Lavia v Brooklyn Hosp. Ctr.
2023 NY Slip Op 34370(U)
December 11, 2023
Supreme Court, Kings County
Docket Number: Index No. 504323/2019
Judge: Consuelo Mallafre Melendez

At an IAS Term, Part 15 of the Supreme Court of the State of NY, held in and for the County of Kings, at the Courthouse, at 360 Adams Street, Brooklyn, New York, on the 11th day of December 2023.

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF KINGS

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ANJOURN AMUNIKE LAVIA, as Administrator of the Estate of ANNETTE BOBB,

Plaintiff,

-against-

THE BROOKLYN HOSPITAL CENTER, AMY HSIU-WEI YEH, D.O., AKIYOMI O. FIELDS, M.D., JOSHUA ROSENBERG, M.D., and ERWIN LEREBOURS, M.D.,

Defendants.

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DECISION & ORDER

Index No. 504323/2019
Mo. Seq. 4 & 5

HON. CONSUELO MALLAFRE MELENDEZ, J.S.C.

Recitation, as required by CPLR §2219 [a], of the papers considered in the review:

NYSCEF #s: Seq 4: 111 – 113, 114 – 131, 152, 153 – 154, 159
Seq. 5: 132 – 134, 135 – 149, 155, 156 – 157, 158

Defendants The Brooklyn Hospital Center (hereinafter "TBHC"), Amy Hsiu-Wei Yeh, D.O., Akiyomi O. Fields, M.D., and Joshua Rosenberg M.D. (hereinafter collectively "Hospital Defendants") move pursuant to CPLR § 3212 for summary judgment on all claims (Sequence 4). Defendant Erwin Lerebours, M.D., moves pursuant to CPLR § 3212 for summary judgment on all claims. Plaintiff opposes Defendant's motion (Sequence 5). Plaintiff Anjourn Amunike Lavia, as Administrator of the Estate of Annette Bobb (hereinafter "Plaintiff") opposes Defendants' motion.

Plaintiff alleges that Defendants failed to adequately prevent the development of a venous thromboembolism, failed to timely diagnose a pulmonary embolism, and failed to properly treat Decedent's pulmonary embolism in June of 2018 when Decedent was at approximately 8 weeks gestation, leading to Decedent's death.

Defendant Joshua Rosenberg, M.D., established his prima facie showing for summary judgment; Plaintiff does not oppose this branch of the motion. Therefore, the branch of the motion

for summary judgment as to Dr. Rosenberg is granted. *144 Woodbury Realty, LLC v. 10 Bethpage Rd., LLC*, 178 A.D.3d 757, 761-62 [2nd Dept 2019].

In evaluating a summary judgment motion in a medical malpractice case, the Court applies the burden shifting process set forth by the Appellate Division:

> "The elements of a medical malpractice cause of action are a deviation or departure from accepted community standards of practice, and that such departure was a proximate cause of the plaintiff's injuries. When moving for summary judgment, a defendant provider has the burden of establishing the absence of any departure from good and accepted medical practice or that the plaintiff was not injured thereby. 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. In opposition, the plaintiff must demonstrate the existence of a triable issue of fact as to the elements on which the defendant has met his or her initial burden. General allegations of medical malpractice, merely conclusory and unsupported by competent evidence tending to establish the essential elements of medical malpractice, are insufficient to defeat [a] defendant['s]… summary judgment motion. Although summary judgment is not appropriate in a medical malpractice action where the parties adduce conflicting medical expert opinions, 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." *Barnaman v Bishop Hucles Episcopal Nursing Home*, 213 AD3d 896, 898-899 [2d Dept 2023] [internal citations, brackets, and quotation marks omitted].

Decedent presented to the ED at TBHC on June 12, 2018, at approximately 8 weeks gestation with nausea and vomiting, and was diagnosed with hyperemesis gravidarum. Decedent was administered IV fluids and symptomatic treatments and ordered venodyne boots for prophylaxis against deep vein thrombosis during this admission, Decedent was under the care of attending OB/GYN physician, Dr. Lerebours. Decedent was discharged on June 14.

Decedent again presented to the ED at TBHC on June 17, 2018, at 9pm, with weakness, dizziness, and vaginal bleeding. She was found to be tachycardic and tachypneic, with an oxygen saturation of 94%. Decedent was examined in the ED by non-party resident Dr. Chen and attending physician, defendant Dr. Amy Yeh; differential diagnoses of pulmonary embolism and threatened abortion were contemplated. A D-dimer blood test was ordered, and if it were positive, Decedent would be admitted for a planned ventilation/perfusion nuclear scan the following day, as the clinical team determined that a CT angiogram was contraindicated given Decedent's pregnancy. At 10:30pm, Decedent's blood pressure was 118/83 mmHg and heart rate was 109 beats/minute.

The result of a D-dimer test, ordered at 10:28 pm and obtained at 12:43 am, was found to be markedly positive. Thereafter, Decedent was admitted to the internal medicine service, allegedly under the care of defendant Dr. Akiyomi Fields, with a V/Q nuclear scan planned for the morning. At 3 am, therapeutic anticoagulation (enoxaparin) was administered, and Decedent remained hemodynamically stable. At 10:57 am, Decedent's blood pressure was 121/88. At 11 am, Decedent was found to be in extremis in the bathroom and was promptly put in a bed. A bedside echocardiogram demonstrated severe right heart strain. CPR was started at 11:06 am, during which Decedent received tissue plasminogen activator (tPA), epinephrine, amiodarone and bicarbonate and was intubated. Thereafter, Decedent was observed exhibiting seizure-like activity, went into cardiac arrest again at 1:40 pm, and again at 3:10 pm. Despite efforts at resuscitation, Decedent was pronounced dead at 4:04 pm.

"A defendant moving for summary judgment in a medical malpractice action must demonstrate the absence of any material issues of fact with respect to at least one of the elements of a cause of action alleging medical malpractice: (1) whether the physician deviated or departed from accepted community standards of practice, or (2) [whether] such a departure was a proximate cause of the plaintiff's injuries." *McHale v Sweet*, 217 AD3d 666, 667 [2d Dept 2023] [internal citations, quotations and references omitted].

It is noted that the submissions indicate that Dr. Lerebours was not involved in Ms. Bobb's admission to TBHC on June 17, 2018. As to the June 12, 2018 admission, the expert witness for Dr. Lerebours, Melissa B. Glasser-Caine, M.D., who is a board-certified obstetrician and gynecologist, opines that Dr. Lerebours conformed to the standard of care, and that no acts or omissions were "the proximate cause" of Decedent's injuries. Dr. Glasser-Caine opines that Dr. Lerebours appropriately diagnosed and treated Decedent's hyperemesis gravidarum, such that

"[a]dministration of anti-coagulants was not medically indicated" given that hyperemesis is not a risk factor for DVT or PE, that the Decedent was ambulatory during her admission, that Decedent did not have any signs or symptoms concerning for DVT/PE, and that the risks of bleeding "far outweigh[ed] any presumed benefits." Moreover, Dr. Lerebours properly assessed Decedent to have a VTE risk score of 2, indicating a low risk, for which chemical DVT prophylaxis was not indicated. In the absence of any signs or symptoms concerning for DVT/PE, Dr. Lerebours' expert opines that there was no indication to check a D-Dimer, a V/Q scan, a doppler study, nor arterial blood gas.

Expert witness for Defendants The Brooklyn Hospital Center, Amy Hsiu-Wei Yeh, D.O., Akiyomi O. Fields, M.D., and Joshua Rosenberg M.D., is Dr. Ian Newmark, M.D.; he holds board certifications in internal medicine, pulmonary medicine, and critical care medicine, has worked as intensivist, and is a member of the Clinical Protocols Committee on the Pulmonary Embolism Response Team Consortium. Dr. Newmark opines that Hospital Defendants all acted in conformance with the standard of care. To wit, Decedent did not have any signs or symptoms concerning for venous thromboembolism during the June 12th admission, that Decedent was ambulatory during this admission, and thus it was appropriate to have not administered chemical DVT prophylaxis. Turning to Decedent's June 17 admission, Hospital Defendants appropriately diagnosed Decedent with a suspected pulmonary embolism, ordered a D-dimer, administered empiric therapeutic anticoagulation, and planned a V/Q scan. Dr. Newmark opines that a CT angiogram was "contraindicated in pregnant patients due to the amount of radiation the fetus would be subjected to…" and thus a V/Q scan was appropriate; V/Q scans are performed by the nuclear medicine department and are not available overnight. Further, Dr. Newmark stated that since therapeutic anticoagulation was administered at 3 am, effective for 12 hours, even if the V/Q study had been performed overnight, "the same treatment would have been administered" and thus it was "inconsequential and entirely appropriate to plan the VQ scan for the morning." Further testing overnight, including an echocardiogram, an arterial blood gas, and lower extremity venous duplex studies would not have changed the treatment plan.

Once Decedent was admitted, Dr. Newmark opines that the internal medicine team's plan of care was appropriate, such that empiric anticoagulation for patients with "high clinical suspicion" of acute pulmonary embolism who are not hypotensive was in conformance with guidelines from the American College of Chest Physicians. The expert opines that tissue

plasminogen activator (tPA) was not indicated, as Decedent never had a systolic blood pressure below 90 mmHg (indicative of shock) prior to her first cardiac arrest, especially given the "tremendous risk of complications" such as hemorrhage, uterine hemorrhage and fetal demise associated with tPA. Moreover, surgical removal of the clot is only indicated in patients who are hypoxemic, hypotensive, or in shock, which Decedent was not prior to 11 am. Further, Dr. Newmark opines that the 2.5 hour delay in administering therapeutic anticoagulation was of no clinical significance, as the clot would dissolve over a period of days, such that Decedent "died of a massive PE, meaning she likely had an occult thrombus that would not have been affected in any meaningful way by administering [enoxaparin] earlier." Nevertheless, once Decedent did suffer her first cardiac arrest, the care rendered by Dr. Rosenberg in resuscitating her was in conformance with the standard of care.

Here, Defendants met their prima facie burden of entitlement to summary judgment by submitting the affidavits of an OB/GYN physician as to Dr. Lerebours, and an intensivist as to the Hospital Defendants in reference to the June 12, 2018 admission.

In opposition to Defendants' expert witnesses, Plaintiff offers the opinion of a physician who is board certified in internal medicine and pulmonary medicine, who has practiced for 40 years, including having "extensive experience in treating patients in a hospital setting, including pregnant patients, with pulmonary embolism." Plaintiff's expert opines that pregnant patients are at a higher risk of venous thromboembolism, as "the body increases the production of blood factors that promote normal clotting," "the growing uterus also impedes return of blood in veins," and that dehydration and hyperemesis all synergize to increase the risk of clot development. Continuing, the expert opines that a CT angiogram "may be performed during pregnancy with relatively low fetal exposure," however, a V/Q scan is the preferred test to detect PE in pregnant patients.

Plaintiff's expert opines that Dr. Lerebours inaccurately assessed Decedent's VTE risk as low risk, such that if other risk factors, including "history of multi gravida [sic], hyperemesis gravidarum, her complaints of dizziness" and a family history of blood clots had been included, Decedent would have been high risk, and would thus have been administered both "chemical prophylaxis with anticoagulants, including Heparin or unfractionated Heparin" and mechanical DVT prophylaxis during her June 12th admission. Moreover, Plaintiff's expert opines that Dr. Lerebours should have tested Decedent's D-Dimer during her June 12th admission to exclude VTE. Therefore, Plaintiff's expert states: "the failure to administer oral [sic] anti-coagulants, such as

heparin during this admission was a departure from the standard of care… The failure to treat the patient with anti-coagulants became the nidus for her subsequent PE."

Turning to the June 17th presentation, Plaintiff's expert opines that Decedent had "signs and symptoms of PE that required immediate intervention and treatment, [which] was [sic] not timely administered, resulting in massive PE…" The expert opines that the D-Dimer test was not ordered until approximately 90 minutes after Decedent's presentation to the ED, and results took an additional 120 minutes, during which time an echocardiogram was not performed, which would have assessed "right heart strain or failure in an attempt to assess pulmonary clot burden… This finding would have been an indication to administer [tPA] since heparin or [enoxaparin] at this time would have been inadequate for such a large clot burden." Moreover, the team should have performed a lower extremity doppler and arterial blood gas during this time, as orthostatic hypotension "suggest[ed] decreased cerebral perfusion from a clot or PE." Although the D-Dimer resulted at 12:40 am, "[s]till, nothing was done for her symptoms or the positive D-dimer result, a clear indication that she had a PE," such that enoxaparin "should have been administered hours earlier when the initial diagnosis was entertained… [and] the one therapeutic dose that was administered over 7 hours before her code was insufficient to treat her massive PE." Further, the team should have performed a CT angiogram instead of a V/Q scan, as it was not contraindicated and would have permitted the team to make a definitive diagnosis more quickly, "so that treatment can be promptly initiated," unlike what was done in this case. The expert further opines that Defendants' acts and omissions "led to a delay in treatment resulting in the decedents [sic] massive PE being left untreated before her cardiac arrest, leading to her death." Finally, the expert opines that tPA should have been administered before Decedent's initial cardiac arrest, such that although Decedent "was not hypotensive, she was high risk for PE, had hypoxemia and RV dysfunction and tachycardia, an indication for thrombolytic therapy… had any of the necessary testing been performed, the patient's massive PE and extensive clot burden would have been diagnosed earlier and treatment with a thrombolytic, particularly with TPA [sic] would have been administered earlier, before her code, and more likely, would have made a difference in her survival. The large clot burden required TPA."

"In a medical malpractice action, a plaintiff, in opposition to a defendant physician's summary judgment motion, must submit evidentiary facts or materials to rebut the prima facie showing by the defendant physician that [she] was not negligent in treating plaintiff so as to

demonstrate the existence of a triable issue of fact" *Alvarez v Prospect Hosp.*, 68 NY2d 320, 324 [1986].

Although Defendants do make prima facie showings of entitlement to summary judgment as a matter of law, Plaintiff presents sufficient evidence to demonstrate the existence of triable issues of fact as to the medical malpractice claim, including the breach, causation, and liability branches, and thus summary judgment is denied. Plaintiff's expert witness opinion, as well as other disputed facts, establish the existence of disputed material issues of fact. *Zuckerman v New York*, 49 NY2d 557 [1980]. "[W]here 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 injuries, 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." *Stukas v Streiter*, 83 AD3d 18, 25 [2d Dept 2011].

The parties offer detailed, non-speculative, conflicting expert opinions as to the care rendered by Dr. Lerebours, both as to causation and liability. Plaintiff's expert opines that Dr. Lerebours improperly stratified Decedent's risk of venous thromboembolism, and thus failed to order chemical DVT prophylaxis; while Dr. Lerebours' expert states that Decedent's risk was properly calculated, and thus chemical DVT prophylaxis was not indicated. Plaintiff's expert affirms that Dr. Lerebours should have checked Decedent's D-dimer; Dr. Lerebours' opines that there was no clinical indication to check this lab test. Plaintiff's expert posits that the failure to administer chemical DVT prophylaxis was the nidus for the development of a DVT, while Dr. Lerebours' expert disputes this opinion.

As to the Hospital Defendants, there are material disputes as to departure from the standard of care, causation, and liability elements of the medical malpractice action. The Hospital Defendants' expert opines that Decedent was properly treated with empiric therapeutic anticoagulation while awaiting a V/Q scan, while it is the opinion of the Plaintiff's expert that Decedent should have been administered tPA, and should have had a CT angiogram, a transthoracic echocardiogram, and an arterial blood gas checked, all completed overnight. The Hospital Defendants' expert states that a CT scan was contraindicated given Decedent's pregnancy, and further, that tPA was not indicated at any time prior to Decedent's first cardiac arrest, as Decedent neither exhibited any signs or symptoms concerning for shock, nor met evidence-based,

guideline-directed criteria for administration of tPA. Plaintiff's expert opines that there were material delays in laboratory testing, which Hospital Defendants' expert disputes.

Accordingly, summary judgment is not indicated here, as the parties have adduced conflicting, non-conclusory, non-speculative medical expert opinions, which can only be resolved by a jury. See *Senatore v Epstein*, 128 AD3d 794 [2d Dept 2015]); *Feinberg v Feit*, 23 AD3d 517 [2d Dept 2005]; *McHale v Sweet*, 217 AD3d 666 [2d Dept 2023]. Triable issues of fact exist as to whether care rendered to Decedent departed from accepted standards of medical care and whether alleged departures were a substantial factor in causing Decedent's death; therefore, summary judgment for the wrongful death cause of action is denied. *Clarke v NY City Health & Hosps*., 210 AD3d 631 [2d Dept 2022]; *Kordonsky v Andrst,* 172 AD2d 497 [2d Dept 1991].

Plaintiff's claims against TBHC all derive "from the duty owed to the plaintiff as a result of a physician-patient relationship;" thus, all claims sound in medical malpractice, not negligence. *Jeter v NY Presbyt. Hosp*., 172 AD3d 1338, 1340 [2d Dept 2019][internal citation, quotation marks, and references omitted]. Moreover, Plaintiff does not oppose the branch of Defendants' motion seeking dismissal of the ordinary negligence branch of the action. Thus, the branch of Defendants' motion for summary judgment seeking dismissal of ordinary negligence branch is Granted as to all Defendants. *Jeter v NY Presbyt. Hosp*., 172 AD3d 1338 [2d Dept 2019].

All Defendants established their prima facie entitlement to summary judgment dismissing the branch of the cause of action for lack of informed consent. Plaintiff does not oppose this branch of the motions. Nevertheless, an action for lack informed consent in emergency situations "is limited to those cases involving… a diagnostic procedure which involved invasion or disruption of the integrity of the body." Public Health Law § 2805-d(3). Here, Plaintiff does not allege any invasion or disruption of Decedent's bodily integrity; to the contrary, Defendants' failure was "alleged to have been the result of a negligent failure to undertake or negligent postponing of such procedure." *Jaycox v Reid*, 5 AD3d 994, 995 [4th Dept 2004]. Accordingly, there is no viable claim related to a lack of informed consent. *Ellis v Eng*, 70 AD3d 887 [2d Dept 2010]. Thus, the branch of Defendants' motion for summary judgment seeking dismissal of the cause of action for lack of informed consent action is Granted.

Defendants also seek to dismiss the action against defendant Dr. Fields arguing that "Dr. Fields established by declining to sign the chart note, and through his deposition testimony, that he did not personally examine or treat the decedent at any point on June 17 or 18, 2018 (Exhibits

B & M).” However, review of the deposition transcript does not establish that Dr. Fields did not treat the patient, nor does it establish that this defendant did not supervise residents who treated the patient at TBHC. “If I was in the hospital that day, I would have been the attending.” (NYSCEF 127 page 46, 2-3). “It's difficult to say because I could have been on other teams. I could have been on the blue team. So at the midnight hour, the resident will either use his memory who they saw on the day before or who they see on the schedule. So, you know, they just type the name of the doctor that's on the team. But I could have been on a different team. I could have been on the blue team.” (NYSCEF 127 page 127 page 46, 3-12). “I have no records assessable to me going back to 2018. I don't have the schedule for that day, and I don't have the list of other patients to see if I may have seen other patients on that day. So no, I don't have any records to verify.” (NYSCEF 127 page 53, 10-15). Therefore, as defendant fails to establish, prima facie, that they were not involved in the treatment and care of the decedent during the June 17th admission. However, any claims pertaining to the June 12th admission are dismissed as against Dr. Fields as it is established that they were not involved in treating the patient that day.

Defendants submitted evidence that the credentials of their organized medical staff were adequate for hiring purposes. Plaintiff does not offer any evidence in the record that TBHC “knew or should have known that an employee had displayed a propensity for the conduct which allegedly caused the injury.” *Flanagan v Catskill Regional Med. Ctr*., 65 AD3d 563, 566 [2d Dept 2009]. Plaintiff does not oppose the branch of TBHC’s motion for negligent hiring. Thus, the branch of TBHC’s motion for summary judgment seeking dismissal of the cause of action for negligent hiring and retention is Granted.

Movants’ request to dismiss the wrongful death cause of action is denied as the medical malpractice claims remain viable as discussed above.

Any claims pertaining to the June 17th admission are dismissed as against defendant Dr. Lerebours as it is established that this defendant was not involved in treating the patient during that admission. Any claims pertaining to the June 12th admission are dismissed as against Dr. Fields as there is no evidence of their involvement with the patient during this admission.

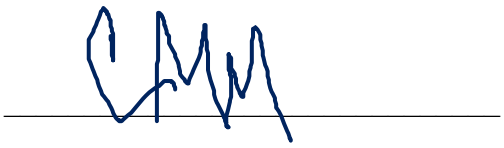
The branches of Defendants’ motions for summary judgment on behalf of The Brooklyn Hospital Center, Amy Hsiu-Wei Yeh, D.O., Akiyomi O. Fields, M.D., (Seq. 4) and Erwin Lerebours, M.D. (Seq. 5) are DENIED in accordance with the above.

The branches of the Defendants' motions for summary judgment related to lack of informed consent, negligent hiring, and ordinary negligence are GRANTED.

The branch of Defendants' motion seeking summary judgment (Sequence 4) on behalf of Joshua Rosenberg, M.D., is GRANTED with prejudice, and the complaint is dismissed as to him. The Clerk is directed to enter judgment in favor of Joshua Rosenberg, M.D.

This constitutes the decision and order of the Court.[1]

ENTER.



Hon. Consuelo Mallafre Melendez

J.S.C.

[1] This decision was drafted with the assistance of legal intern Alexander Weller, MD, Brooklyn Law School.