Gousgounis v Malkani
2018 NY Slip Op 30952(U)
May 15, 2018
Supreme Court, New York County
Docket Number: 805288/2013
Judge: George J. Silver

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

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ATHANASIOS GOUSGOUNIS and MARO GOUSGOUNIS,

Plaintiffs,

-against-

BRIJESH MALKANI, M.D., ALBERT FAVATE, M.D., LIA ERNST, M.D., NEKEE PANDYA, M.D., DANIEL WANG, MD., BELLEVUE HOSPITAL CENTER and NEW YORK CITY HEALTH AND HOSPITALS CORPORATION,

Defendants.

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Motion Seq. 003

DECISION & ORDER

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

In this medical malpractice action, defendants BRIJESH MALKANI, M.D., ALBERT FAVATE, M.D., LIA ERNST, M.D., NEKEE PANDYA, M.D., BELLEVUE HOSPITAL CENTER and NEW YORK CITY HEALTH AND HOSPITALS CORPORATION ("defendants") move for summary judgment. Plaintiffs ANTHANASIOS GOUSGOUNIS and MARO GOUSGOUNIS (collectively "plaintiffs") oppose the motion. For the reasons discussed below, the court denies the motion.

Plaintiff Athanasios Gousgounis (individually "plaintiff"), first began experiencing heart palpitations in 2001 when he was 58 years-old, and was diagnosed with paroxysmal atrial fibrillation ("PAF") shortly thereafter. From 2002 through 2004, plaintiff reportedly had three to four episodes of PAF each year, with the frequency of the episodes increasing in 2005. Plaintiff's cardiologist, located in Athens, Greece prescribed him with a beta blocker and an anti-arrhythmic medication, Inderal, which was later switched to propafenone. Plaintiff underwent successful pharmacological conversion of his PAF with propafenone and other anti-arrhythmic medication.

On August 6, 2009, plaintiff was admitted to General Hospital of Athens following an episode of atrial fibrillation with rapid ventricular response. While there, he was treated with three tablets of propafenone, after which his heart rate returned to a normal rhythm. On December 10, 2010, plaintiff consulted with Dr. Hasan Garan ("Dr. Garan"), a cardiac electrophysiologist, for an ablation procedure. At the time of his visit, plaintiff had palpitations, chest discomfort, decreased exercise tolerance, and hypertension. An echocardiogram revealed minimal septal hypertrophy and an enlarged left artery, and Dr. Garan noted that plaintiff experienced symptomatic PAF with relatively short, but frequent, episodes. He recommended treatment to control plaintiff's cardiac rhythm, including medication, and documented that plaintiff was a candidate for a cardiac catheter ablation to restore regular rhythm to his heart.

On January 12, 2011, plaintiff underwent a successful ablation procedure at New York-Presbyterian/Columbia Hospital. During plaintiff's post-ablation visit on February 15, 2011 at Dr. Garan's office, an echocardiogram revealed normal rhythm and left ventricular hypertrophy. Dr. Garan determined that plaintiff's $CHADS_2$ score[1] was one (1) since plaintiff was positive only for hypertension, and therefore, his risk of having a stroke from PAF was relatively low. Dr. Garan prescribed plaintiff 325 mg of aspirin to be taken daily.

On April 29, 2011, plaintiff was admitted to Onassis Cardiac Surgery Center in Greece after experiencing a new onset of atrial fibrillation with rapid ventricular response for twelve hours. He underwent pharmacologic cardioversion, which successfully converted him back to sinus rhythm. Plaintiff was discharged on Angoron (anti-arrhythmic), Sintron, and Clexane (enoxaparin/Heparin) injections. On June 2, 2011, plaintiff informed Dr. Garan of the recurrent

[1] $CHADS_2$ score is a clinical prediction tool used to calculate the risk of embolic stroke among people with atrial fibrillation.

atrial fibrillation on April 29, 2011 while in Greece, and stated that he had not had a reoccurrence, although he remained fatigued. Dr. Garan changed plaintiff's metoprolol medication to 25/50 mg to be taken twice daily, and recommended a second ablation procedure if there was a recurrence of the atrial fibrillation.

Plaintiff continued to report PAF episodes following his January 12, 2011 ablation procedure, including on May 8, 2012, two days prior to his initial stroke. That afternoon, plaintiff called Dr. Daniel Wang ("Dr. Wang"), the on-call cardiac electrophysiologist while Dr. Garan was out of town at a conference. Plaintiff informed Dr. Wang that he was having palpitations that had started that morning and was feeling fatigued. Plaintiff then asked if he should take a dose of propafenone to resolve the arrhythmia. Dr. Wang asked plaintiff if he had any symptoms other than palpitations and fatigue, and plaintiff responded that he did not. Dr. Wang agreed for plaintiff to take the propafenone, and instructed plaintiff to call back to report how he was feeling and to follow-up with Dr. Garan when he returned to the office. Plaintiff called back and reported that he was feeling better.

Two days later, on May 10, 2012, an ambulance brought plaintiff to Bellevue Hospital Center's Emergency Department as a stroke alert. According to EMS, plaintiff was found slumped over at the DMV, and exhibited slurred speech, left sided weakness, and limited movement of his left side. Plaintiff also had a left facial droop. At triage by the Emergency Department, plaintiff reported his cardiac history, and the neurology team was notified, including junior neurology resident, Dr. Lia Ernst ("Dr. Ernst"), senior neurology resident, Dr. Brijesh Malkani ("Dr. Malkani"), and the supervising stroke neurology attending, Dr. Albert Favate ("Dr. Favate"). Upon arrival, plaintiff was able to move his left upper and lower extremities with 4/5 strength and had a mild left-sided facial droop. A head CT scan performed at 2:10 P.M. indicated that plaintiff had

not suffered a brain bleed, but an MRI that followed revealed an infarction of plaintiff's right middle cerebral artery ("MCA"). Plaintiff was given 325 mg of aspirin. Plaintiff was subsequently examined by Dr. Stephen H. Menlove, an Emergency Department physician, who noted that plaintiff's symptoms were resolved.

Dr. Malkani evaluated plaintiff in the emergency room and described him as initially exhibiting limited movement of the left side (although he was also noted as being able to bring his left upper extremity over his head and left lower extremity toward his hamstring). Dr. Malkani further indicated that plaintiff demonstrated improved strength on the left when he gave his best effort, although on testing, he pronated his left upper extremity. Upon talking with plaintiff, Dr. Malkani did not observe a speech abnormality. Dr. Malkani also documented a questionable left facial droop and possible left-sided weakness. Dr. Malkani scored plaintiff as a "2" on the National Institute of Health Stroke Scale ("NIHSS") based on positive findings for left arm drift and left-sided neglect, which highlighted a minor stroke.

Following his stroke evaluation, Dr. Malkani discussed his findings and the results of plaintiff's radiological scans with Dr. Favate, who ultimately decided not to administer tPA due to plaintiff's low stroke scale score, improved left-sided motor function, and overall improvement since arriving at the Emergency Department. Dr. Favate testified that based on his discussion with Dr. Malkani, the risk/benefit ratio of using tPA was not in plaintiff's favor because six to nine percent of incidents lead to hemorrhage.

After Dr. Malkani's consultation with Dr. Favate, plaintiff was admitted to the medicine floor for monitoring and was given 25 mg of metoprolol. At 10:34 P.M., Dr. Ernst spoke to plaintiff's family, who informed her that plaintiff had palpitations 48 hours earlier, went into atrial fibrillation, and had taken an anti-arrhythmic medication to return to normal rhythm. Dr. Ernst

discussed this information with Dr. Favate, who recommended contacting plaintiff's electrophysiologist to find out why plaintiff was not given anticoagulation following his ablation procedure and whether plaintiff would have proper follow-up after anticoagulation was started.

Dr. Ernst contacted Dr. Wang, who confirmed that plaintiff did not take anticoagulants in the past year because his $CHADS_2$ score was 1. Dr. Ernst then calculated that plaintiff's $CHADS_2$ score was now 3 due to hypertension and his recent stroke. After speaking to Dr. Wang, Dr. Ernst consulted with Dr. Favate, who decided to anticoagulate plaintiff with a dose of Heparin as a bridge to Coumadin around 3:30 A.M. based on plaintiff's $CHADS_2$ score of 3. Dr. Favate testified that he knew at the time that Heparin would not resolve all of plaintiff's stroke symptoms, but it might prevent a future stroke from occurring.

During nursing rounds the following morning, on May 11, plaintiff was reportedly alert and oriented. At around 5:00 A.M., plaintiff complained of a severe headache, and a neurology team doctor who examined plaintiff said that the sharp pain behind plaintiff's eyeballs did not indicate a stroke and recommended Tylenol. At that time, plaintiff could lift his arms and legs on both sides. At around 7:00 A.M., plaintiff was still complaining of a severe headache and could not get out of bed to go to the bathroom alone. At around 8:30 A.M., plaintiff had nausea and vomiting. Upon evaluation, Dr. Favate and the neurology team found that plaintiff had left-sided paralysis, elevated blood pressure, and a low heart rate. Plaintiff was initially verbal and able to follow commands, but rapidly became unresponsive. A head CT scan performed at 9:31 A.M. revealed a hemorrhagic stroke of the right middle cerebral artery infarction.

Plaintiff was then evaluated by the neurosurgery team and admitted to the medical ICU for close monitoring and frequent neurology checks, with recommendations for no acute neurosurgical intervention and head CT scans every 4 to 6 hours. An MRI revealed a severe hemorrhage and that

plaintiff needed platelets. A head CT scan at 12:29 P.M. showed an increased size clot, and plaintiff thereafter became unresponsive. At around 4:00 P.M., plaintiff had a craniotomy by the neurosurgery team to evacuate a right intracranial clot. He remained hospitalized at Bellevue until May 25, 2012, at which time he was transferred to Columbia under the care of his treating electrophysiologist, Dr. Garan. Over the following months, plaintiff underwent post-stroke rehabilitation at Rusk Rehabilitation and Village Care Rehabilitation. He also underwent a stroke study and outpatient physical therapy at NYPH/Weill Cornell. He remains neurologically compromised with severe left-sided hemiplegia.

ARGUMENTS

Based on the record before the court, defendants argue that summary judgment must be granted, because plaintiffs 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. Mary Kalafut ("Dr. Kalafut"), a stroke neurologist. In her affirmation, Dr. Kalafut asserts that Bellevue's neurology team did not depart from the accepted medical standards, and that none of the alleged negligence by defendants proximately caused plaintiff's injuries. Specifically, Dr. Kalafut opines that the neurology team rendered a timely consultation, and that their decisions not to administer tPA nor an anticoagulant (Heparin) on May 10, 2012 were in accordance with appropriate standards of care and accepted medical guidelines.

According to Dr. Kalafut, Dr. Malkani properly employed the NIHSS, and accurately scored plaintiff based on his improvement in left-sided mobility. Dr. Kalafut notes that a NIHSS score may be used as a clinical stroke assessment tool to evaluate and document neurological status

in stroke patients, but is not required to be used when a practitioner diagnoses a stroke, and is not the only piece of data neurologists consider when determining whether to administer tPA. Dr. Kalafut explains that tPA, a lytic drug used to break up clots, can be used to treat an embolic or thrombotic stroke, however, the standard of care does not require administering tPA to a patient who has suffered a transient ischemic attack or whose symptoms are improving. Dr. Kalafut points out that the neurology team performed a complete neurologic exam, which showed improvement in plaintiff's condition, and that Dr. Malkani did not document any speech abnormality when he conversed with plaintiff during his evaluation. Dr. Kalafut also adds that plaintiff's facial droop during the assessment did not warrant a point on the scale and did not require treatment with tPA because it would not affect plaintiff's overall quality of life. In her opinion, it was reasonable for the neurology team to consider plaintiff's improvement in symptoms in conjunction with plaintiff's treatment plan.

Dr. Kalafut further asserts that the neurology team appropriately assigned plaintiff a $CHADS_2$ score of 3 based on his history of hypertension and a recent stroke, which placed him at a higher risk of recurrent stroke. Dr. Kalafut also states that the team's decision to anticoagulate plaintiff with Heparin-bridge to Coumadin was appropriate due to his history of atrial fibrillation and a small initial infarct seen on the MRI. In that regard, Dr. Kalafut agrees with Dr. Favate's opinion that at the time, Heparin would not resolve plaintiff's stroke symptoms, but it might prevent a future stroke from occurring. Dr. Kalafut also agrees with the team's assessment that Coumadin was an appropriate long-term therapy in anticipation of plaintiff's discharge home. Dr. Kalafut explains that, in general, patients with atrial fibrillation have a higher risk of embolic stroke and refers to the American Heart Association's reasons for immediate use of anticoagulants to prevent early recurrent embolic stroke, as long as there is no contraindication to do so.

Accordingly, Dr. Kalafut states that there was no such indication in this situation because the MRI film on May 10, 2012 showed a small infarct, and based on the American Heart Association guidelines, clinical judgment should prevail in the treatment decision. She emphasizes that anticoagulants reduce the risk of recurrent stroke, and although anticoagulants have a risk of bleeding, the risk of a recurrent stroke outweighs the risk of bleeding in patients with atrial fibrillation. In her opinion, "the subsequent hemorrhage was not the proximate cause of the failure to administer tPA given the inherent bleeding risk associated with tPA," and concludes that the neurology team timely diagnosed and treated plaintiff's hemorrhagic stroke.

Additionally, Dr. Kalafut asserts that there are no issues of fact as to the treatment rendered by Bellevue's neurology residents because they acted under the direction and supervision of the attending physician, Dr. Favate, who made the ultimate decision to not administer tPA as well as the decision to anticoagulate plaintiff. Dr. Kalafut also states that plaintiff's information, including his medical history, was properly documented in the hospital chart. She further adds that plaintiff's allegations that Bellevue failed to promulgate rules and regulations and adhere to approved standards with respect to plaintiff's care are vague and nonspecific.

In opposition, plaintiffs argue that departures from accepted standards of medical care set forth by plaintiffs' medical expert create questions of fact that can only be determined at trial, and preclude summary judgment. According to plaintiffs, there is a question of fact as to whether the NIHSS stroke test was administered properly, and that defendants' expert, Dr. Kalafut based her opinion on the assumption that Dr. Malkani properly performed the test. Specifically, plaintiffs' expert states that a complete documentation of each facet of the NIHSS test was not in plaintiff's chart, and that there was no mention of cognitive status, visual fields, sensory examination or coordination on the initial admission note. Plaintiffs' expert avers that plaintiff would have had a

higher NIHSS score if the formal cognitive testing portion had been performed because when Dr. Nekee Pandya examined plaintiff the following day on May 11, 2012, plaintiff was confused and could not recognize that he was in the hospital or remember that he had an MRI the night before. Additionally, plaintiffs' expert notes that defendants did not record a visual field testing and sensory examination as part of the NIHSS, and that abnormalities would have been expected since plaintiff demonstrated extinction of the left side. Plaintiffs' expert also states that Dr. Malkani did not record speech abnormality on plaintiff's chart, and that good and accepted medical practice in neurology requires documentation of each NIHSS facet. Plaintiffs' expert also points out that Dr. Malkani did not include a left facial droop in the NIHSS score, and did not mention whether plaintiff's drift of the left leg was tested according to the NIHSS or whether plaintiff could lift his leg off the bed against gravity. According to plaintiffs' expert, if the evaluation was conducted properly, plaintiff's score would have most likely been higher than 2, and it would have been appropriate to administer tPA. As such, this departure from the standard of care was a substantial factor in causing plaintiff's injuries.

Plaintiffs' expert also asserts that Dr. Malkani's failure to perform an adequate neurological assessment was a departure from the standard of care, which led to the incorrect conclusion that plaintiff's stroke symptoms were improving. Contrary to defendants' belief that plaintiff was improving because he was able to move his left arm, plaintiffs' expert opines that plaintiff was not actually improving, but rather, he was able to lift his left arm when his left-sided neglect was overcome by the examiner prodding him. According to plaintiffs' expert, plaintiff's ability to move his left arm was because his deficit was mainly sensory from the parietal lobe stroke, and the primary motor function from the frontal lobe was actually intact. Plaintiffs' expert avers that an adequate neurological examination would have detected that the improvement of plaintiff's left

arm use was not an actual improvement of plaintiff's stroke symptoms, and this departure from the standard of care prevented plaintiff from receiving appropriate tPA treatment. Plaintiffs' expert states that this was an additional departure from the standard of care.

Plaintiffs' expert further asserts that treatment with Heparin within the first 12 hours after an embolic stroke from atrial fibrillation was a departure from the standard of care because it caused plaintiff's "hemorrhage into the area of infarction that required neurosurgical intervention." According to plaintiffs' expert, the 2012 relevant guidelines for stroke care indicate that in patients with embolic stroke from atrial fibrillation, immediate anticoagulation is contraindicated because of a high risk of hemorrhagic conversion that can lead to deterioration and death. Plaintiffs' expert emphasizes that acute administration of Heparin in this setting is contrary to established guidelines for stroke management because of the high risk of hemorrhage within the first 48 hours. Accordingly, plaintiffs' expert opines that the standard of care requires that anticoagulation be delayed for at least 48 hours so that the risk of hemorrhagic conversion dissipates, and that the decision to anticoagulate plaintiff within 12 hours of the stroke was not an issue of physician judgment.

In reply, defendants contend that plaintiffs' expert speculates, without proof, that plaintiff had more deficits than those documented by Dr. Malkani, and that plaintiffs do not state that those deficits would have sufficiently raised plaintiff's final NIHSS score to require tPA. Defendants also claim that plaintiffs' expert's opinion is insufficient to establish a proximate causal link between the decision not to administer tPA and the subsequent hemorrhage, and that the expert failed to establish that the decision to anticoagulate plaintiff constituted a departure from the standard of care.

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 207). 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 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, 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' expert's affidavit, 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. Dr. Kalafut's affidavit in particular is detailed and predicated upon ample evidence within the record. As defendants have made *prima facie* showing, the burden shifts to plaintiffs.

To defeat summary judgment, plaintiffs highlight several issues of fact that cannot be resolved as a matter of law. Plaintiffs properly contend that issues of fact exist as to whether Dr. Malkani properly administered the NIHSS stroke test, on which defendants' expert bases her opinion. For instance, contrary to Dr. Malkani's testimony that he performed the full NIHSS test using an app on his phone, plaintiffs argue that defendants did not perform a complete neurological assessment involving all NIHSS factors because there was no documentation of cognitive status, visual fields, sensory examination or coordination on plaintiff's chart. Plaintiffs also dispute over Dr. Malkani's evaluation of plaintiff's speech difficulties and left facial droop, and whether Dr. Malkani's assessment of those factors warranted points on the NIHSS scale. Plaintiffs argue that if Dr. Malkani's evaluation was done properly, plaintiff's score would most likely have been higher than 2, and it would have been appropriate to administer tPA. However, defendants argue that Dr. Malkani was able to converse with plaintiff, and that the testimony of plaintiff's family demonstrates that he recounted to them what had happened. Based on the disputed facts surrounding plaintiff's initial evaluation by Dr. Malkani, the factors considered in plaintiff's NIHSS score, and both experts' divergent opinions regarding the NIHSS score in determining whether to administer tPA, the court finds that issues of fact exist sufficient to preclude summary judgment.

Plaintiffs and defendants also dispute whether plaintiff showed improvement after arriving at the Emergency Department. Specifically, plaintiffs aver that plaintiff's symptoms were not

improving based on Dr. Pandya's note that plaintiff had confusion on May 11, 2012, and that plaintiff was only able to lift his left arm when prodded. Defendants, however, argue that plaintiffs' expert fails to cite any relevant documentary proof that plaintiff's symptoms had not improved since initially arriving to the Emergency Department. In particular, defendants state that Dr. Pandya's finding was made nearly 15 hours after Dr. Malkani's initial assessment in the Emergency Department, and that the testimony of Dr. Favate, Dr. Ernst, and Dr. Malkani contradicts the assertion that Dr. Malkani prompted or coaxed plaintiff to move his left arm. Because these facts challenge Dr. Favate's testimony that he decided against using tPA based on plaintiff's observed improvements, this issue must be resolved by a jury.

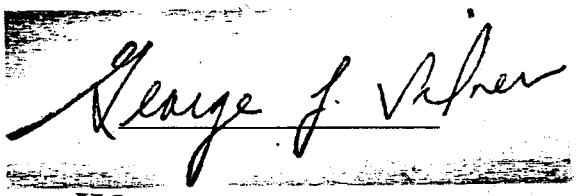
Plaintiffs' expert affirmation also raises triable issues of fact. Plaintiffs' expert assertion that treatment with Heparin for anticoagulation was a departure from the standard of care is contested by defendants' argument that anticoagulation was advisable based on plaintiff's history of atrial fibrillation, his recent stroke, and $CHADS_2$ score of 3. Plaintiffs' expert, however, asserts that treatment with Heparin within the first 12 hours after an embolic stroke from atrial fibrillation caused plaintiff's hemorrhage. Plaintiffs' expert also refutes that the $CHADS_2$ score is used to assess the need for long-term anticoagulation for the future risk of stroke from atrial fibrillation. Since these issues cannot be resolved based on the record before the court, plaintiffs contend that summary judgment cannot be granted. The court agrees.

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 to appear for a conference on June 19, 2018 at 9:30 A.M. in Part 10, Room 1227 at 111 Centre Street, New York, New York 10013.

This constitutes the decision and order of the court.

May 15, 2018



HON. GEORGE J. SILVER