Gereeva v LaJeune
2020 NY Slip Op 32082(U)
June 29, 2020
Supreme Court, Kings County
Docket Number: 506714/2015
Judge: Ellen M. Spodek

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 29th day of June, 2020.

P R E S E N T:

HON. ELLEN M. SPODEK,
Justice.

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ZOULPO GEREEVA,

Plaintiff,

- against - Index No. 506714/2015

JEAN G. LAJEUNE, M.D. AND MAIMONIDES MEDICAL CENTER,

Defendants.

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The following papers numbered 1 to 13 read herein:	Papers Numbered
Notice of Motion/Order to Show Cause/ Petition/Cross Motion and Affidavits (Affirmations) Annexed	1
Opposing Affidavits (Affirmations)	2
Reply Affidavit (Affirmation)	3

Defendants Jean G. LaJeune, M.D. ("Dr. LaJeune") and Maimonides Medical Center ("MMC"), by their attorneys, move for an order pursuant to CPLR 3212 for summary dismissing the complaint on the grounds that there is no triable issue of fact.

Background

On December 3, 2012, Hana Gere, the non-party daughter and primary care giver of plaintiff took her to her primary care physician. Plaintiff was weak and thought she

had an infection, "she felt something." Ms. Gere could not recall any recommendations made or any treatment performed at the primary care physician, except possibly blood work. Plaintiff presented to the Emergency Department at MMC on December 3, 2012 via ambulance at approximately 8:38 p.m.

Plaintiff was 73 years of age at the time of this presentation and suffered from multiple medical co-morbidities including uncontrolled HTN, uncontrolled diabetes and asthma. Ms. Gereeva was also overweight and had made multiple complaints of dizziness to her primary care providers in the months preceding the subject presentation. Her list of home medications included Metformin (Glucophage), Albuterol (Proventil), Insulin Glargine (Lantus), Atorvastatin calcium (Lipitor), and Quinapril (Accupril). The ambulance call report from December 3, 2012 notes that plaintiff was weak beginning that morning and began to develop abdominal pain at approximately 4:00 p.m. The report further indicated no shortness of breath or chest pain though her blood pressure was noted to be elevated (180/90 and 176/90).

Upon arrival at MMC, plaintiff's temperature was 98.4, her blood pressure was 229/71 and her blood sugar was noted at 416. Her chief complaint was lower left quadrant abdominal pain. She reported a past surgical history of cholecystectomy and an appendectomy. Plaintiff failed to tell the medical staff in the Emergency Department that she had a history of CAD, that she had been to her primary care physician earlier that day for similar complaints and that in 2006 she underwent prior posterior spinal fusion (L4-L5) and laminectomy with screws and rods. Plaintiff reported that she had not been

feeling well for more than a month and a urinary tract infection may have been treated by her primary care physician.

On examination in the Emergency Department, plaintiff was noted to have positive bowel sounds. Her abdomen was mildly distended with diffuse tenderness to palpation and severe pain in the left lower quadrant with guarding and no rebound. The MMC record notes that Ms. Gere advised that plaintiff vomited six times since 4:00 p.m. At 9:21 p.m., her white blood count was 11.3 and her creatinine was 1.4. There was no palpable organomegaly. A large right lower quadrant hernia was not tender to palpation and easily reduced. Plaintiff was treated with Zofran, Dilaudid and IV Enalapril for her blood pressure elevation. Fluids were started at 250ccs per hour. An abdominal and pelvic CT scan with contrast documented a 3mm obstructing stone at the ureterovesical junction ("UVJ") with mild hydronephrosis and moderate left perinephric and periureteric stranding. A urology consult was requested, and the responding physician assistant suggested that the placement of a stent would be considered after the patient's blood pressure and hyperglycemia was better controlled.

While in the Emergency Department, plaintiff's vital signs fluctuated. The Emergency Department staff attempted to reach plaintiff's primary care physician to no avail. On December 4, 2012, at 12:1l a.m., plaintiff was admitted to the Medicine Service after which IV Flagyl was started (WBC 11.3) and fluids at 250 ml. per hour were continued. At 8:45 a.m., Dr. LaJeune first saw the plaintiff. He noted her history, physical and laboratory findings, and suggested insertion of a JJ stent and cystoscopy. The

medical records indicate that plaintiff refused the procedure, however, both plaintiff and Ms. Gere both testified that plaintiff did not refuse the procedure. Dr. LaJeune noted that he should be re-contacted if plaintiff changed her mind about the urological procedure. Attending Medicine's pre-surgical evaluation of the plaintiff on December 4 indicated she was both a “low” and an “intermediate” risk for cardiac complications. He requested a pulmonary consult due to her history of asthma. The pre-op pulmonary consult was performed on December 4 and there were no pulmonary contraindications to the procedure.

On December 5, 2012, at 12:40 a.m., Ms. Gereeva’s creatinine was 2.0. At 5:00 a.m., Ms. Gereeva’s white blood cell count was 11.3 and her creatinine was 2.2. The surgical consent for the cystoscopy and placement of the JJ stent was signed at 6:50 a.m. and witnessed by an adult critical care physician assistant. At 1:30 p.m., Dr. LaJeune returned to see the plaintiff who had decided to go forward with the surgical procedure. Dr. LaJeune testified that he fully informed plaintiff of all pertinent risks, benefits and alternatives to the procedure. Dr. LaJeune advised that because the plaintiff remained symptomatic and her creatinine was rising, she required the procedure urgently. Ms. Gere recalled signing a consent but recalled very little else about the discussion surrounding the consent.

Following the medical and pulmonary clearances, it was determined that plaintiff was optimized for surgery. A pre-operative anesthesia clearance examination was performed and consent for anesthesia obtained. The operative procedure took 20 minutes,

with a total anesthesia time of 1 hour, 3 minutes. The plan was to follow-up with laser lithotripsy. According to the operative report, there was no untoward intraoperative event and the EKG was documented to show normal sinus rhythm. Plaintiff was admitted to the PACU at 3:10 p.m. on December 5, 2012. She was noted to be tachypneic and restless and her O2 sat was noted to be 79%. Coarse lungs sounds were auscultated. She was started on Albuterol and fluids. While in the PACU she was seen and monitored by anesthesia and a chest x-ray was ordered. Plaintiff was placed on a cardiac monitor and oxygen. Albuterol improved plaintiff's oxygen saturation to 90%. The chest x-ray reported interval development of pulmonary vasculature congestion, perihilar interstitial edema and right medial basilar consolidation. Plaintiff received diuresis with Lasix and Labetalol which brought her blood pressure and pulse rate into normal range. Her oxygen saturation improved from 92% to 93%.

At 5:00 p.m., plaintiff was complaining of difficulty breathing and the nurses heard crackles on auscultation. Additional Lasix was given as well as insulin. Thereafter, plaintiff reported breathing easier, her oxygen saturation was noted to be 96 to 97% and arrangements were made to transfer her to the floor. There were no urology complaints.

On the morning of December 6, 2012, an echocardiogram and cardiac labs were performed which demonstrated that Ms. Gereeva had suffered an acute myocardial infarction. The echocardiogram report noted borderline normal LV systolic function with an ejection fraction of 50%, no definite evidence of LVH, mild to moderate left atrium enlargement, normal LV/RA/RV chamber sizes, thickening of the aortic/mitral valves, no

significant valve disease, grade 1 diastolic dysfunction, and atrial septal hypokinesis. Ms. Gereeva's troponin was 29, her myoglobin was 153, her CPK was 735, and her BNP was 901. Ms. Gereeva was admitted to the CICU. The report from a cardiac catheterization performed on December 7, 2012 documented triple vessel coronary artery disease.

On June 2, 2015, plaintiff commenced this action against defendants. The verified complaint asserts three causes of action: (1) medical malpractice; (2) lack of informed consent; and (3) negligent hiring. Discovery is now complete, and the instant summary judgment motion has been presented.

Legal Standard

Summary judgment is a drastic remedy that deprives a litigant of his or her day in court and should, thus, only be employed when there is no doubt as to the absence of triable issues of material fact (*Kolivas v Kirchoff*, 14 AD3d 493 [2005]; *see also Andre v Pomeroy*, 35 NY2d 361, 364 [1974]). However, a motion for summary judgment will be granted if, upon all the papers and proof submitted, the cause of action or defense is established sufficiently to warrant directing judgment in favor of any party as a matter of law (CPLR 3212 [b]; *Gilbert Frank Corp. v Federal Ins. Co.*, 70 NY2d 966, 967 [1988]; *Zuckerman v City of New York*, 49 NY2d 557, 562 [1980]), and the party opposing the motion for summary judgment fails to produce evidentiary proof in admissible form sufficient to establish the existence of material issues of fact (*Alvarez v Prospect Hosp.*, 68 NY2d 320, 324 [1986], citing *Zuckerman*, 49 NY2d at 562).

"The proponent of a motion for summary judgment must make a prima facie showing of entitlement to judgment, as a matter of law, tendering sufficient evidence to demonstrate the absence of any material issues of fact" (*Manicone v City of New York*, 75 AD3d 535, 537 [2010], quoting *Alvarez*, 68 NY2d at 324; *see also Zuckerman*, 49 NY2d at 562; *Winegrad v New York Univ. Med. Ctr.*, 64 NY2d 851, 853 [1985]). If it is determined that the movant has made a prima facie showing of entitlement to summary judgment, "the burden shifts to the opposing party to produce evidentiary proof in admissible form sufficient to establish the existence of material issues of fact which require a trial of the action" (*Garnham & Han Real Estate Brokers v Oppenheimer*, 148 AD2d 493 [1989]).

The court must evaluate whether the issues of fact alleged by the opposing party are genuine or unsubstantiated (*Gervasio v Di Napoli*, 134 AD2d 235, 236 [1987]; *Assing v United Rubber Supply Co.*, 126 AD2d 590 [1987]; *Columbus Trust Co. v Campolo*, 110 AD2d 616 [1985], *affd* 66 NY2d 701 [1985]). Mere conclusory statements, expressions of hope, or unsubstantiated allegations are insufficient to defeat a motion for summary judgment (*Gilbert Frank Corp. v Federal Ins. Co.*, 70 NY2d 966, 967 [1988]; *Spodek v Park Prop. Dev. Assoc.*, 263 AD2d 478 [1999]). "[A]verments merely stating conclusions, of fact or of law, are insufficient to defeat summary judgment" (*Banco Popular N. Am. v Victory Taxi Mgt.*, 1 NY3d 381, 383-384 [2004], quoting *Mallad Constr. Corp. v County Fed. Sav. & Loan Assn.*, 32 NY2d 285, 290 [1973]). If there is

no genuine issue of fact, the case should be summarily determined (*Andre*, 35 NY2d at 364).

"In order to establish the liability of a professional health care provider for medical malpractice, a plaintiff must prove that the provider 'departed from accepted community standards of practice, and that such departure was a proximate cause of the plaintiff's injuries'" (*Schmitt v Medford Kidney Ctr.*, 121 AD3d 1088, 1088 [2014], quoting *DiGeronimo v Fuchs*, 101 AD3d 933, 936 [2012] quoting *Stukas v Streiter*, 83 AD3d 18, 23 [2011] [internal quotation marks omitted]).

A defendant moving for summary judgment dismissing a medical malpractice action must make a prima facie showing either that there was no departure from accepted medical practice, or that any departure was not a proximate cause of the patient's injuries (*see Williams v Bayley Seton Hosp.*, 112 AD3d 917, 918 [2013]; *Makinen v Torelli*, 106 AD3d 782, 783-784 [2013]). "Once the health care provider has made such a showing, the burden shifts to the plaintiff to demonstrate the existence of a triable issue of fact, but only as to the elements on which the defendant met the prima facie burden" (*Schmitt*, 121 AD3d at 1088; *see Stukas*, 83 AD3d at 30).

"Physicians offering opinions in medical, dental, podiatric, chiropractic, or other specialty malpractice actions must establish their credentials in order for their expert opinions to be considered by the court." *Bongiovanni v. Cavagnuolo*, 138 AD3d 12, 18 (2d Dept. 2016). "Thus, when a physician offers an expert opinion outside of his or her

specialization, a foundation must be laid tending to support the reliability of the opinion tendered." *Id.*

Discussion

Defendants submits the expert affirmation of Jonathan Vapnek, M.D., a board-certified physician in the practice of Urology, duly licensed to practice in the State of New York. Dr. Vapnek opined that Dr. LaJeune and the staff of MMC adhered to acceptable standards of care in their treatment of plaintiff and that the acute myocardial infraction was not caused or contributed to by any action or inaction on the part of the subject treatment. Dr. Vapnek further opined that Dr. LaJeune'6s recommendation to admit the patient for optimization of her other medical issues, such as her elevated blood pressure and blood sugars, was appropriate and in accordance with good and accepted standards of urological care. The doctor noted that delay had resulted in an urgent need for surgery. In addition, Dr. Vapnek opined that surgical intervention was necessary and that further delay, coupled with plaintiff's preexisting chronic medical conditions, would have allowed her urological condition to worsen and lead to urosepsis, severe complications and possible death.

In further support of their motion, defendants submit the affirmation of Malcolm Charles Phillips, M.D., a physician board-certified in Internal Medicine with a subspecialty in Cardiovascular Disease, licensed to practice medicine in the state of New York. Dr. Phillips opined, with a reasonable degree of medical certainty, that the care and

treatment rendered to plaintiff by Dr. LaJeune and the staff at MMC was appropriate and did not depart from acceptable standards of medical care, or proximately cause the alleged injuries. The doctor further opined that plaintiff was appropriately cleared for the surgical procedure, noting that pre-surgical clearance by medicine and pulmonary was sufficient and appropriate. Lastly, Dr. Phillips opined the acute myocardial infarction sustained by plaintiff was *de minimus*.

In opposition, plaintiff submits the affirmation of a physician licensed to practice in the State of New York, who is board certified in Internal Medicine and Cardiovascular Disease. Plaintiff's expert opined that Dr. LaJeune and the staff at MMC deviated from acceptable standards of care in the management of plaintiff's medical treatment during her hospitalization at MMC. Specifically, the doctor stated defendants deviated by failing to appropriately evaluate plaintiff's cardiac risk factors for cardiac complications, failing to obtain a cardiac pre-surgical clearance, and failing to address plaintiff's risk factors in order to prevent cardiac complications. The doctor further opined that pre-surgical cardiac testing would have documented Ms. Gereeva's CAD and would have mandated that the defendants change their treatment plan for Ms. Gereeva.

After oral argument and 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 burden then shifted to plaintiff to provide evidence to the Court that the defendants did in fact deviate from the accepted standards of medical care, raising a triable issue of fact. The Court finds that plaintiff has not sustained her burden.

In order for plaintiff's expert's opinion to be considered in opposition to defendant's motion for summary judgment, he needed to lay a proper foundation to show that he has the proper credentials to opine on the area of Urology, which is at issue in this case. The expert states that he is board certified in Internal Medicine and Cardiovascular Disease. Plaintiff's Aff. in Opp., Expert Aff., para. 1. Plaintiff's expert does not state that he has any board certification in Urology, only that he is "familiar with the standards of care of the treatment options for ureteral stones and with indications, contraindications, risks, benefits, and alternatives to those treatments." Id, at para 2. He goes on to opine about the field of practice for a urologist and the standards of care applicable to medical clearances for urological procedures, specifically the stenting procedure at issue in this case. Plaintiff's expert goes on to suggested alternative urological treatments "such as draining the kidney via percutaneous nephrostomy and/or use of ureteroscopy and laser lithotripsy." Id, at para 45. His opinions cannot be considered reliable for any discussions on the topic of Urology as he failed to lay a proper foundation. The Court finds that he did not lay a proper foundation to show the reliability of the opinion he rendered about the care provided to plaintiff by defendants, and therefore the Court will not consider the affirmation. Without an expert's opinion, plaintiff has failed to sustain her burden to show that there is a question of fact that the defendant departed from good and accepted medical practice in the treatment of plaintiff.

Assuming arguendo, that plaintiff's expert had laid a proper foundation to allow the Court to consider his affirmation, it is filled with speculation and conclusory statements which are unsupported by any evidence. Plaintiff's expert states the standard of care required defendants obtain a pre-surgical consultation with a cardiologist for any patient presenting with plaintiff's symptomology and medical history. The expert then speculates the cardiologist would have evaluated plaintiff's functional capacity as well as obtain "a pre-surgical echocardiogram, pre-surgical stress test, and a pre-surgical coronary angiography." Id, at para 43. The expert concludes that this testing would have revealed additional cardiac risks, which would have prompted the defendants to conduct alternative treatments, and ultimately prevented the acute myocardial infarction. Moreover, the expert states, in conclusory fashion, that the stenting procedure caused the acute myocardial infarction, without offering any medical evidence substantiating that claim. Id, at para 45. "Where the expert's ultimate assertions are speculative or unsupported by any evidentiary foundation, however, the opinion should be given no probative force and is insufficient to withstand summary judgment." *Diaz v. New York Downtown Hosp.*, 99 NY2d 542 (2002). Plaintiff's expert affirmation is purely speculative and unsupported and is therefore insufficient to defeat summary judgment in this case.

As plaintiff has failed to sustain her burden, defendants' motion for summary judgment must be granted. Accordingly, it is

ORDERED that Defendants Jean G. LaJeune, M.D., and Maimonides Medical Center's summary judgment motion is granted. Plaintiff's complaint is dismissed against defendants.

This constitutes the decision and order of the court.

E N T E R,

J. S. C