Dodenc v Dodenc
2018 NY Slip Op 32229(U)
August 20, 2018
Supreme Court, Kings County
Docket Number: 511464/15
Judge: Ellen M. Spodek
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PRESENT:
HON. ELLEN M. SPODEK, Justice

At an IAS Term, Part 63 of the Supreme Court of the State of New York, held in and for the County of Kings, at the Courthouse, at Civic Center, Brooklyn, New York on the 2nd day of August 2018.

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ALEKSANDRA DODENC and JAMES DODENC,

Plaintiffs,

DECISION AND ORDER
Index No. 511464/15

-against-

VASA DODENC, ELIZABETH DODENC, WYCKOFF HEIGHTS HOSPITAL and MUHAMMED EL-DAKKAK,

Defendants.

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KINGS COUNTY CLERK FILED 2018 SEP 10 AM 9:20

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Defendants WYCKOFF HEIGHTS HOSPITAL and MUHAMMED EL-DAKKAK move pursuant to CPLR 3212 for an order granting summary judgment and dismissing the complaint against them. Plaintiff opposes the motions.

On December 14, 2014, plaintiff Aleksandra Dodenc, a 26-year old female, fell down the stairs at home landing on her leg. She was taken by ambulance to the emergency room at defendant Wykoff Heights Medical Center. Upon arrival at the hospital, an X-ray was taken. The X-ray revealed a displaced distal tibial fracture and comminuted displaced mid fibular fracture. The plan was for a closed reduction of the fracture and pain management.

On December 16, 2014, the Defendant, Dr. El-Dakkak, performed the closed reduction. While performing the procedure, defendant observed that "AP and lateral satisfactory, hence

more safe than open induction internal fixation. There was no room for internal fixation with some abrasion also." There were no complications to the surgery. The plaintiff was taken to the recovery room in satisfactory condition and was ultimately discharged home on December 17, 2014 with instruction to follow up at the orthopedic clinic and her primary care physician in one week.

At the time of her follow-up visit at the orthopedic clinic on December 22, 2014, plaintiff could wiggle her toes freely and had good capillary refill. Her cast was in place and she was in minimal pain. Defendant prescribed Vicodin for her.

Plaintiff next went to see her primary care physician, Myat San, on January 9, 2015. She reported to Dr. San that she had run out of painkillers and requested a refill until she next saw defendant Dr. El-Dakkak. Dr. San noted that she was overweight and, prescribed another 30 pills of Vicodin, and instructed her on weight loss.

On January 12, 2015, plaintiff returned to see defendant Dr. El-Dakkak. She complained of minimal pain and reported that the Vicodin helped relieve her pain. Plaintiff could still wiggle her toes, and there were no neurovascular defects on exam. The defendant prescribed another 20 pills of Vicodin, to be taken as needed one tablet at a time with no refills and instructed plaintiff to return in three weeks. However, Plaintiff did not return to the defendant. She testified that between the time of discharge from Wyckoff Heights Medical Center and her last visit with the defendant, she had fallen twice. The first time she fell was when she was trying to get out of the car and slipped on the ice and fell backwards. The second fall happened while she was trying to get out of the shower. As a result of the fall, the cast was wet. Plaintiff testified at her deposition that she was instructed on how to take care of her cast. Most notably, she was told

to keep the cast dry. Plaintiff testified that during one of her visits with the defendant she told him that the cast felt loose, to which the defendant responded by replacing the bottom of the cast because of damage.

On January 31, 2015, plaintiff saw her Primary Care Physician Dr. San. She reported to Dr. San that she was taking Vicodin two pills at a time, despite instructions to only take one tablet, and she had run out of her pain medication quickly. Dr. San instructed the plaintiff to exercise more and prescribed an additional 60 pills of Vicodin.

On February 19, 2015, plaintiff presented to a new orthopedist, Dr. Joseph Stubel. Dr. Stubel wrote that the plaintiff came to see him because "she was in a cast and had to take it off because [her] leg was swollen." At her deposition, plaintiff testified that her cast had in fact slipped off on its own after losing approximately 50 pounds. According to Dr. Stubel's note, plaintiff's weight at the time of the February 19, 2015 visit was 195 pounds – up from 175 during her visit on January 31 with Dr. San. Dr. Stubel continued that plaintiff was walking with one crutch, and thus, all her weight was on one leg. Her prescription history listed only Xanax and had no mention of painkillers. An X-ray taken in the office revealed a nondisplaced tibial distal fracture in good alignment, with early callus formation. He recommended using a Cam walker and to follow up in two weeks.

One week later, plaintiff returned to Dr. Stubel. She was not using a Cam walker. When the plaintiff went to DocCare on March 3, 2015, she reported falling in the snow two days earlier and hurting her leg. Dr. John Shimkus, an orthopedist who treated her on this date, indicated that she "tore her appliance and aggravated a pre-existing fracture." He noted it was hard to tell whether union was complete or if the fracture was new, so a CT was ordered. Dr. Shimkus

indicated that she would be getting a new appliance the next day and prescribed Percocet until her next visit with Dr. Stubel. Plaintiff refused a splint.

At the time of her next visit, on March 9, 2015, plaintiff had pretibial pain following her fall. Dr. Stubel again prescribed Percocet. She still had not had her CT scan at the time of this visit. On March 14, 2015, plaintiff returned to her PCP, Dr. San. She told Dr. San that her father had passed away the night before, and she needed to go to Europe that day. She also reported that her fracture was not healing well, and she needed to undergo surgery. Plaintiff asked Dr. San for a medication refill, and accordingly, Dr. San prescribed 90 pills of Percocet.

Despite the fact the plaintiff had told Dr. San that she needed to go to Europe on March 14, she returned to Dr. Stubel on March 16, 2015. At that time, she was walking without any external support and told Dr. Stubel that she was going to Europe. Dr. Stubel recommended that she use a Cam walker while in Europe and wrote that he would prescribe painkillers upon her return.

On March 23, 2015, plaintiff presented to an orthopedist named Edward Yang at Mount Sinai hospital. Dr. Yang wrote that plaintiff had had a closed reduction under anesthesia at defendant Wyckoff Heights Hospital, but over the two months and two weeks that she was wearing the cast, she had lost 50 pounds and removed the cast herself. Her weight was listed as 191 pounds during this visit, while it had been listed at 175 pounds at Dr. San's visits and 195 pounds when she first presented to Dr. Stubel, and she had denied weight loss. An X-ray taken in the office at this visit revealed that the fracture had partially healed. Dr. Yang recommended a Cam walker and physical therapy, and to take Tylenol or Motrin as needed. She was to return in

one month and was given a referral to physical therapy. She did not have a follow-up visit with Dr. Yang.

Plaintiff testified that in the few weeks between visits with Dr. Stubel, she fell again. Plaintiff tripped and fell on her knee while walking on the sidewalk. As a result, the boot was ruined.

The CT scan was performed on March 28, 2015 and revealed comminuted displaced fractures of both the distal tibial shaft and the mid fibular shaft with evidence of cortical changes of healing of the malalligned fragments consistent with malunion/nonunion. The report was not ready at the time of plaintiff's next visit with Dr. Stubel on March 30, 2015, however, and Dr. Stubel commented that the CT film showed that callus formation – which had begun before plaintiff's March fall – was not yet complete. The plan was to follow up in two weeks.

Plaintiff admitted at her deposition that she had told doctors she was experiencing pain when in fact she was not in pain, in order to get more pain medication. Additionally, she told Dr. Shimkus that she wanted to switch from Percocet to Vicodin because the Percocet was not helping her with her pain. In reality, plaintiff admits that she really wanted the different pain medication because she had run out of painkillers.

When plaintiff returned for her previously scheduled visit with Dr. Stubel on April 13, 2015, swelling was no longer present, but healing was not yet complete. Dr. Stubel recommended a bone growth stimulator and referred her to the Hospital for Special Surgery ("HSS") to discuss surgical options.

Plaintiff traveled to Serbia from April 15, 2015 to April 22, 2015 to attend her father's funeral. While in Serbia, Plaintiff fell purportedly once more because the floors were uneven.

On April 30, 2015, plaintiff presented to her PCP, Dr. San, complaining of back pain in addition to left ankle pain. She requested more pain medication because she was not scheduled to see her orthopedist for another week. Again, Dr. San commented that plaintiff was obese, and had gained a lot of weight in the previous two months. As with her prior visits, she was counseled on diet, exercise, and lifestyle change. Dr. San prescribed both Motrin and Vicodin on this visit.

On May 4, 2015, plaintiff returned to Dr. Stubel, again complaining of back pain in addition to leg pain. On this visit, an X-ray revealed slowly progressive union with some mild angulation. Dr. Stubel instructed her to follow-up in four weeks and commented that she was to see a specialist at HSS in the coming days. Plaintiff testified at her deposition, however, that she did not see anyone at HSS until 2017.

On May 18, 2015, plaintiff presented to Dr. Stubel with left leg numbness, pain, shakiness, and cramping. She had an appointment scheduled at HSS in two weeks. Dr. Stubel replaced the plaintiff's Percocet with Vicodin on this visit. On exam, Dr. Stubel noted mild pain and tenderness over the fracture site. He instructed the plaintiff to stay off her leg, noting that she had now obtained a bone growth stimulator.

When plaintiff returned to Dr. Stubel on June 4, 2015, she reported that a specialist was going to perform surgery in August, and in the meantime, she would be going to Europe with her mother. Her exam was unchanged, and Dr. Stubel renewed her Vicodin.

Before her next visit with Dr. Stubel, plaintiff presented to Dr. Robert Zeits, an orthopedist at Beth Israel Medical Center on June 11, 2015. An X-ray that he took revealed distal one-third tibial shaft fracture with malunion and fibula mid-shaft fracture, also with non-union. Dr. Zeits order a CT scan to assess fracture healing and advised the plaintiff that she may require an open

reduction and indicated that he would contact her with the results and a further plan. She did not return to see Dr. Zeits.

When plaintiff returned to Dr. San on June 20, 2105, she was now taking Ibuprofen 600 mg for her pain, and Dr. San renewed the prescription. Nine days later, however, Dr. Stubel wrote that plaintiff was to continue taking Vicodin. Then on July 1, 2015, she complained to Dr. San that Ibuprofen 600 mg was not working, and Dr. San wrote a prescription for 60 pills of Percocet, while also listing an allergy to Percocet. On July 11, 2015, Dr. San prescribed another 90 pills of Percocet.

On July 21, 2015, Dr. Shimkus at DocCare saw plaintiff to correct a prescription given by Dr. Stubel (for Percocet 7.5 mg) the day prior. Dr. Shimkus prescribed 40 tablets of Percocet 5 mg and instructed her to return in 10 days to see Dr. Stubel for more pills. He received a call later that day, however, from the pharmacist, reporting that the plaintiff had altered the prescription to 90 mills. Dr. Shimkus voided the prescription and wrote that he no longer had a need to see her.

Following this incident, Dr. San referred plaintiff to pain management to try to control her pain without the narcotics prescribed by himself and Dr. Stubel. After this time and continuing at least through the final day of her deposition, plaintiff alternatively managed her pain with Suboxone or painkillers. She only returned to Dr. Stubel once more, in June of 2016, instead treating with pain management and Dr. San. She also consulted further orthopedists regarding her continuing ankle pain, but as of the time of her completed deposition, she had not yet had any further surgery.

On a motion for summary judgment dismissing a medical malpractice cause of action, a defendant has the prima facie burden of establishing that there was no departure from good and accepted medical practice, or, if there was a departure, the departure was not the proximate cause of the alleged injuries. *Brinkley v. Nassau Health Care Corp.,* 120 A.D.3d 1287 (2d Dept. 2014); *Stukas v. Streiter,* 83 AD 3d. Once the defendant has made such a showing, the burden shifts to the plaintiff to submit evidentiary facts or materials to rebut the prima facie showing made by the defendant, so as to demonstrate the existence of a triable issue of fact. *Alvarez v. Prospect Hosp.,* 68 NY2d 320, 324 (1986); *Brinkley v. Nassau Health Care Corp.,* supra; *Fritz v. Burman* 107 A.D.3d 936, 940 (2d Dept. 2013); *Lingfei Sun v. Cirt of New York*, 99 A.D.3d 673,675 (2d Dept. 2013); *Bezerman v. Baline,* 95 A.D. 3d 1153, 154 (2d Dept. 2013); *Stukas v. Streiter,* at 24. A plaintiff succeeds in a medical malpractice action by showing that a defendant deviated from accepted standards of medical practice and that this deviation proximately caused plaintiff's injury. *Contreras v. Adeyemi,* 103 AD3d 720, 721 (2d Dept. 2013); *Gillespie v. New York Hosp. Queens*, 96 A.D.3d 901, 902 (2d Dept. 2012); *Seml v. Guzman,* 84 AD3 d 1054, 1055-56 (2d Dept. 2011). The plaintiff opposing a defendant physician's motion for summary judgment must only submit evidentiary facts or materials to rebut the defendant's prima facie showing. *Stukas,* at 24.

Defendants submitted the affidavit of Dr. Jeffrey Dermkasian, a board-certified orthopedic surgeon, licensed in New York in support of their motion. Dr. Dermkasian, stated that there was no departure from the standard of care because "following a fracture such as the one at issue it is within the standard of care to treat a patient conservatively and perform a closed reduction if a patient has a tibia shortening of no greater than one centimeter, and there is at least 50% contact with the in the bayonetting of the fracture (overlap of the fractured

portions of the bones)." Def. Motion, Exh. A, para. 23. "Further, an abrasion at the site of the fracture is a reason not to perform an open reduction. Open reductions, which involve cutting through the skin, are knowing to have a higher infection rate than closed reductions, which does not involve cutting through the skin." Def. Motion, Exh. A, para. 24. Finally, Dr. Dermkasian stated that "plaintiff's own actions contributed to any potential injuries. The records indicate that she took off her own cast prior to February 19, 2015. She was also walking with only one crutch at the time. She then delayed getting a Cam Walker, despite being told to get one one on March 3, 2015." Def. Motion, Exh. A, para. 27.

After a review of the papers, the court finds that the defendants have sustained their burden of showing that they did not depart from good and accepted medical standards. The fracture was shown to be healing well on an x-ray subsequent to the last treatment with Dr. El-Dakkak. The burden then shifted to the plaintiff to provide evidence to the court that the defendants departed from good and accepted standards of medical care, raising a triable issue of fact. The court finds that plaintiff has not sustained her burden as to the Hospital and Dr. El-Dakkak. The law in New York states that "the standard to which a physician is held in gauging the acceptability of her performance is whether he or she exercised his or her best judgment and reasonable care. A doctor is not a guarantor of correct diagnosis or successful treatment, nor is a doctor liable for a mere error in judgment if he or she has considered his patient's best interest after careful evaluation." Bernard v. Block, 176 A.D.2d 843, 847 (2nd Dept. 1991). The admissible evidence demonstrates that at the time of the closed reduction, it was within the standard of care to treat the patient conservatively and perform a closed reduction. Further, there was no indication to perform an open reduction when Dr. El-Dakkak saw plaintiff after the initial closed

reduction, and it was plaintiff's own actions, including taking off her cast and walking with one crutch, which may have led to her subsequent falls and failing to follow doctor's orders, and to her current complaints.

The motions by defendants Wyckoff Heights Hospital and Dr. El-Dakkak are granted in their entirety, and plaintiff's complaint is severed and dismissed as to Wyckoff Heights Hospital and Dr. El-Dakkak, and the Clerk of the Court is directed to enter Judgment accordingly.

This constitutes the opinion, decision and order of the court.

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