French v New York City Health & Hosps. Corp.
2018 NY Slip Op 30522(U)
March 23, 2018
Supreme Court, New York County
Docket Number: 805005/2014
Judge: George J. Silver

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

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JEANETTE FRENCH,

Plaintiff,

-against-

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION, DENNIS BROWN, M.D.; ISAAC BRUCK, M.D.; and MICHELLE MCCOLLOUGH, P.A.,

Defendants

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Index 805005/2014
Motion Seq. 001

DECISION & ORDER

GEORGE J. SILVER, J.S.C.:

In this medical malpractice action, defendants move for summary judgment. Plaintiff opposes the motion. For the reasons below, the court denies the motion.

Plaintiff Jeannette French ("plaintiff"), visited the Emergency Department at Harlem Hospital on May 28, 2013. At triage, plaintiff complained that she was "sore all over my body, can't hold water down." She was triaged as a Level III patient. Plaintiff's initial vital signs revealed a normal blood pressure of 130/69, a slightly elevated pulse rate of 109 beats per minute, a normal respiratory rate of 17/minute, a normal temperature of 99.5°F, and a normal oxygen saturation of 99%.

During her visit, plaintiff was initially been seen by defendant Michelle McCullough, P.A. ("McCullough"), who directed her to give a urine sample for a urinalysis. That initial urinalysis was contaminated, and plaintiff subsequently gave a second urine sample. Plaintiff was then seen by defendant Isaac Bruck, M.D. ("Dr. Bruck"), a then third-year resident in the Emergency Department. Plaintiff reported to Dr. Bruck that her chief complaints were nausea, vomiting and increased urination. She further reported chills, subjective fever, increased urination and an

inability to hold anything down for the last five days. She also reported having episodes of vomiting daily and decreased appetite.

Upon hearing plaintiff's complaints, Dr. Bruck performed a physical examination and documented that plaintiff appeared "well-developed, nourished, in no distress." In his examination, Dr. Bruck further noted that plaintiff's skin was normal and her eyes were documented to have moist conjunctivae and oral mucosa. Her neck was supple and asymmetric. Ausculation of the lungs revealed normal breath sounds and a cardiac evaluation was normal in all respects. An abdomen examination was normal, revealing a soft and non-tender abdomen with normal bowel sounds. Plaintiff's gait was documented as normal as well as her muscle strength and tone. Her extremities revealed no cyanosis, clubbing or edema and her neurological function was documented as alert and oriented with normal affect.

Dr. Bruck ordered a urinalysis, basic labs, intravenous fluids, Zofran and a bedside ultrasound. His initial evaluation was that the patient had cystitis, which is a urinary tract infection localized to the bladder, versus pyelonephritis, which is inflammation of the kidney tract.

At his deposition, attending physician defendant Dennis Brown, M.D. ("Dr. Brown"), testified that he also examined plaintiff and agreed with Dr. Bruck's findings and diagnosis of cystitis. Dr. Brown did, however, also note the presence of early pyelonephritis. Plaintiff was then given anti-nausea medication and intravenous ciprofloxacin antibiotics in the Emergency Department. He further states that a renal ultrasound was normal. At his deposition, Dr. Bruck testified that he also evaluated plaintiff's flank during his abdominal examination and found that it was normal.

Following intravenous fluid therapy, a second set of vital signs were normal in all respects, revealing a blood pressure of 132/69, a temperature of 99.6°F, a pulse rate of 80 bpm and a

respiratory rate of 14 bpm. Plaintiff was then given discharge instructions, and was instructed to follow-up with her primary care physician within one week. She was also given a prescription for ciprofloxacin and ondansetron hydrochloride. At their respective depositions, both Drs. Bruck and Brown testified that plaintiff was asked to drink a quantity of fluids before returning home. Plaintiff's daughter Danielle Richardson ("Richardson"), at her deposition, testified that her mother did not object to going home.

Plaintiff left the emergency room on her own and returned to her home following her discharge. That night, May 28, 2013, plaintiff allegedly drank some soup, did not have any nausea or vomiting and did not appear dehydrated, according to Richardson. On either May 29, 2013 or May 30, 2013, plaintiff started to have diarrhea and Richardson urged her to return to the hospital but plaintiff initially refused because she wanted to speak with her primary care physician.

The next day, May 31, 2013, plaintiff agreed to seek medical attention in the Emergency Department at Mount Sinai Hospital. At triage, plaintiff reported that she had been diagnosed with a urinary tract infection at Harlem Hospital, and had started taking ciprofloxacin to treat it. Since that time, plaintiff reported that she had experienced vomiting and diarrhea. Nevertheless, her vital signs were normal other than a slightly elevated heartrate of 104 bpm. A physical examination noted that she was well-developed, well-nourished and not in acute distress but appeared "uncomfortable," " dry," and " tacky."

Plaintiff's labs subsequently revealed renal insufficiency and she was started on aggressive intravenous fluid therapy. Hemodialysis was not considered necessary. Later that day, plaintiff suffered an ischemic stroke and a subsequent MRI of the brain revealed an acute infarction within the right middle cerebral artery with no evidence of hemorrhage. A transesophageal echocardiogram found no evidence of a cardiac obstruction and, upon discharge, plaintiff's stroke

was described as "cryptogenic," meaning of an unknown cause, by her treating neurologist and stroke specialist, Dr. Stanley Tuhrim ("Dr. Tuhrim").

On July 23, 2013, during a follow-up visit, Dr. Jesse Weinberger, a professor in neurology at Mount Sinai, indicated that the "exact etiology of the stroke was not detected with the diagnostic studies performed on her admission."

ARGUMENTS

Based on the record before the court, defendants argue that summary judgment must be granted, because plaintiff cannot establish that defendants' medical treatment deviated from accepted standards of care or that this treatment proximately caused plaintiff's alleged injuries.

In support of their motion, defendants annex the affirmation of Dr. Saul Melman ("Dr. Melman"), an expert in Emergency Department medicine. In his Affirmation, Dr. Melman states that defendants appropriately diagnosed and treated plaintiff's condition at Harlem Hospital on May 28, 2013. Dr. Melman describes plaintiff's visit on May 28, 2013 as routine and not warranting urgent or medical care in any respect. Indeed, Dr. Melman emphasizes that plaintiff presented with a urinary tract infection, early-pyelonephritis, and mild dehydration, which defendants properly recognized, diagnosed and treated with antibiotics, anti-nausea medication, and fluid therapy.

Dr. Melman further opines that plaintiff's condition on May 28, 2013 did not warrant admission, as her course was uneventful, and she was stable at the time of her discharge. In that regard, Dr. Melman avers that while plaintiff's initial heartrate was slightly elevated at 109 bpm (normal: <100 bpm), her temperature of 99.5°F blood, blood pressure of 130/69, respiratory rate of 17/min and oxygen saturation of 99% established that she was not in distress. Dr. Melman also

notes that a physical examination was normal in all respects and, following fluid therapy and intravenous antibiotics, a second set of vital signs were normal in all respects.

Dr. Melman also details that defendants appropriately diagnosed plaintiff, as a urinalysis and a blood test established that she had a urinary tract infection, early-pyelonephritis and mild dehydration. Dr. Melman refutes any suggestion that plaintiff presented with significant dehydration while she was at Harlem Hospital. A physical examination revealed that she had moist, not dry, conjunctivae and mucosa membranes, normal capillary refill cardiac rhythm and skin, all of which indicated that she was not significantly dehydrated. Moreover, Dr. Melman notes that plaintiff never reported any episodes of headaches, dizziness or feeling lightheaded, which dehydration can cause, and she specifically stated that she was not excessively thirsty.

Defendants highlight the following passage from Richardson's deposition to further emphasize the notion that plaintiff was not dehydrated during her visit.

Q. While she was in the hospital did she ask for a glass of water?
A. No.
Q. At any point on May 28, 2013, did she ask for a glass of water at the hospital?
A. No.
Q. Was there a water fountain in the lobby where the waiting area is?
A. I believe so, yes.
Q. At any point did you see your mom go up and try to drink from the water fountain?
A. No.
Q. At any point while you were at the hospital on May 28, 2013, did your mom say if she was hungry?
A. No.
Q. At any point on May 28, 2013, while your mom was in the hospital do you recall her specifically saying that she was thirsty?
A. No.

(*see* Richardson Deposition Transcript at pages 92-93)

Dr. Melman also emphasizes that lab reports refute any suggestion of significant dehydration, as plaintiff had a normal BUN/creatinine ratio of 10.9 and normal levels of sodium and potassium, which are all inconsistent with claims of dehydration.

Ultimately, while Dr. Melman states that it is possible that plaintiff had mild dehydration, the record unequivocally establishes that this was properly appreciated and treated at Harlem Hospital with intravenous fluids.

Dr. Melman further explains that ciprofloxacin was an entirely appropriate antibiotic to treat plaintiff's urinary tract infection and early pyelonephritis. Dr. Melman states that ciprofloxacin is well within the standard of care and is commonly prescribed for those medical conditions. Dr. Melman asserts that plaintiff did not meet the criteria for admission in any respect on May 28, 2013. Indeed, he notes that she was stable at discharge and a second set of vital signs taken following treatment were completely normal, revealing a blood pressure of 132/69, temperature of 99.6°F, a pulse rate of 80 bpm and a respiratory rate of 14/min. Based on this, Dr. Melman concludes that there was not any treatment that the medical personnel at Harlem Hospital could administer to plaintiff that she could not administer to herself at home to warrant her admission on May 28, 2013.

Dr. Melman also states that the medical personnel at Harlem Hospital gave plaintiff appropriate discharge instructions, as she was advised to follow-up with her primary care physician within one week and, most importantly, to seek medical attention if her condition began to worsen.

Plaintiff verbalized understanding of the instructions and signed a consent form acknowledging that she read and would comply with same. Dr. Melman notes that plaintiff initially did not have any difficulty returning home, and temporality felt better following her discharge. Dr. Melman further states that while plaintiff subsequently complained of diarrhea and

worsening nausea on May 30, 2013, she specifically did not follow Harlem Hospital's discharge instructions by failing to seek medical attention prior to speaking to her primary care physician. In Dr. Melman's opinion, it was not defendants' medical care, but the plaintiff's failure to timely seek medical attention that caused her condition to worsen, resulting in her admission to Mount Sinai Hospital on May 31, 2013.

In further support of their motion, defendants annex the affirmation of Dr. Tuhrim. Following plaintiff's stroke on June 1, 2013, Dr. Tuhrim and the neurology service at Mount Sinai Hospital conducted imaging studies and diagnostic investigations to ascertain the cause of her stroke. Following those studies and investigations, Dr. Tuhrim concluded that plaintiff's stroke was "cryptogenic," meaning that its cause was unknown. In his affirmation, Dr. Tuhrim explains that this is not uncommon and that approximately 30% of all strokes are a result of unknown causes. Dr. Tuhrim specifically refutes plaintiff's claim that the stroke was caused or contributed to by dehydration and says that any such theory is baseless, not supported by the factual record and is based upon pure speculation. Indeed, Dr. Tuhrim also states that it is highly unlikely that dehydration was contributory because the patient received at least seven liters of intravenous fluids and was not dehydrated by the time she suffered the stroke at Mount Sinai on June 1, 2013. Ultimately, Dr. Tuhrim states that plaintiff cannot credibly, to a reasonable degree of medical certainty, state dehydration caused or even contributed to plaintiff's stroke on May 28, 2013 and that any such allegations are baseless and without any factual support. As such, this case must be dismissed in all respects.

In opposition, plaintiff argues that critical elements of what transpired at Harlem Hospital in the Emergency Department are unsettled by the record of plaintiff's visit, and remain in contention. For example, the question of whether a sufficient amount of fluid was administered

before discharging plaintiff is one that plaintiff argues must be decided by a jury since the amount of fluid plaintiff consumed was not recorded on plaintiff's chart. Plaintiff also recalls receiving less fluid at Harlem Hospital than she was required to obtain. Plaintiff states that the same inconsistency applies to the issue of her blood work: a jury must decide if blood was actually drawn from her since her hospital records are deficient. Plaintiff further argues that the performance of an examination of plaintiff's flank and an oral challenge test are critical items that cannot be resolved on account of defendants' assertions and plaintiff's medical record. Indeed, plaintiff highlights that Dr. Bruck only provided the information that he performed these acts at his deposition. Plaintiff also notes that the issue of whether the renal ultrasound was performed is not recorded in the hospital record. Plaintiff argues that if defendants failed to administer sufficient fluids, run blood tests, thoroughly examine plaintiff's flank, perform an oral challenge test, and/or perform a renal ultrasound, defendants may be found guilty of medical malpractice because of their deviations from accepted procedures. Since those issues cannot be resolved based on the record before the court, plaintiff contends that summary judgment cannot be granted.

Furthermore, plaintiff asserts that numerous departures from accepted standards of medical care set forth by plaintiff's medical expert create questions of fact that can only be determined upon a trial of this action, and preclude summary judgment. Plaintiff's expert opines that defendants deviated from accepted medical practice, and that those departures, which were accompanied by the plaintiff's noted chronic hypertension and her acute kidney disease, caused and permitted the plaintiff to suffer a stroke. For instance, plaintiff's expert states that defendants' failure to provide plaintiff with adequate fluid, caused plaintiff to suffer further dehydration and a more severe kidney injury, which caused plaintiff to suffer a stroke. Plaintiff goes on to contend that rather than stating unequivocally that dehydration could not have caused plaintiff's stroke,

defendants' experts merely contend that it is extremely unlikely that dehydration caused plaintiff's stroke. Ultimately, plaintiff argues that neither of defendants' experts explains the cause of plaintiff's stroke. Rather, the statements of both experts are filled with conclusory denials and are lacking explanations of any sort except that of coincidence. Conversely, plaintiff submits that plaintiff's expert explains how the defendants' failure to recognize the seriousness of plaintiff's dehydration by correctly interpreting the available laboratory data, in conjunction with her untreated hypertension, and her acute kidney injury, set the stage for her stroke to occur after several days of the continuance and the worsening of her condition. Plaintiff's expert further contends that tests for her kidney function done at Harlem Hospital demonstrated that her kidneys were not properly functioning, and three days later her kidney function was so decreased that she was at first thought to be a candidate for dialysis when she arrived at Mount Sinai. As such, plaintiff argues that it is axiomatic that defendants failed to properly recognize plaintiff's dehydration, and the potential stroke risk associated with it considering her medical history of hypertension and acute kidney injury. As such, plaintiff submits that judgment in defendants' favor is inappropriate based on the record before the court.

In reply, defendants challenge the credentials of plaintiff's expert, and further argue that his assertions are conclusory in nature and not supported by the medical records.

DISCUSSION

To prevail on summary judgment in a medical malpractice case, a physician must demonstrate that he did not depart from accepted standards of practice or that, even if he did, he did not proximately cause the patient's injury (*Roques v. Noble*, 73 AD3d 204, 206 [1st Dept. 2010]). In claiming treatment did not depart from accepted standards, the movant must provide an expert opinion that is detailed, specific and factual in nature (*see e.g.*, *Joyner-Pack v. Sykes*, 54

AD3d 727, 729 [2d Dept. 2008]). The opinion must be based on facts in the record or personally known to the expert (*Roques*, 73 AD3d at 195). The expert cannot make conclusions by assuming material facts which lack evidentiary support (*id.*). The defense expert's opinion should state "in what way" a patient's treatment was proper and explain the standard of care (*Ocasio-Gary v. Lawrence Hosp.*, 69 AD3d 403, 404 [1st Dept. 2010]). Further, it must "explain 'what defendant did and why'" (*id. quoting Wasserman v. Carella*, 307 AD2d 225, 226 [1st Dept. 2003]).

Once defendant makes a prima facie showing, the burden shifts to the plaintiff "to produce evidentiary proof in admissible form sufficient to establish the existence of material issues of fact which require a trial of the action" (*Alvarez v. Prospect Hosp.*, 68 NY2d 320, 324 [1986]). To meet that burden, a plaintiff must submit an expert affidavit attesting that defendant departed from accepted medical practice and that the departure proximately caused the injuries (*see Roques*, 73 AD3d at 207). "Summary judgment is not appropriate in a medical malpractice action where the parties adduce conflicting medical expert opinions" (*Elmes v. Yelon*, 140 A.D.3d 1009 [2nd Dept 2016] [citations and internal quotation marks omitted]). Instead, the conflicts must be resolved by the factfinder (*id.*).

Here, defendants set forth a prima facie case in favor of dismissal, as evidenced by the submission of defendants' medical records, and defendants' experts' affidavits, each of which attests to the good care of defendants within the requisite fields of expertise, and provides support for the contention that nothing each defendant did or did not do caused any injury to plaintiff. The affidavits are detailed and predicated upon ample evidence within the record. As defendants have made prima facie showing, the burden shifts to plaintiff.

To defeat summary judgment, plaintiff highlights several issues of fact that this court finds cannot be resolved as a matter of law. Plaintiff properly contends that issues of fact are raised by

the notion that her chart from Harlem Hospital is at odds with own testimony of what transpired while she was at the hospital. For instance, plaintiff states that contrary to her chart, no blood was drawn during her visit. Plaintiff further contends that her urination decreased following her visit to Harlem Hospital, thus evidencing her dehydration. Plaintiff also contends that a sonogram was not performed at Harlem Hospital, that she was throwing up and had diarrhea during her visit, and that she was only given three quarters of the IV fluid bag even though the order for fluids was for the entire bag to be given. Richardson corroborates several of these claims by stating that no blood was taken from plaintiff, no sonogram was performed on plaintiff, and that plaintiff was only given one half of the IV fluid bag.

Plaintiff further notes that Dr. Bruck's assertion that he performed an oral challenge test is contested by the fact that there is no record of that such a test on plaintiff's hospital chart. Given Dr. Brown's admission that a failure to administer an oral challenge test would be a departure from acceptable standards of care, plaintiff contends that this issue must be resolved by a jury. The court agrees.

Plaintiff's expert affirmation of Dr. Bernard Schayes, M.D., also raises triable issues of fact. Dr. Schayes states that defendants' failure to provide plaintiff with adequate fluid, caused plaintiff to suffer further dehydration and a more severe kidney injury, which in turn triggered plaintiff's stroke. He argues that, contrary to defendants' position, that defendants' failure to recognize the seriousness of plaintiff's dehydration by correctly interpreting the available laboratory data, in conjunction with her untreated hypertension and her acute kidney injury, set the stage for her stroke to occur after several days of the continuance and the worsening of her condition. Moreover, he disputes defendants' claims that plaintiff's kidneys were functioning properly. He also raises an issue as to whether defendant should have recognized the increased

risk of stroke that plaintiff faced considering her medical history of hypertension and acute kidney injury. Because defendant did not adequately address these issues, the expert states, defendants were negligent and, in addition, proximately caused plaintiff's injuries.

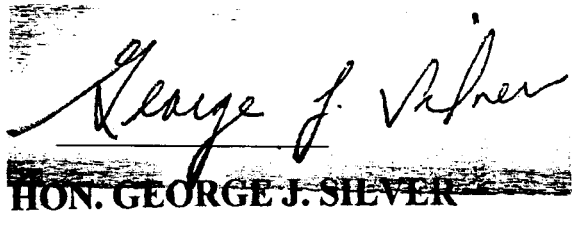
Defendants' challenges to Dr. Schayes' expertise have no merit. Although he does not work in an emergency department, Dr. Schayes established that he has the necessary experience to qualify as an expert (*see Walsh v. Brown*, 72 AD3d 806, 806 [2nd Dept. 2010]). His alleged lack of knowledge as to the intricacies of emergency department practice merely raises a credibility issue defendant can advance at trial. Similarly, defendants' comments that Dr. Schayes has a simplistic understanding of the medical issues at hand and that he does not grasp the nuances of plaintiff's situation are arguments regarding his credibility and are trial issues.

Accordingly, based on the foregoing, it is hereby ORDERED that defendants' motion for summary judgment is DENIED; and it is further

ORDERED that the parties are directed to appear for a pre-trial conference on Tuesday June 12, 2018 at 9:30 AM at 111 Centre Street, Room 1227, New York, NY 10013.

This constitutes the decision and order of the court.

March 23, 2018



HON. GEORGE J. SILVER