorta was noted intraoperatively as suturing efforts were undertaken. S/he notes that Dr. Goncalves' post-operative report notes "fresh" acute injuries which needed to be treated right away and that the delay was a substantial contributing factor in effecting Mrs. Poplarski's post-surgical neurological status as well as her multi-system organ failure, and the foregoing resulted in malperfusion which was caused by the "devastating dissection".

The plaintiff's expert, have established the existence of a material issue of fact necessitating the denial of the defendants' motions.

While the New Island Hospital's expert opines that Mrs. Poplarski's transfer was more important than controlling her blood pressure, the plaintiff's expert opines that in any event, timely and adequate efforts to control her blood pressure and diagnose her were absent with pronounced negative consequences. Issues of fact exist as to New Island Hospital's negligence.

While Dr. Goncalves's expert opines that stabilizing Mrs. Poplarski took precedence over the surgery and that surgery was contraindicated by signs of an evolving stroke and so its delay until the morning hours was appropriate, the plaintiffs' expert disagrees and opines that her condition not only necessitated immediate surgery but that surgery was in fact possible and appropriate upon her arrival at Winthrop University

Hospital. The delay until the morning had dire consequences. Finally, since defendant Dr. Goncalves remains a defendant, Winthrop University Hospital also remains vicariously liable.

The parties have not addressed the other causes of this action, which consequently remain in tact.

The Court was impressed with the submissions of the parties and recognizes that the plaintiff's diagnosis and treatment required diverse concerns and considerations regarding an appropriate course of action of a patient presenting with such difficult signs and symptoms, but finds that a jury must be presented with the determination of the existent standard(s) and the departure(s) therefrom, if any and the effects thereafter of those actions on plaintiff if present, thus

Summary judgment is **denied**.

This constitutes the Order of the Court.

Dated: June 22, 2012

J.S.C.

ENTERED
JUL 17 2012
NASSAU COUNTY
COUNTY CLERK'S OFFICE