Caroselli v New York City Health & Hosps. Corp.
2016 NY Slip Op 32600(U)
December 21, 2016
Supreme Court, New York County
Docket Number: 805137-2014
Judge: George J. Silver
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+SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NEW YORK: PART 10

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BRITTANY CAROSELLI,

Plaintiff,

-against-

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION,

Defendant.

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Index No. 805137-2014

DECISION/ORDER

Motion Sequence 001

HON. GEORGE J. SILVER, J.S.C.

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

Papers	Numbered
Notice of Motion, Attorney's Affirmation & Collective Exhibits Annexed	1, 2, 3
Affirmation In Opposition, Affirmation, Memorandum of Law & Collective Exhibits Annexed	4,5, 6, 7
Reply Affirmation	8

In this action for medical malpractice defendant New York City Health and Hospitals Corporation (defendant) moves pursuant to CPLR § 3212 for an order granting it summary judgment dismissing plaintiff Brittany Caroselli's (plaintiff) complaint. Plaintiff opposes the motion.

According to the chart, plaintiff, then 19 years old, presented to the Bellevue Hospital Emergency Department (Bellevue) by ambulance on May 25, 2013 at approximately 9:46 p.m. with complaints of headache, right-sided weakness and right facial droop. Upon presenting to Bellevue plaintiff had difficulty following commands and speaking and had weakness in the right face and the upper and lower extremities. A stroke code was called immediately after plaintiff arrived at the emergency department. A head CT was performed which showed no acute intracranial hemorrhage or abnormality. A CT angiograph of the head and neck were also performed which showed normal intracranial and extracranial carotid and vertebral arterial systems. Tissue plasminogen activator (tPA) was ordered and prepared but never administered to plaintiff. Plaintiff alleges that defendant's failure to administer tPA deviated from good and accepted medical practice and proximately caused her alleged neurological injuries.

Defendants' neurologist, Dr. Steven A. Sparr (Sparr), contends that defendants' decision not to administer tPA to plaintiff within 3 hours of the onset of plaintiff's stroke symptoms was not a departure from good and accepted practice. According to Sparr, the decision to administer tPA is a judgment call based upon myriad factors including the timing of the onset of stroke of symptoms, the patient's clinical presentation, the patient's past medical and surgical history, the National Institutes of Health (NIH) stroke scale, and findings on a non-contrast CT. Sparr contends that a physician must weight the risks and benefits associated with the administration of tPA, particularly published studies that have demonstrated that tPA helps 30% of patients who receive it but has been shown to cause intracranial bleeding in 6% of patients who receive. Sparr claims that a physician must make the decision to administer tPA before a stroke is seen on a CAT scan and that it is not standard practice to obtain an MRI/MRA before deciding whether to administer tPA. Sparr opines that based upon plaintiff's age, lack of significant medical history, the absence of abnormality on CT imaging, the complaint of a headache and the evidence of rapidly improving symptoms, defendants' decision not to give tPA was an appropriate exercise of judgment and not a departure from good and accepted practice. According to Sparr, because plaintiff was only 19 years old and did not have any risk factors for a stroke, it was within the standard of care for defendants' personnel to consider another etiology for plaintiff's symptoms. Moreover, Sparr claims that plaintiff suffered an intracranial dissection of the posterior cerebral artery (PCA) based upon plaintiff's history of recent participation on high velocity rides, her complaint of headache, which is classic for a dissection and the lack of any compelling reason for a stroke. Sparr also opines that even if plaintiff did not suffer a dissection and that tPA should have been administered it cannot be said within a reasonable degree of medical certainty that the use of tPA would have given plaintiff a better outcome.

Defendants also submit an affirmation from Dr. Allan L. Brook (Brook), a radiologist. Brook opines that plaintiff suffered a dissection of the PCA which led to the ischemic stroke she suffered. According to Brook, a dissection is a tear in the wall of a blood vessel that can be caused by trauma, an intrinsic weakness in the vessel or an unknown inflammation. According to Brook, the PCA is the most likely intracranial vessel to suffer a dissection in a young adult and in the absence of trauma because of its anatomical location over the tentorium. Brook claims that the strokes suffered by plaintiff are clearly in the same vascular territory as the PCA. Brook claims that patients with PCA dissections classically present with complaints of a headache and stroke as plaintiff did. Brook opines that there were no departures from good and accepted practice in defendants' interpretation of the head CT, neck and head CTA and CT perfusion scans and that none of the care rendered to plaintiff contributed to her current condition.

In opposition plaintiff submits a redacted affirmation from a board certified neurologist. Plaintiff's expert contends plaintiff should have received tPA as quickly as possible upon her arrival at Bellevue with stroke symptoms and no later than 4½ hours, or 1:45 a.m. on May 26, 2013, after the onset of her symptoms. According to plaintiff's expert, plaintiff presented with classic symptoms of a stroke, which the expert contends is a clinical diagnosis and the most important criterion for administering tPA. Plaintiff's expert also contends that defendant's expert's reliance upon the supposed contraindications to the administration of tPA, i.e., plaintiff's score on the NIH stroke scale, headache as an initial symptom and rapidly improving symptoms, is misplaced. Plaintiff's expert argues that there is scant evidence in the Bellevue

chart that plaintiff's symptoms were scored serially on an NIH stroke scale as a means of objectifying the neurological deficit by which to draw the conclusion that plaintiff was rapidly improving during the 4½ hour window. Plaintiff's expert also takes issue with plaintiff having scored a 7 on the NIH stroke scale while at Bellevue. Plaintiff's expert contends that, based upon the information in the chart, plaintiff's score should have been more than double. Because of the lack of documentation in the Bellevue chart that plaintiff's stroke symptoms were improving within 4½ hours of their onset plaintiff's expert argues that it cannot be concluded that the administration of tPA was contraindicated. Alternatively, plaintiff's expert claims there are a number of highly reliable studies that have come out since the marketing of tPA in 1996 which question the reliance on a patient's improving condition as a contraindication to the administration of tPA.

Plaintiff's expert further opines that there is nothing in the record to support defendant's experts' conclusion that plaintiff's stroke was related to a dissection of the PCA and that dissection is not a contraindication to the administration of tPA. Finally, plaintiff's expert contends that plaintiff's permanent injuries, including those relating to her vision and short term memory loss were the direct result of an untreated ischemic stroke caused not by a dissection but by an embolus to the PCA and claims that defendant's failure to administer tPA deprived plaintiff of a substantial opportunity for a complete neurological cure.

Plaintiff also submits a redacted affirmation from a second neurologist licensed to practice medicine in the Massachusetts. This neurologist opines that plaintiff presented to Bellevue with the classic symptoms of a stroke and that tPA administration was indicated to treat plaintiff. According to this expert, plaintiff was suffering from a hemorrhagic stroke and that the administration of tPA to plaintiff within the first 4½ hours of her presentation to Bellevue would have benefitted plaintiff. The expert further contends that the benefits of administering tPA to plaintiff on May 25, 2013 outweighed the risks and that even if plaintiff was suffering from an arterial dissection, the dissection was not a contraindication to the administration of tPA[1].

In an action premised upon medical malpractice, a defendant doctor establishes *prima facie* entitlement to summary judgment when he/she establishes that in treating the plaintiff there was no departure from good and accepted medical practice or that any departure was not the proximate cause of the injuries alleged (*Thurston v Interfaith Med. Ctr.*, 66 AD3d 999, 1001 [2d 2009]; *Myers v Ferrara*, 56 AD3d 78, 83 [2d 2008]; *Germaine v Yu*, 49 AD3d 685 [2d Dept 2008]; *Rebozo v Wilen*, 41 AD3d 457, 458 [2d Dept 2007]; *Williams v Sahay*, 12 AD3d 366, 368 [2d Dept 2004]).

With respect to opinion evidence, it is well settled that expert testimony must be based on facts in the record or personally known to the witness, and that an expert cannot reach a conclusion by assuming material facts not supported by record evidence (*Cassano v Hagstrom*, 5 NY2d 643, 646, 159 NE2d 348, 187 NYS2d 1 [1959]; *Gomez v New York City Hous. Auth.*, 217

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[1] The affirmation was not considered by the court in resolving this motion. Pursuant to CPLR § 2106, only physicians authorized to practice in the State of New York may submit an affirmation in lieu of and with the same force and effect as an affidavit. Even if the affirmation had been in proper evidentiary form it would not have raised an issue of fact on the question of causation because it suffers from the same deficiencies as the admissible affirmation submitted by plaintiff.

AD2d 110, 117 [1st Dept 1995]; *Matter of Aetna Cas. & Sur. Co. v Barile*, 86 AD2d 362, 364-365 [1st Dept 1982]). Thus, a defendant in a medical malpractice action who, in support of a motion for summary judgment, submits conclusory medical affidavits or affirmations, fails to establish *prima facie* entitlement to summary judgment (*Winegrad v New York Univ. Med. Ctr.*, 64 NY2d 851, 853, 476 NE2d 642, 487 NYS2d 316 [1985]; *Cregan v Sachs*, 65 AD3d 101, 108 [1st Dept 2009]; *Wasserman v Carella*, 307 AD2d 225, 226 [1st Dept 2003]). Further, medical expert affidavits or affirmations, submitted by a defendant, which fail to address the essential factual allegations in the plaintiff's complaint or bill of particulars fail to establish prima facie entitlement to summary judgment as a matter of law (*Cregan*, 65 AD3d at 108; *Wasserman* 307 AD2d at 226).

Once the defendant meets its burden of establishing prima facie entitlement to summary judgment, it is incumbent on the plaintiff, if summary judgment is to be averted, to rebut the defendant's prima facie showing (*Alvarez v Prospect Hosp.*, 68 NY2d 320, 324, 501 NE2d 572, 508 NYS2d 923 [1986]). The plaintiff must rebut defendant's prima facie showing without "[g]eneral allegations of medical malpractice, merely conclusory and unsupported by competent evidence" (*id.* at 325). Specifically, to avert summary judgment, the plaintiff must demonstrate that the defendant did in fact commit malpractice and that the malpractice was the proximate cause of the plaintiff's injuries (*Coronel v New York City Health and Hosp. Corp.*, 47 AD3d 456 [1st Dept 2008]; (*Koeppel v Park*, 228 AD2d 288, 289 [1st Dept 1996]). In order to meet the required burden, the plaintiff must submit an affidavit from a medical doctor attesting that the defendant departed from accepted medical practice and that the departure was the proximate cause of the injuries alleged (*Thurston* 66 AD3d at 1001; *Myers* 56 AD3d at 84; *Rebozo* 41 AD3d at 458).

To prevail on an informed consent claim, a plaintiff must establish, via expert medical evidence, that the defendant failed to disclose material risks, benefits and alternatives to the medical procedure, that a reasonably prudent person in plaintiff's circumstances, having been so informed, would not have undergone such procedure, and that lack of informed consent was the proximate cause of her injuries (*Balzola v Giese*, 107 AD3d 587 [1st Dept 2013]). An informed consent a claim is limited "to those cases involving either (a) non-emergency treatment, procedure or surgery, or (b) a diagnostic procedure which involved invasion or disruption of the integrity of the body" (Public Health Law § 2805-d [2]). Here, plaintiff's lack of informed consent claim consent fails because defendant's treatment of plaintiff was rendered on an emergency basis and the head CT scan and the CT angiogram of plaintiff's head and neck did not involve an invasion or disruption of the integrity of plaintiff's body[2].

With respect to plaintiff's clam for medical malpractice, defendant met its initial burden of establishing their *prima facie* entitlement to judgment as a matter of law through its expert affirmations establishing that defendant did not deviate from accepted standards of medical practice and that defendant's treatment and care of plaintiff was not the proximate cause of plaintiff's injuries. In opposition, plaintiff raises a triable issue of fact with respect to both malpractice and proximate cause. On the question of malpractice, the conflicting expert affirmations raise questions of fact as to whether plaintiff sustained a dissection of the PCA or a

[2] Plaintiff's opposition papers do not address the lack of informed consent claim.

hemorrhagic stroke and whether, based upon plaintiff's condition during the applicable time frame, the administration of tPA was contraindicated. While there is an entry in the Bellevue chart stating that tPA was not administered because plaintiff's deficit was improving, the same chart also states that plaintiff's altered mental status and right sided weakness was waxing and waning during the time window for the administration of tPA. It is for a jury to determine whether plaintiff's condition was in fact improving and if so, whether that improvement was a contraindication to the administration of tPA.

On the issue of proximate cause, Sparr, defendant's neurologist, opines that tPA is successful only 30% of the time and that the success of tPA is measured by the condition of the patient 3 months post stroke. If a patient, post stroke, scores 0 or 1 on the modified Rankin scale, the administration of tPA is deemed to have been a success. Sparr, who examined plaintiff on December 18, 2015, opines that plaintiff's scored a 1 on the modified Rankin scale. Thus, Sparr concludes that it cannot be determined to a reasonable degree of medical certainty that plaintiff would have had a better neurological outcome if defendant had administered tPA. In response to this prima facie showing, plaintiff's expert contends defendant's failure to administer tPA deprived plaintiff of a substantial opportunity for a neurological cure. "In 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 probable than not" that the defendant's deviation was a substantial factor in causing the injury (*Goldberg v Horowitz*, 73 AD3d 691 [2d Dept 2010]). It is well settled that a plaintiff's evidence of proximate cause may be found legally sufficient even if the plaintiff's 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 (*id.*; *Hernandez v New York City Health & Hosps. Corp.*, 129 AD3d 532 [1st Dept 2015]) so long as the plaintiff offers 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 (*Goldberg*, 73 AD3d at 694). Plaintiff's expert's opinion supports the inference that defendant's failure to administer tPA to plaintiff within the prescribed time period following the onset of her symptoms diminished plaintiff's chances of recovery (*King v St. Barnabas Hosp.*, 87 AD3d 238 [1st Dept 2011]).

To the extent defendant contends the complaint must be dismissed because plaintiff's parents did not give defendant permission to administer tPA[3] plaintiff's expert's opinion that tPA was not contraindicated by plaintiff's condition and that the benefits of administering tPA to plaintiff outweighed the risks raises a question of fact as to whether plaintiff's parents were given appropriate medical advice.

Accordingly, it is hereby

ORDERED that defendant's motion for summary judgment is granted to the extent that plaintiff's lack of informed consent claim is dismissed. Defendant's motion is otherwise denied; and it is further

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[3] Plaintiff was unable to give consent due to her condition.

ORDERED that the parties are to appear for a conference on February 28, 2017 at 9:30 a.m. in Part 10, room 422 of the courthouse located at 60 Centre Street, New York, New York 10007; and it is further

ORDERED that defendant is to serve a copy of this order, with notice of entry, upon plaintiff within 20 days of entry.

George J. Silver, J.S.C.

Dated: 12/21/16

New York County

GEORGE J. SILVER