

**Kellman v New York City Health & Hosps. Corp.**

2017 NY Slip Op 31437(U)

July 5, 2017

Supreme Court, New York County

Docket Number: 805276-2015

Judge: George J. Silver

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This opinion is uncorrected and not selected for official publication.

SUPREME COURT OF THE STATE OF NEW YORK  
COUNTY OF NEW YORK: PART 10

-----X  
SARITA KELLMAN,

Plaintiff,

Index No. 805276-2015

-against-

**DECISION/ORDER**

Motion Sequence 001

NEW YORK CITY HEALTH AND HOSPITALS  
CORPORATION,

Defendant.  
-----X

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

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

<u>Papers</u>	<u>Numbered</u>
Notice of Motion, Attorney’s Affirmation & Collective Exhibits Annexed.....	<u>1, 2, 3</u>
Affirmation In Opposition & Collective Exhibits Annexed.....	<u>4, 5</u>
Reply Affirmation.....	<u>6</u>

In this action for medical malpractice, defendant New York City Health and Hospitals Corporation (defendant) moves by notice of motion dated December 16, 2016 for an order granting it summary judgment dismissing the complaint of plaintiff Sarita Kellman (plaintiff) Plaintiff opposes the motion.

On May 3, 2014, plaintiff, 70 years old at the time, injured her left ankle while at a dog park and was taken by ambulance to the Bellevue Hospital Emergency Department (Bellevue). X-rays taken at Bellevue revealed a trimalleolar fracture of the left ankle with disruption of the ankle mortise. Close reduction of the fracture was performed followed by splint and ace wrap application. Plaintiff was advised the fracture would require surgical repair. Plaintiff was also advised no weight bearing on the left lower extremity, strict elevation, pain control as needed and to follow up on May 6,, 2014 at the Orthopedic Fracture Clinic. Plaintiff was discharged home from the emergency department

Plaintiff testified at her 50-h hearing testified that when she went to the discharge planning area at Bellevue Hospital she was given a pair of crutches and was told how to use them. Specifically, plaintiff testified that she given crutches by a male nurse and was told to put the crutches under her arms and to put one foot in front of the other. Plaintiff testified that she

physically attempted to use the wooden crutches but “not getting it” and that she was “wobbly” when she tried to use the crutches. Plaintiff further testified that she was unable to use the crutches because she was “groggy” and that she informed hospital personnel that she could not use the crutches. Plaintiff also testified that prior to her discharge she had to use the bathroom and was told that she could not use the crutches and was provided with a wheelchair. Plaintiff testified that she was given morphine, that she was dizzy as a result and that using the crutches made her symptoms worse. She testified that asked hospital personnel how long it would take for the effects of the morphine to wear off but she was not given an answer. According to plaintiff, she told the male nurse that she could not use the crutches, that she did not feel safe using the crutches and that she wanted a wheelchair. Plaintiff testified that the male nurse told her that he could not give her one. Plaintiff claims that she repeated her request for a wheelchair many times to the male nurse. Plaintiff further testified that she requested an escort service to take her home because she could not go home alone and that none of her requests where met. Plaintiff testified that she was wheeled out of the emergency room and put into in a taxi while she was still feeling the effects of the morphine. When the taxi arrived at plaintiff’s residence, plaintiff attempted to exit the taxi and as she was doing so lost her balance, fell and injured her right wrist and left leg.

Plaintiff testified at her deposition that when she went to the discharge planing area she felt “woozy” and drowsy. And that she was feeling awful, light-headed and off balance. Plaintiff testified that she was given a pair of crutches by a male nurse which she could not use. Plaintiff asked for wheelchair and that she was told to practice with the crutches. Plaintiff testified that she was not very good at using the crutches. Plaintiff testified that she was told to put one foot in front of the other but she did not remember the male nurse actually demonstrating how to use the crutches. Plaintiff repeated her 50-h testimony that she was given a wheelchair to take to the bathroom. Plaintiff testified that after using the bathroom she told the male nurse that using crutches was impossible and that she needed a wheelchair to go home. Plaintiff claims that she told that Bellevue did not have a wheelchair and that she offered to pay for wheelchair and have it returned to Bellevue the following day. Plaintiff testified that she repeatedly requested a wheelchair for at least half an hour until she finally accepted that a wheel chair was not going to be provided to her. Plaintiff further testified that she requested that a hospital volunteer go home with her or she be taken home by ambulette because she did not feel safe leaving the hospital alone with crutches. Plaintiff was taken out the emergency department by wheelchair and out into a taxi. Plaintiff also testified that she had not been instructed how to use the crutches when getting out of the taxi.

Orlando Baquiran, R.N. (Baquiran) testified on behalf of defendant. Baquiran was plaintiff’s discharge nurse on May 3, 2014. Baquiran testified that his duties as discharge nurse including discussing with patients treatment, care, referrals, activity and to ensure that the patient understood the discharge instructions and to provide the patient with a copy of the discharge instructions. Baquiran also testified that as a discharge nurse he would assess the patient’s needs abilities upon discharge. Baquiran further testified that a discharge nurse he, along with the doctor, would determine what equipment or devices, if any, a patient would require. Baquiran testified that his assessment of a patient being discharged with a lower extremity fracture would include demonstrating to the patient the proper use of crutches. Baquiran further testified that

part of his assessment would include determining whether a patient was comfortable using crutches or a cane. If a patient indicated that he or she was uncomfortable using crutches, Baquiran testified that he would refer the patient to the doctor or social worker and that such a referral would be documented in the hospital notes. Factors in determining whether crutches were a viable option for a patient being discharged include the patient's age and strength. On average, Baquiran's demonstration to a patient of how to use crutches lasted between 10 and 15 minutes if the patient was comfortable using crutches and would last longer if the patient was uncomfortable. If a patient proved to be unable to use crutches Baquiran would refer the patient to the doctor. Baquiran testified that a patient with a foot or ankle injury who is unable or uncomfortable using crutches could also be discharged with a wheelchair if approved by a doctor.

Baquiran also testified that when demonstrating to a patient how to use crutches he would demonstrate how to use crutches on a flat surface, how to negotiate stairs and how to get in and out of bed. Baquiran testified that he did not specifically demonstrate how to get out of a car using crutches but that the process is similar to getting out of a bed with crutches. Baquiran had no independent recollection of discharging plaintiff but testified, based upon the medical record, that plaintiff showed that she could use crutches properly.

In support of the motion, defendant submits an affidavit<sup>1</sup> by Ramona Jimenez (Jimenez), a nurse licensed in the State of New York. Jimenez avers that in reaching her opinion she reviewed the verified bill of particulars, the Bellevue medical record and the deposition transcripts of Baquiran and Dara Kass, M.D., the attending physician. Jimenez does not claim to have read plaintiff's deposition transcript or the transcript of plaintiff's 50-h hearing. Jimenez's opinion is that Baquiran exercised proper medical judgment within the standard of care in evaluating plaintiff and implementing the discharge plan as dictated by the emergency department. According to Jimenez, if it appears that a patient will be reasonably safe it is appropriate and in accordance with the standard of care for a nurse to release the patient. Jimenez further opines that the initial recommendation by the emergency department for discharge with crutches for non-weight bearing is a standard plan for patients with a single lower extremity fracture and that it was appropriate for the discharge nurse to implement the discharge plan as written. Jimenez further opines that there is no evidence that plaintiff's subsequent fall was the result of any improper discharge plan or instructions and, therefore, the hospital's actions were not a substantial factor in causing plaintiff's subsequent fall and injuries.

In an action premised upon medical malpractice, a defendant hospital 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]).

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<sup>1</sup> The affidavit was notarized in New Jersey and although defendant initially failed to include a certificate of conformity, defendant remedied the defect *nunc pro tunc* by providing a new conforming affidavit (*Bank of N.Y. v Singh*, 139 AD3d 486 [1<sup>st</sup> Dept 2016]).

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 AD2d 110, 117 [1<sup>st</sup> Dept 1995]; *Matter of Aetna Cas. & Sur. Co. v Barile*, 86 AD2d 362, 364-365 [1<sup>st</sup> 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 [1<sup>st</sup> Dept 2009]; *Wasserman v Carella*, 307 AD2d 225, 226 [1<sup>st</sup> 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 her 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 [1<sup>st</sup> Dept 2008]; *Koeppel v Park*, 228 AD2d 288, 289 [1<sup>st</sup> 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).

Defendant's motion for summary judgment is denied. Defendant's expert's opinion that defendant's discharge nurse did not deviate from accepting standards of medical practice by discharging plaintiff with crutches is conclusory and of no probative value because defendant's expert expressly ignored plaintiff's deposition and 50-h testimony in reaching her opinion. Bare conclusory denials of negligence without any factual relationship to the alleged injuries, and the submission of the affidavit of a medical expert which fails to address the essential factual allegations set forth in the complaint, are insufficient to establish that defendant is entitled to summary judgment (*Wasserman v Carella*, 307 AD2d 225 [1<sup>st</sup> Dept 2003]). The specific factual allegations of medical malpractice set forth in plaintiff's bill of particulars are that defendant failed to timely and properly perform a fall risk assessment prior to plaintiff's discharge; that defendant failed to properly train and instruct plaintiff in the proper and safe use of crutches prior to discharge; that defendant failed to provide an escort, ambulette and/or wheelchair prior to plaintiff's discharge; that defendant failed to discharge plaintiff in a safe condition; and that defendant discharged plaintiff on crutches while she was still under the effects of pain medication. Defendant's expert does not refute, or even address these specific factual allegations but merely opines in a conclusory manner that defendant did not deviate from the standard of

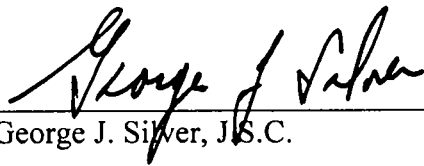
care by discharging plaintiff with crutches (*Berkey v Emma*, 291 AD2d 517 [2d Dept 2002]). The reason why defendant's expert ignored plaintiff's sworn testimony is obvious - it contradicts the very evidence relied upon by the expert in reaching her opinion that defendant did not deviate from the accepted standards of medical care. Specifically, plaintiff's expert cites the fact that there is nothing the record establishing that plaintiff communicated to the discharge nurse, the emergency department physicians or anyone else at Bellevue that she was not comfortable using crutches and wished not to leave without further assistance and the notation in medical chart that defendant's discharge nurse demonstrated to plaintiff how to use the crutches and that plaintiff showed understanding as the factual predicates supporting her opinion. Plaintiff's testimony, which was consistent during both the 50-h hearing and her deposition, contradicts each of these claims. "The failure to make ... a prima facie showing requires the denial of the motion and renders the sufficiency of plaintiff's opposition immaterial" (*Wasserman*, 307 AD2d at 226). However, even assuming that defendant established is prima facie entitlement to summary judgment, plaintiff's testimony and the opinion of her expert that defendant departed from the standard of care by discharging plaintiff with crutches when she was not comfortable and/or skilled to use crutches and that such departure proximately caused plaintiff's accident raise questions of fact and issues of credibility that must be resolved by a jury. Accordingly, it hereby

ORDERED that defendant's motion for summary judgment is granted solely to the extent that plaintiff's claims of physician medical malpractice are dismissed.<sup>2</sup> Defendant's motion is otherwise denied; and it is further

ORDERED that the parties are to appear for a pre-trial conference on September 12, 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 movant is to serve a copy of this order, with notice of entry, upon plaintiff within 20 days of entry.

Dated: 7/5/17  
New York County

  
George J. Silver, J.S.C.

**GEORGE J. SILVER**

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<sup>2</sup> Plaintiff expressly consents to the dismissal of these claims.