Lachana v Geröva
2021 NY Slip Op 31886(U)
June 1, 2021
Supreme Court, Kings County
Docket Number: 516488/2017
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 1st day of June 2021

P R E S E N T:

HON. ELLEN M. SPODEK, Justice

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SOONDAREE LACHANA, as Administrator of the Estate of SADONEY D. SANNASEE,

Plaintiff,

DECISION AND ORDER

-against-

Index No. 516488/2017

LUDMILA GERÖVA, M.D., RICHARD CONN, M.D., FOREST HILLS HOSPITAL and NORTHWELL HEALTH, INC.,

Defendants

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Defendant LUDMILA GERÖVA, M.D., moves pursuant to CPLR 3212 for an order granting summary judgment and dismissing the complaint against her. Defendants FOREST HILLS HOSPITAL and NORTHWELL HEALTH, INC., also move pursuant to CPLR 3212 for an order granting summary judgment and dismissing the complaint against them. Plaintiff opposes the motions.

On June 22, 2016 at 11:56 p.m., the decedent, a 69 year old woman presented to the Forest Hills Hospital emergency room with complaints of bilateral leg pain, swelling and a rash with blisters. At that time, her blood pressure was 156/80 and her heartrate was 81. Her pain was noted as 8/10. Within minutes, she was brought into the Emergency

treatment area and seen by Nurse Jemell Williams. He indicated the patient was alert and oriented to self, place and time and was speaking coherently. The decedent advised that two to three weeks prior she had a pedicure and spa treatment for her feet and about a week later, she developed swelling with blisters. She advised that she went to her primary care physician who prescribed a one-week course of Acyclovir with no improvement, so she came to the emergency room.

The decedent was eventually seen by the emergency room attending, Dr. Salma Habib. Dr. Habib noted a history showing “no significant past medical history, presents with swelling of lower extremities, onset 1 week.” Dr. Habib also noted that the decedent’s family stated that she had numbness and swelling on the lower extremities. The note also shows the decedent’s family stated that it started one week ago and gradually got worse. The notes showed that the decedent denied having a fever, denied starting any new medication, or any other complaints and that she had no known drug allergies. The decedent was admitted to defendant Dr. Gerova’s service.

The chart included a note saying, "outpatient medication status not yet specified." Dr. Gerova testified that this could mean either the Patient did not bring her medication list, does not take any medication or could not remember her medications. Dr. Gerova further testified that the indication in the chart of medications not specified required further investigation with the Patient regarding her medications. Dr. Gerova testified she did this when she first saw the decedent.

Nurse Jemell Williams testified at his deposition that it was his custom and practice to inquire of a patient he was to examine if they took any medications. Nurse Williams further testified that his note in the decedent’s chart says "outpatient medications status

not yet specified" because nothing was entered at this point which was attributable to the fact that the decedent, when asked, did not advise that she currently takes any medication. He testified that the note did not include a past medical history because the decedent, when asked, did not provide any information of a past medical history. The emergency room attending physician's note also does not document any past medical history or medication history. Plaintiff testified that she told the emergency room doctor who she spoke with approximately an hour after the decedent presented to the hospital that her mother takes blood pressure medication.

Dr. Habib's impression was peripheral edema, rash and nonspecific skin eruption. Dr. Habib ordered bloodwork, antibiotics and an ultrasound of the lower extremities to rule out a deep vein thrombosis ("DVT"). The decedent was admitted to the hospital and Dr. Gerova accepted the admission.

The decedent was admitted to Dr. Gerova's service on June 23rd. Her blood pressure was tested at 5:50 a.m. and it was 119/58. Dr. Gerova developed a differential diagnosis which included cellulitis, DVT, vasculitis and occult fracture. She started IV vancomycin to cover for MRSA and called for an infectious disease consult. A venous doppler study was performed which was negative for DVT. Lab tests were ordered to evaluate the decedent for vasculitis and an x-ray showed no occult fracture.

The decedent was seen by infectious disease consultant Dr. Jhaveri. His note indicates the decedent had a history of cholecystectomy, but no other past medical history. Regarding medications, Dr. Jhaveri indicated that she was taking aspirin, Lovenox (DVT prophylaxis), Vancomycin (antibiotic) 1 gram IV every 12 hours, morphine as needed for pain, Zofran for nausea and protonics. Dr. Jhaveri recommended

continuing the antibiotic, Vancomycin. He specifically noted that the decedent was alert and oriented, but there was no note regarding the decedent's medical history or medications.

The decedent's blood pressure became elevated during the overnight hours between June 23 and June 24, 2016. On June 23 at 5:12 pm the patient's blood pressure was 184/76. At 12:58 a.m. on June 24th, her blood pressure was 171/89 and her heartrate was 86. At 6:00 a.m. on June 24th, her blood pressure was 155/77 and her heartrate was 96. Dr. Gerova testified that the decedent's blood pressure was checked every shift by hospital staff.

Dr. Gerova next saw the decedent on June 24, 2016 at around 2:30 p.m. The note indicates she was sitting in the bed, alert and oriented times 3, complaining of lower extremity pain. The decedent denied any headaches. The assessment/plan indicated that the cellulitis was improving, and the decedent was on IV Vancomycin. The assessment/plan also noted that the decedent had stated that she was not taking any medication for hypertension which Dr. Gerova inquired about due to the elevated blood pressure readings. Dr. Gerova's note states "Patient with elevated blood pressure which could be secondary to pain. Patient denies history of hypertension and states that she does not take any medications. I discussed this with the patient's daughter at the bedside. She connected me with the other daughter over the phone … home medication Atenolol 25 milligrams a day. As per daughter takes Atenolol at home." Dr. Gerova ordered that Atenolol be resumed, and she instructed both the resident and the attending nurse to check the decedent's blood pressure one hour after the Atenolol was administered to

ensure its efficacy. There is a notation on the order with special instructions to hold the Atenolol if the systolic blood pressure was too low, if measured at less than 110.

Dr. Gerova also performed a physical examination of the decedent at the time that she prescribed the resumption of the Atenolol. The decedent did not complain of headaches during the examination. The examination revealed that the decedent was asymptomatic. The medication order for Atenolol was received and processed at 3:00. p.m. and administered at 4:15 p.m. The decedent's blood pressure was taken at 4:07 p.m. and was 184/88. The blood pressure was not taken an hour after the Atenolol was given, as Dr. Gerova had directed. Subsequently, at 5:57 pm, the medical records note an episode of vomiting and Zofran given to the decedent as per MD order. The note also shows the decedent complained of epigastric pain, with Dr. Han being notified and Maalox ordered.

The plaintiff testified that during the afternoon of June 24th, the decedent developed a headache and she advised hospital nurses. According to the plaintiff's testimony, the nurse suggested that the medication is probably causing the decedent not to feel well. The plaintiff testified that approximately three hours later, she again complained to a nurse that her mother was not feeling well and asked if her mother was given her blood pressure medication and the nurse responded that she would check but never gave the plaintiff an answer.

The decedent began vomiting again at around 10:30 p.m. om June 24th. She was vomiting blood and complaining that she was dizzy, hot, agitated and confused. The decedent was seen by resident Dr. Gupta who noted "Patient was seen and examined at bedside for vomiting. Patient was drowsy, but responsive. Answered all questions

correctly. No abdominal pain, had bowel movement yesterday, no chest pain, nausea or palpitations. Zofran was ordered as needed. She was also given the antibiotic vancomycin for bilateral cellulitis."

The plaintiff testified that a nurse responded and plaintiff asked to see a doctor but was advised there was no doctor available. She testified that she requested again to see a doctor, and approximately twenty to thirty minutes later, a doctor came to examine the decedent. Plaintiff testified that this doctor advised "I am not her doctor. I am just a fill in doctor, that she is using antibiotic and I would alert the doctor to let them know if she has an allergy to the medication." She testified that this doctor did not take the decedent's blood pressure.

At around 12:00 a.m., an employee came to check the decedent's vital signs at which time the plaintiff asked him to come back later as she was cleaning up her mother. The plaintiff testified that at this point, her mother had vomited a second time in between when the doctor saw her and the nurse seeking to take her vitals. However, she did not advise anyone of the second vomiting episode.

On June 25th at 12:30 a.m., the decedent was found to be unresponsive and the rapid response team was called. Her blood pressure was markedly elevated to 198/112, and her heart rate dropped to the 40s. Her pulse oximetry was 93% on 2-liters of oxygen and her blood glucose was 214. She was intubated after administration of the sedative Versed, and despite the administration of this sedative, her blood pressure shot up further to 230/106. The decedent was sent for a brain CT which showed a large bleed with a rupture in the ventricular system in midline shift. Dr. Gerova was notified of the change in the decedent's condition at 1:35 am. At 3:45 a.m., Dr. Conn, the ICU attending

physician, was consulted and brought the decedent to the intensive care unit. The case was discussed with neurosurgery and it was determined she was not a candidate for surgical intervention. At 5:00 a.m., it was determined that the decedent had suffered a large hemorrhagic stroke and had non-reactive pupils and labile hypertension. Her prognosis for recovery was very poor. The decedent did not regain consciousness and died on July 3, 2016.

An autopsy found that the final diagnosis indicated: hypertensive and atherosclerotic cardiovascular disease; A) atherosclerosis of the coronary arteries and aorta, moderate to marked; B) arteriolonephrosclerosis; and C) acute intracerebral hemorrhage centered in the left basal ganglia with ventricular extension. The cause of death was determined to be "intracerebral hemorrhage complicating hypertensive and atherosclerotic cardiovascular disease."

Defendant Dr. Gerova submits the affidavit of Dr. Martin Bolic, a board-certified doctor of internal medicine. Dr. Bolic opined that Dr. Gerova did not depart from the standard of care in the treatment and care rendered to the decedent in getting the medication and medical history of the decedent.

Dr. Bolic also affirmed that Dr. Gerova did not depart from the standard of care for not thinking that the decedent maybe suffering from long term hypertension based upon the one moderately elevated blood pressure reading upon admission. Dr. Bolic states that the elevated blood pressure could be explained not only due to the pain the decedent was experiencing, but also due to the anxiety and stress associated with presentation to the emergency room. Dr. Bolic affirms that by the time Dr. Gerova entered her note on June 23rd at 1:42 p.m., there was no basis for her to believe the decedent had a history

of hypertension. When Dr. Gerova examined the decedent the next day, Dr. Bolic affirms that she appropriately inquired with the decedent and her family regarding a history of hypertension due to moderately elevated blood pressure readings during the overnight hours, and when she determined that the decedent took anti-hypertensive medications, Dr. Gerova immediately had the medication (Atenolol 25mg) ordered. Dr. Gerova also appropriately instructed the resident and attending nurse to take the blood pressure reading one hour after the Atenolol was given to ensure the pressure normalized. Dr. Bolic affirmed that a STAT dose of Atenolol was not needed as the decedent had only missed one day of the medication during which her blood pressures were only moderately elevated and normal. Dr. Bolic opines that it was within the standard of care for Dr. Gerova to order that the blood pressure be followed up an hour after the medication was administered, as it showed strict monitoring and follow-up.

Dr. Bolic affirms that Dr. Gerova's diagnosis and treatment for the infection and cellulitis were within the standard of care, with the appropriate blood tests being ordered, an infectious disease consult being ordered, and the antibiotic Vancomycin being ordered.

Dr. Bolic opines that nothing that Dr. Gerova did or did not do was a proximate cause to any injury or the death of the decedent.

Defendants Forest Hills Hospital and Northwell Health Inc. submit the affidavit of Dr. Mark S. Silberman, a board certified doctor in Emergency Medicine, Internal Medicine, Pulmonary and Critical Care Medicine. The expert opined that there were no departures from good and accepted medical practice by the hospital staff and that no act or omission by the staff caused or contributed to the stroke or death of the decedent. Dr. Silberman

opined within a reasonable degree of medical certainty that the decedent was appropriately evaluated and treated. The expert affirmed that It is clear from the record that questions were asked regarding her medical history and medications and the patient did not provide the information concerning her history of hypertension or that she took Atenolol. Dr. Silberman affirmed that the patient has an obligation to provide a complete history and if she chooses to omit information, the health care providers cannot be faulted for that. The expert also opines that the decedent received proper care in the emergency department in accordance with good and accepted standards of care, and there were no signs and symptoms at that time of an impending stroke. The expert affirms that the blood pressure reading in the emergency room may have been slightly elevated, but that is not uncommon for an emergency department setting and a patient who has pain as was noted in her lower extremities due to a red, swollen, rash. Dr. Silberman states that pain in and of itself can cause an elevation in blood pressure. The expert opines that the decedent was appropriately examined and treated by the residents and staff, including during the evening of June 24th. The decedent's vital signs were supposed to be taken at midnight, but the family refused as the patient was resting. Dr. Silberman states that it was reasonable for the PCA to advise the nurse of the refusal and for both to document the refusal. Dr. Silberman opines that there are no departures from accepted medical practice by the staff of Forest Hills Hospital, including the nurses, the residents, and the rapid response team. Dr. Silberman affirms that the decedent had an acute, unforeseeable, and unpreventable cerebral hemorrhage, with a grave prognosis based upon the rapidly performed head CT. The expert opines that "this patient did not have an intracerebral hemorrhage due to one or two missed doses of 25 mg of Atenolol, which is a modest

dose, but rather the cerebral hemorrhage was due to longstanding, significant, atherosclerotic disease of her arterial circulation."

Plaintiff opposed the motions for summary judgment and submitted the affidavit of a board-certified doctor in Internal Medicine. The doctor opined that Forest Hills Hospital and Dr. Gerova departed from good and accepted standards of medical care by failing to obtain a medical history that included the decedent's hypertension and by failing to obtain a medication history from the decedent which included her use of Atenolol. The expert says that there were several factors which should have allowed Forest Hills Hospital and Dr. Gerova to conclude that the patient had a history of hypertension and that she was taking Atenolol at home. The expert opines that it was the duty and responsibility of Forest Hills Hospital to determine that the decedent was taking Atenolol at home, and to ensure that an admission medication reconciliation was done and the failure to do this was a departure from standard of care, within a reasonable degree of medical certainty, and is the cause of the decedent's acute hemorrhagic stroke with subsequent death. Plaintiff's expert affirms that Dr. Gerova should have been able to determine the decedent's medical history and medication history either by speaking with the patient and her family or by speaking with the patient's primary care physician. The expert opines that the defendants should have looked up old admission records for continuity of care and if those records were not available, they should have been ordered. The expert also states that Dr. Gerova should have telephoned Dr. Chowdhury (the decedent's primary care physician) to speak with him in the middle of the day, as it was 1:42 p.m. when she first saw the decedent. The expert states that "Presumably Dr. Chowdhury, the patient's primary care physician, would have been in his office at the time and could have easily

provided the information." The expert opines that the failure to obtain this information was a departure from the standard of care.

Plaintiff's expert affirms that a review of the elevated blood pressure readings and heart rates shows that the decedent was experiencing rebound tachycardia from the lack of administration of Atenolol, which will normally prevent the heart rate from going too high. The expert opines that it was a departure by Dr. Gerova to order the patient's blood pressure be taken one hour after the Atenolol was given and not order additional blood pressure monitoring parameters. The expert opines that proper monitoring of the blood pressure should have been ordered by Dr. Gerova, with readings to be taken once an hour for the first four hours after the Atenolol was administered, then every two hours for the next four hours and then once per shift, provided that vital signs were normal and the patient had no new symptoms. According to plaintiff's expert it was also a departure for Dr. Gerova not to have written orders for parameters for her to be contacted if the patient's blood pressure was elevated. The expert states that Dr. Gerova should have written orders to be immediately notified if the patient's blood pressure rose above 160/90. The expert found that Dr. Gerova departed in not knowing that her order was not followed by the staff and the decedent's blood pressure was not taken one hour after the Atenolol was administered. It was her duty to know what the blood pressure was one hour after the medication was given, whether that blood pressure was taken by a nurse, a resident or Dr. Gerova did it herself. The expert opines that it was a departure of the standard of care for the staff of Forest Hills Hospital not to follow Dr. Gerova's order and take the blood pressure reading one hour after the Atenolol was administered. Plaintiff's expert states that had the blood pressure been properly monitored, to a reasonable degree of

medical certainty, it would have shown to be significantly elevated, which would have required additional antihypertensive medications to be administered.

Plaintiff's expert opines that it was a departure from the standard of care for Dr. Gerova not to order the Atenolol to be administered STAT and such failure resulted in a nearly two hour delay in having the Atenolol administered. As the decedent's blood pressure prior to the Atenolol being administered was 184/88, the expert finds she was suffering from a hypertensive crisis, and it was a departure for Forest Hills Hospital not to transfer the decedent to the ICU to be monitored and treat her hypertensive crisis. The expert finds that it was obvious the decedent's blood pressure did not respond to the Atenolol and she should have been transferred to the ICU.

The expert opines that it was a departure from good and accepted standards of medical care for the defendants not to have assessed the patient's complaints of nausea at or around 10:30pm, as this was an early warning sign of a hypertensive crisis and impending encephalopathy from uncontrolled hypertension which should have been picked up if proper and expedient clinical evaluation by a physician was done. At the time of the evaluation by the resident, when the decedent was described as drowsy but responsive, the expert believes that this is when the intracranial bleed occurred. It was a departure of the standard of care for the decedent's vital signs not to be read after this examination by the resident, as the plaintiff's testimony was that they did not refuse to allow the vital signs to be taken.

Plaintiff's expert opines that there were departures from the standards of care by the defendants in not complying with the hospital's policies in communicating with the Primary Care physician of the decedent.

According to the plaintiff's expert, all the departures by the defendants were a substantial factor in causing the decedent's injuries and death. The expert opines that had the defendants taken a proper medication history of the patient, had the patient been prescribed Atenolol 25mg in a timely manner, had the patient's blood pressure been properly monitored and assessed for signs of nausea and headaches, and had her condition been properly treated with Labetalol, Metropolol and Nicardipine, the stroke and the patient's death would have been avoided. The expert opines that the progression of events (from hypertension, to encephalopathy, to a hypertensive, hemorrhagic stroke and ultimately respiratory arrest, intubation and death) could and should have been prevented.

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 AD3d 18, 24-26 (2d Dept. 2011). 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. City of New York*, 99 AD3d 673, 675 (2d Dept. 2012); *Bezerman v. Bailine*, 95 AD3d 1153, 1154 (2d Dept. 2012); *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*, 102 AD3d 720, 721 (2d Dept. 2013); *Gillespie v New York Hosp. Queens*, 96 A.D.3d 901, 902 (2d Dept. 2012); *Semel v Guzman*, 84 AD3d 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.

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 of care. 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. "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). It is purely conclusory to say that there were departures by the defendants as no standard of care is stated in the plaintiff's expert affirmation. It was even more speculative for plaintiff's expert to conclude that the alleged departures caused the stroke and ultimate death of the decedent. Plaintiff's expert states that had the departures not occurred, the stroke and the patient's death would have been avoided. This is purely conclusory. Plaintiff's expert tries to say that the departure in not getting a medical history and medication list from the decedent and not contacting the decedent's primary care physician to get the medical history and medications started the chain of events which caused the decedent's death. Doctors and hospital staff are entitled to rely on what their patients tell them or not tell them. In this case, the decedent was never found to be

unstable or unable to provide the information. Dr. Gerova did get a medical history and medication list from a family member after the increased elevated blood pressure readings, which is when she prescribed the Atenolol 25 mg. The Atenolol was administered 75 minutes after it was prescribed. Plaintiff's expert states that it was a departure not to order the Atenolol STAT but fails to state what the standard of care is, and what the difference would have been if the Atenolol had been administered any earlier. Plaintiff's expert affidavit is purely speculative and conclusory and cannot be used to defeat summary judgment in this case.

Assuming the plaintiff could show that there were issues of fact regarding alleged departures by the defendants, the plaintiff fails to show that there are issues of fact showing the defendants were the proximate cause of the injuries and death of the decedent. Dr. Silberman's opinion was that the decedent did not have a stroke due to one or two missed doses of 25 mg of Atenolol, but that it was caused due to longstanding, significant, atherosclerotic disease of her arterial circulation, which the defendants did not cause. This opinion was not discussed by the plaintiff's expert. Plaintiff's expert finds that the decedent's history of microvascular ischemic brain disease (which dated back to 2011) "is not of any consequence here" as the decedent was compliant with taking her Atenolol to keep her blood pressure controlled. The autopsy confirms that intracerebral hemorrhage complicating hypertensive and atherosclerotic cardiovascular disease and lower extremity cellulitis were the cause of death of the decedent. Plaintiff's expert fails to show that there are issues of fact regarding the proximate cause of the decedent's stroke and therefore summary judgment must be granted.

As to the lack of informed consent claims, plaintiff does not mention them at all in her Affirmation in Opposition, and therefore the claims must be dismissed.

Defendants' motions for summary judgment are granted and the complaint is dismissed against Dr. Gerova, Forest Hills Hospital and Northwell Health Inc.

This constitutes the decision and order of the Court.

ENTER,

Ellen Spodek

JSC