Chowdhury v Bellevue Hosp. Ctr.
2019 NY Slip Op 33527(U)
November 22, 2019
Supreme Court, New York County
Docket Number: 805470/2016
Judge: George J. Silver
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Index №. 805470/2016

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

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AMIRUL CHOWDHURY AND SULTANA BEGUM **Index №. 805470/2016**

Plaintiffs

-against-

BELLEVUE HOSPITAL CENTER and NEW YORK CITY HEALTH + HOSPITALS CORPORATION,

Defendants

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HON. GEORGE J. SILVER:

In this medical malpractice action, defendant NEW YORK CITY HEALTH AND HOSPITALS CORPORATION ("defendant") moves, pursuant to CPLR §3212, for summary judgment and an order dismissing the complaint of plaintiff AMIRUL CHOWDHURY ("plaintiff") as against it. Plaintiff opposes defendant's application.

BACKGROUND AND ARGUMENTS

The crux of plaintiff's claim in this lawsuit is that the medical staff at Bellevue Medical Center ("Bellevue"), one of defendant's facilities, failed to timely administer tPA, a thrombolytic protein involved in the breakdown of blood clots, while plaintiff was a patient in the emergency department on October 1, 2015, when he presented with symptoms of a stroke. To be sure, on October 1, 2015, at approximately 1:00 a.m., plaintiff presented to Bellevue's emergency department with stroke-like symptoms, with a reported onset of 12:00 a.m. A head CT scan, performed within fifteen (15) minutes of arrival, ruled out a brain bleed. At 1:25 a.m., less than an hour and a half after the initial onset of symptoms, hospital staff determined that plaintiff was a candidate for tPA, and, over the course of the next hour, advised him of the benefits, risks, and alternatives of treatment.

The medical records reveal that Bellevue staff subsequently explained to plaintiff that tPA is a thrombolytic that can reduce the neurological deficits caused by a stroke, but only under specific circumstances. At the time of the alleged malpractice, defendant contends that it was accepted within the medical community that tPA could only be used within 4.5 hours from the onset of stroke symptoms. Indeed, defendant argues that tPA is contraindicated where the patient has had hemorrhaging or is at risk of bleeding. Further, the use of tPA, even when indicated, carries serious risks, including internal bleeding and death.

Following an informed consent discussion, plaintiff contends that plaintiff consented to the administration of tPA. Defendant challenges plaintiff's position, arguing that plaintiff orally declined the

administration of tPA. Defendant further states that plaintiff argain declined tPA after an MRI, again within the 4.5-hour window.

Based on the foregoing, defendant argues that there is nothing within the record to indicate that defendant, or any staff at Bellevue, committed malpractice by failing to administer tPA to plaintiff. In support of its position that plaintiff's claims are not supported by the evidence, defendant cites to deposition testimony as well as the expert affirmation of board-certified neurologist Stanley Tuhrim, MD ("Dr. Tuhrim") , who opines that the care and treatment rendered by defendant was at all times in accordance with good and accepted medical practice and that nothing that defendant or its staff did, or did not do, was the proximate cause of plaintiff's alleged injuries.

Specifically, Dr. Tuhrim explains that to be a candidate for tPA, several criteria must be met, as there are absolute contraindications to its use. Dr. Tuhrim states that in 2015, the window for the administration of tPA was accepted to be 4.5 hours from the onset of symptoms or the last known time when the patient was symptom-free. For this reason, in 2015, Dr. Tuhrim opines that it was accepted in the medical community that tPA could be administered, assuming no other contraindications were present, up to 4.5 hours of the onset of symptoms.

Dr. Tuhrim states that as soon as the Bellevue staff determined that a stroke, and more specifically an ischemic stroke involving the narrowing of the arteries of the brain, may have been the cause of plaintiff's symptoms, the standard of care was to perform an immediate CT scan to rule out an intracranial hemorrhage, which is a contraindication to tPA due to the risk of increased bleeding.

Dr. Tuhrim further explains that the well-known risks of tPA include, intracerebral hemorrhage, worsening of neurological deficits, and, in some cases, death. To be sure, Dr. Tuhrim opines that the risks may outweigh the possible gains from treatment with tPA for patients with only minimal presenting symptoms. In this case, Dr. Tuhrim highlights that plaintiff was taken for a CT scan within fifteen (15) minutes of his presentation to Bellevue. The CT scan was completed by 1:25 a.m., less than thirty (30) minutes from his presentation to the emergency department. The findings were discussed between Doria Gold, MD ("Dr. Gold") and the radiologist while the study was being performed. Upon plaintiff's return from the CT scan, he was noted to have increased symptoms. At that point, Dr. Tuhrim explains that the record shows that plaintiff was appropriately found to be a candidate for tPA, as the contraindications had been ruled out.

Thereafter, Dr. Tuhrim posits that the record showed that the risks, benefits, and alternatives of tPA were discussed with plaintiff. Dr. Tuhrim states, in his medical opinion, that the timing of offering tPA –that is, immediately following the CT scan –was entirely within the standard of care. Despite the fact that plaintiff was offered tPA as soon as treatment was found to be indicated, and well within the 4.5 hour window, Dr. Tuhrim points to indications within that record that plaintiff did not consent to its administration. As such, Dr. Tuhrim concludes that the Bellevue chart unequivocally shows that plaintiff was repeatedly offered tPA, and that the treatment was not given only because plaintiff did not consent. As such, defendant argues that the proof annexed to its motion establishes that plaintiff was timely offered tPA, but that the medication was

not administered solely because plaintiff did not consent. As such, defendant states that plaintiff's central claim of negligence is unsupported by the record, thereby warranting dismissal of plaintiff's lawsuit.

In opposition, plaintiff contends that defendant's characterization of the hospital records is inaccurate. According to plaintiff, a note by one of defendant's resident physicians indicating that plaintiff did not consent to the administration of tPA is contradicted by plaintiff's sworn deposition testimony that he did consent to the administration of tPA following his discussion with defendant's resident physician. Moreover, plaintiff annexes the expert affirmation of an emergency room physician who opines, based on a review of the medical records and plaintiff's relevant testimony, that plaintiff consented to the administration of tPA, and that defendant and its staff deviated from accepted standards of medical care by failing to treat plaintiff's stroke symptoms with tPA.

Plaintiff's expert further states that as a result of the failure to administer tPA, plaintiff's stroke symptoms were permitted to progress, causing him permanent neurological damage in the form of memory loss and right-sided weakness. Defendant's failure, plaintiff argues, deprived plaintiff of a chance and opportunity to minimize the long-term side effects of his stroke. In plaintiff's view, from the time plaintiff's symptoms began at 12:15 A.M., the window to administer tPA was open until 4:45 A.M. Plaintiff's expert disagrees with the conclusions of Dr. Tuhrim, and opines that defendant failed to take advantage of this window even though plaintiff was almost immediately a proper candidate for the administration of tPA. Plaintiff states that defendant's physicians only conversation with plaintiff concerning the administration of tPA occurred after the CT-scan, as the window of time for effective administration was closing. Accordingly, plaintiff concludes that issues of fact exist to preclude a finding of summary judgment in defendant's favor.

In reply, defendant challenge plaintiff's expert affirmation and the conclusions drawn therefrom. To be sure, defendant contends that plaintiff's expert's affirmation is redacted and contains several speculative statements that do not take into consideration the entirety of the record, and plaintiff's purported failure to give consent to the administration of tPA. Defendant's further challenge plaintiff's testimony indicating that plaintiff consented to the administration of tPA by arguing that such testimony is self-serving and specifically tailored to avoid the consequences of judgment in defendant's favor. For these reasons and more, defendant restates its position that it is entitled to judgment in its favor.

DISCUSSION

In an action premised upon medical malpractice, a defendant doctor or hospital establishes prima facie entitlement to summary judgment when he or 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 (*Roques v. Noble*, 73 AD3d 204, 206 [1st Dept 2010]; *Thurston v Interfaith Med. Ctr.*, 66 AD3d 999, 1001 [2d Dept. 2009]; *Myers v Ferrara*, 56 AD3d 78, 83 [2d Dept. 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]). In claiming that 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 Dept2008]). The opinion must be based on facts within the record or personally known to the expert (*Roques*, 73 AD3d at 207, *supra*). Indeed, 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 [1959]; *Gomez v New York City Hous. Auth.*, 217 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 [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 do not establish prima facie entitlement to summary judgment as a matter of law (*Cregan*, 65 AD3d at 108, *supra*; *Wasserman*, 307 AD2d at 226, *supra*). To be sure, 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 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 [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]). 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, *supra*; *Myers,* 56 AD3d at 84, *supra*; *Rebozo*, 41 AD3d at 458, *supra*).

Here, defendant's submission of deposition transcripts, medical records and Dr. Tuhrim's affirmation, based upon the same, established a prima facie defense entitling defendant to summary judgment (*Balzola v Giese*, 107 AD3d 587 [1st Dept 2013]). To be sure, Dr. Tuhrim opines that the care and treatment rendered by defendant was in accordance with good and accepted medical practice and that nothing that defendant or its staff did, or did not do, was the proximate cause of plaintiff's alleged injuries. Specifically, Dr. Tuhrim opines that at the time of the alleged malpractice, it was accepted within the medical community that tPA could only be used within 4.5 hours from the onset of stroke symptoms. Dr. Tuhrim further highlights, based on notations within the record, that tPA was contraindicated during the time when plaintiff was still hemorrhaging or at risk of bleeding. Further, the use of tPA, even when indicated, carries serious risks, including internal bleeding and death. Accordingly, Dr. Tuhrim opines that it was appropriate for defendant to perform an immediate CT scan to rule out intracranial hemorrhaging, which would have contraindicated the administration of tPA due to the risk of increased bleeding. Dr. Tuhrim explains that defendant performed a CT scan without delay, and that plaintiff subsequently discussed the benefits and risks of tPA administration with members of defendant's staff. Dr. Tuhrim, referring to the medical records, then

submits that following those discussions, plaintiff did not consent to the administration of tPA. As such, defendant argues that the proof annexed to its motion establishes that plaintiff was timely offered tPA, but that the medication was not administered solely because plaintiff did not consent. As defendant's submission and expert affirmation are detailed and predicated upon ample support within the record, defendant has shown that plaintiff was treated in full accord with good and accepted standards of medical care, and that no actions on its part proximately caused plaintiff's alleged injuries.

In opposition to defendant's prima facie showing, plaintiff raises triable issues of fact to preclude summary judgment. Indeed, plaintiff cites to his own testimony as evidence that he did, in fact, consent to the administration of tPA. Moreover, plaintiff's expert opines, based on a review of the medical records, that defendant and its staff should have performed the duties required with greater speed, and that defendant's failure to do so narrowed the window for plaintiff to successfully receive tPA, thereby diminishing plaintiff's chance for a better outcome (*see King v St. Barnabas Hosp.*, 87 AD3d 238 [1st Dept 2011]*; see also, Hernandez v New York City Health & Hosp. Corp.*, 129 AD3d 532 [1st Dept 2015]). Plaintiff's expert also opines that while there are numerous notes throughout the record that assert that plaintiff did not consent to the administration of tPA, the record does not include a written refusal for the administration of tPA, which would have been standard hospital practice under the circumstance. Plaintiff's expert's observation on this point is key, as it blunts defendant's argument that plaintiff's own recollection is simply tailored to avoid the consequences of summary judgment (*see Phillips v. Bronx Lebanon Hosp.*, 268 AD2d 318, [1st Dept 2000]). Moreover, defendant's assertion that plaintiff's testimony must be disregarded because of plaintiff's interest in the outcome of this litigation is without merit. Indeed, the Appellate Division, First Department, does not countenance a plaintiff advancing an argument in opposition to a motion for summary judgment that is inconsistent with the plaintiff's earlier deposition testimony, because such a change in position lends credence to the notion that a plaintiff is merely attempting to avoid the consequences of summary judgment (*see Perez v. Bronx Park South Associates*, 285 AD2d 402 [1st Dept 2001]; *see also Beahn v. New York Yankees Partnership*, 89 AD3d 589 [lst Dept 2011]). However, where a plaintiff testifies at a deposition in a manner consistently at odds with a defendant's version of events, a trial court may rightfully find that an issue of fact exists (*see Lopez v. Bovis Lend Lease LMB, Inc.*, 26 AD3d 192 [1st Dept 2006]). And that is precisely the case here, where plaintiff's deposition testimony reveals that plaintiff consented to the administration of tPA even though defendant argues to the contrary. Such a factual discrepancy raises a fundamental issue of fact that a jury, rather the court, is charged to reconcile.

Beyond that consideration, it is apparent to the court that plaintiff's expert affirmation presents a credible contrast to Dr. Tuhrim's contention that plaintiff's eventual outcome was inevitable following his purported refusal to take tPA. Illustratively, plaintiff's expert surmises that plaintiff's course of treatment could have been handled more aggressively, and that such an approach likely would have led to earlier administration of tPA, and an avoidance of plaintiff's permanent neurological damage in the form of memory loss and right-sided weakness. Importantly, based on the same records that Dr. Tuhrim reviewed, plaintiff's expert reaches a different conclusion regarding whether plaintiff's injuries could have been prevented.

Where, as here, the affirmation of defendant's expert is credibly challenged by plaintiff's own expert affirmation, there is insufficient evidence to credit the conclusions of one expert over the conclusions of

another. Indeed, the weight to afford the respective expert's conclusions is for a jury, not this court, to decide. To be sure, the very fact that plaintiff's expert's opinions differ from those proffered by Dr. Tuhrim illustrates the existence of issues of triable fact. "Summary judgment is not appropriate in a medical malpractice action where the parties adduce conflicting medical expert opinions" (*Elmes v. Yelon*, 140 AD3d 1009 [2d Dept 2016] [citations and internal quotation marks omitted]). Instead, the conflicts must be resolved by the fact finder (*id.*).

Finally, plaintiff's failure to reveal the name of plaintiff's expert is not a fatal deficiency to the viability of plaintiff's opposition. Indeed, CPLR §3101(d) has been amended to encourage full disclosure of expert opinion testimony, and the statute provides that in "an action for medical, dental or podiatric malpractice, a party, in responding to a request [for expert disclosure], may omit the names of medical, dental or podiatric experts" to mitigate the concern that "some physicians would attempt to discourage other physicians from testifying against them if the witnesses' identities were revealed prior to trial" (*see e.g., Pizzi v. Muccia*, 127 AD2d 338, 340 [3d Dept 1987]). As such, plaintiff was under no obligation here to reveal the name of plaintiff's expert.

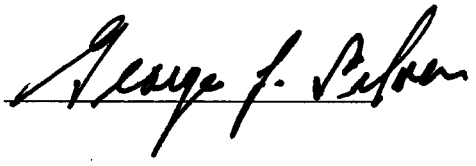
Based on the foregoing, it is hereby

ORDERED that defendant's motion for summary judgment is denied in its entirety; and it is further

ORDERED that the parties are directed to appear for a conference before the court on Tuesday December 17, 2019 at 9:30 AM at the courthouse located at 111 Centre Street, Room 1227 (Part 10), New York, New York.

This constitutes the decision and order of the court.

Dated: 11-22-19



GEORGE J. SILVER