

**Britt-Gaines v Mitchell Complex Family Health
Ctr.**

2008 NY Slip Op 31831(U)

June 27, 2008

Supreme Court, Suffolk County

Docket Number: 0003873/2000

Judge: Thomas F. Whelan

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Upon the following papers numbered 1 to 34 read on these motions for summary judgment; Notice of Motion/ Order to Show Cause and supporting papers 1 - 4; 5 - 8; 9 - 12; 13 - 16; Notice of Cross Motion and supporting papers ; Answering Affidavits and supporting papers 17 - 19; 20 - 22; 23 - 25; Replying Affidavits and supporting papers 26 - 27; 28 - 30; 31 - 32; 33 - 34; Other ; (~~and after hearing counsel in support and opposed to the motion~~) it is,

ORDERED that the motion (006) by defendant, Sisters of Charity Healthcare Corp., s/h/a Mitchell Complex Family Health Center, Bailey Seton Hospital, Sisters of Charity Medical Center, for summary judgment dismissing the action as against it is denied; and it is further

ORDERED that the motion (007) by defendant, Theodore Fink, M.D., for summary judgment dismissing the action as against him pursuant to CPLR 3212 is denied; and it is further

ORDERED that the motion (008) by defendant, the Public Administrator of Suffolk as Administrator of the Estate of Charles Stewart, M.D., for summary judgment dismissing the action as against it pursuant to CPLR 3212 is denied; and it is further

ORDERED that the motion (009) by defendant, Siddharth Sharma, M.D., for summary judgment dismissing the action as against him pursuant to CPLR 3212 is granted.

Plaintiff, Tiesha Britt-Gaines, seeks to recover damages for alleged departures in her medical care by defendants from February 3, 1995 through February 12, 1998.¹ Plaintiff alleges that defendants failed to take a proper history, failed to perform a proper examination, failed to timely diagnose kidney disease, failed to appreciate the plaintiff's abnormal laboratory values, failed to treat and stabilize the plaintiff's hypertension, failed to provide referrals to specialists, failed to prevent the occurrence of an intra cranial hemorrhage.² Plaintiff alleges that as a result, she was required to undergo a kidney transplant and will need to take anti-rejection medications for the remainder of her life. Before the court are four motions for summary judgment: the first by defendants, Mitchell Complex Family Health Center, Bailey Seton Hospital, Sisters of Charity Medical Center (hereinafter "the Sisters of Charity defendants"); a second motion for summary judgment by defendant, Theodore Fink, M.D.; a third motion for summary judgment by the Public Administrator of Suffolk as the Administrator of the Estate of Charles Stewart, M.D.; and a fourth motion by defendant, Siddarth Sharma, M.D., for summary judgment dismissing the action as against them.

The record reveals that the plaintiff, then eight years of age, presented to Mitchell Health Complex, administered by the Sisters of Charity Medical Center, in February, 1995 and was seen by defendant, Theodore Fink, M.D., for routine examinations. The record reveals that in 1997 the plaintiff was seen at Nassau Road Medical Center, where diagnostic tests revealed iron deficiency anemia and pigmented retinitis pigmentosa. On or about December 2, 1997, the infant presented to Nassau County Medical Center and was diagnosed with end stage renal disease. Immediately thereafter, she was transferred to Stony Brook Medical Center (hereinafter "Stony Brook") for pediatric dialysis. During her stay at Stony Brook her labile blood pressure readings required constant medical intervention. In the late evening of December 25, plaintiff became unresponsive and was taken to the operating room for evacuation of an intra cranial hemorrhage. The record reveals that she sustained residual effects. Plaintiff then began peritoneal dialysis and within a few months, received a kidney transplant.

The requisite elements of proof in a medical malpractice action are a deviation or departure from accepted practice and evidence that such departure was a proximate cause of injury or damages (*see Ramsay v Good Samaritan Hosp.*, 24 AD3d 645, 808 NYS2d 374 [2d Dept 2005]; *see also DiMitri v Monsouri*, 302 AD2d 420, 754 NYS2d 674 [2d Dept. 2003]). In a medical malpractice action, the party moving for summary judgment must make a prima facie showing of entitlement to judgment as a matter of law by showing the absence of a triable issue of fact as to whether the defendant/physician was negligent (*see Taylor v Nyack Hosp.*, 18 AD3d 537, 795 NYS2d 317 [2d Dept 2005], *Alvarez v Prospect Hosp.*, 68 NY2d 320, 508 NYS2d 923 [1986]). Thus, a moving defendant/physician has the initial burden of establishing the absence of any departure from good and accepted medical practice or that the plaintiff was not injured thereby (*see Williams v Sahay*, 12 AD3d 366, 783 NYS2d 664 [2d Dept 2004], *Winegrad v N.Y. Univ. Med. Ctr.*, 64 NY2d 851, 487 NYS2d 316 [1985]). Resident physicians will not be held liable when they are following the orders of

¹ By a So-Ordered Stipulation dated January 28, 2005 (Whelan, J.) and filed with the Clerk of the Court on February 9, 2005, the caption was amended to delete the infant plaintiff's mother and natural guardian inasmuch as plaintiff, Tiesha Britt-Gaines, had reached the age of majority.

² The Court's Order dated August 24, 2000 (Underwood, J.), which granted a default judgment as against defendants, Nassau Road Family Health, P.C., a/k/a Nassau Road Medical Associates and John Mitchner, M.D., and awarded judgment in favor of plaintiff on the issue of liability, was vacated by the Preliminary Conference Order dated September 12, 2000 (Underwood, J.), filed with the Clerk of the Court on September 13, 2000.

attending doctors whose directions are not clearly contraindicated by normal practice (*see Cerny v Williams*, 32 AD3d 881, 822 NYS2d 548 [2d Dept 2006]; *Petty v Pilgrim*, 22 AD3d 478, 802 NYS2d 217 [2d Dept 2005]).

In support of their motions, the Sisters of Charity defendants and Dr. Fink submit, among other things, the pleadings, bill of particulars, the Mitchell Health Complex medical record, the examination before trial testimony of Dr. Fink and an affirmation by Kenneth V. Lieberman, M.D. Dr. Fink adopts and incorporates by reference the Sisters of Charity defendants' arguments and exhibits. In the bill of particulars, plaintiff alleges that the Sisters of Charity defendants and Dr. Fink departed from accepted standards of medical care in that they failed to diagnose and treat the infant's kidney disease which proximately caused end stage renal failure, malignant hypertension, left ventricular hypertrophy, kidney dialysis, cerebral hemorrhage and a kidney transplant, which necessitated a course of kidney dialysis and an eventual kidney transplant.

Dr. Fink testified that in 1995 he was employed as a pediatric fellow by Winthrop Hospital which contracted his services to the Mitchell Complex Family Health Center (hereinafter referred to as "Mitchell Complex"), a satellite clinic of the Bailey Seton Hospital. He stated that he was responsible for ambulatory pediatrics at the clinic and was not supervised by an attending physician. He initially saw the infant on June 3, performed an examination and planned a return appointment to draw laboratory tests. A urine test result charted above his signature was brought to his attention during the examination before trial. The test revealed three-plus protein and leukocytes, which he conceded was an abnormal reading. However, he stated that he was unaware of the result on that date and denied ordering the test. He questioned the placement of the test result above his signature on the page, in that he would have noticed it when he signed off on the progress note. In addition, the custom and practice at the facility was that the person who performed the test would also sign their name where the test result is recorded which was not done in this case. He stated that if he had known the result, he would have ordered follow-up tests and repeated the urine test. He further stated that he doubted that the urine test result was correctly placed in the infant's record since he did not order it. In addition, he averred that the infant was asymptomatic at the time he saw her.

Dr. Lieberman avers that he is a professor of pediatrics, chief of pediatric nephrology and a pediatrics attending at two teaching hospitals. In his opinion, the infant's kidney disease was caused by Senior-Loken Syndrome, also known as Familial Renal/Retinal Dystrophy, a rare hereditary disease that combines renal disease with retinal degeneration, for which there is no cure. He opines that an earlier diagnosis of her kidney disease would not have prevented her end stage disease. He notes that the plaintiff was diagnosed with pigmented retinitis pigmentosa syndrome, the second portion of the disease, in May of 1997. However, after reviewing the Stony Brook medical records, no mention is made of the infant's retinitis pigmentosa.

Dr. Lieberman further states that the renal portion of the disease is very insidious and gives little warning before the development of advanced disease. In addition, symptoms such as hypertension and edema do not appear until the disease is very advanced. In the latter stages, the kidneys become shrunken, as was the case with this plaintiff. Another associated physical abnormality in this syndrome is short stature. Dr. Lieberman notes that the plaintiff's medical record revealed that she only ranked in the 15th percentile in height. In any event, Dr. Lieberman states that there is no cure for this disease and an earlier diagnosis by Dr. Fink in June of 1995 would not have affected her outcome. The above evidence demonstrates defendants' prima facie entitlement to judgment as a matter of law (*see Winegrad v N.Y. Univ. Med. Ctr.*, 64 NY2d 851, *supra*).

In opposition, plaintiff submits an affirmation of her medical expert³, whose name has been redacted (see *Carrasquillo v Rosencrans*, 208 AD2d 488, 617 NYS2d 51 [2d Dept 1994]). The original unredacted affidavit has been submitted to the court for inspection under separate cover. According to the affirmation, the expert is board certified in pediatrics and pediatric nephrology. The expert avers that she reviewed the defendants' medical records and opines that at the February 3, 1995 visit, the physician at the Mitchell Complex, non-party Dr. Zinzarella, failed to appreciate the plaintiff's short stature for her age. At the June 3, 1995 visit, the expert avers that Dr. Fink failed to evaluate the plaintiff's blood pressure, height or weight. In addition, the plaintiff's urine tested positive for protein which was not followed-up by Dr. Fink. Moreover, the complete blood count that was ordered by Dr. Fink revealed several abnormal values. In addition, Dr. Fink signed a form for the plaintiff for physical activities at school without having first examined her. The expert opines that the plaintiff was suffering from early kidney disease in 1995 that had not yet become severe. The protein in the urine required a further work up and a referral to a nephrologist. At that point in time, the condition could have been treated appropriately and the prognosis would have been much better. The court finds that plaintiff's expert has contradicted the conclusions by defendants' expert and thus an issue of credibility is raised which requires a denial of the motions (see *Viti v Franklin Gen. Hosp.*, 190 AD2d 790, 593 NYS2d 840 [2d Dept 1993]). Accordingly, the motions by the Sisters of Charity and Dr. Fink are denied.

Turning to the motion for summary judgment by defendant, Public Administrator of Suffolk as the Administrator of the Estate of Charles Stewart, M.D., defendant submits, among other things, the bill of particulars, portions of the Stony Brook University Hospital (hereinafter "Stony Brook") medical record, a portion of the examination before trial testimony of Dr. Kaskel and the affirmation of Morton J. Kleiner, M.D. In the bill of particulars, plaintiffs allege that Dr. Stewart departed from accepted medical practice by his failure to properly control the plaintiff's blood pressure, prescribe the proper medications, give proper instructions to the fellows, residents, interns and hospital staff regarding medications and monitoring, and stabilize the infant via dialysis, which proximately caused the plaintiff to suffer a cerebral hemorrhage with residual effects. The record reveals that Dr. Stewart died in 2003 before an examination before trial was conducted. The Public Administrator was appointed as administrator of the estate by decree of the Suffolk County Surrogate's Court dated November 17, 2003.⁴

The medical record reveals that the plaintiff presented to Stony Brook with chronic advanced renal failure, uremia, profound anemia and high blood pressure. She was admitted to the pediatric intensive care unit at Stony Brook on December 3, 1997 for dialysis. From December 12 through December 23, Dr. Stewart was the plaintiff's attending physician on the pediatric floor and he managed her dialysis, blood pressure, fluid intake and ordered anti-hypertensive medications. At that time, he also issued an order forbidding the use of Procardia or labetalol and other medications to treat acute hypertension without his knowledge or approval. He had frequent meetings with the nephrology fellow, Dr. Musarrat Hussain, and adjusted the plaintiff's medications as needed. On December 16, 1997, the plaintiff underwent the insertion of a peritoneal dialysis

³The Court has conducted an in-camera inspection of the original unredacted affirmation and finds it to be identical in every way to the redacted affirmation in plaintiff's opposition papers with the exception of the redacted expert's name. In addition, the Court has returned the unredacted affirmation to the plaintiff's attorney.

⁴ By order dated March 29, 2004 (Underwood, J.), the Court granted plaintiff's motion to substitute the Public Administrator of Suffolk County as the Administrator of the Estate of Charles L. Stewart as defendant in the stead of defendant Charles L. Stewart, M.D., which was filed with the Clerk of the Court on April 15, 2004.

catheter. The last order written by Dr. Stewart was on December 23 to start the peritoneal dialysis. Dr. Stewart then went on vacation from December 24 through December 26, at which time Dr. Kaskel, another attending nephrologist, managed the plaintiff's care until Dr. Stewart's return on December 27. Dr. Kaskel testified to the effect that during the care and treatment of the plaintiff, Dr. Stewart was an attending physician, and the assistant professor of pediatrics and pediatric nephrology.

Dr. Kleiner avers that he is board certified in internal medicine with a sub-certification in nephrology. He opines that the care rendered by Dr. Stewart to the plaintiff was within the standard of care and was not the proximate cause of the plaintiff's cerebral hemorrhage or any of her resulting injuries. At the time Dr. Stewart left the hospital for vacation on December 23, his medication orders and other treatments were appropriate. The plaintiff was in clinically stable condition. This evidence demonstrates defendant Public Administrator's prima facie entitlement to judgment as a matter of law (*see Winegrad v N.Y. Univ. Med. Ctr.*, 64 NY2d 85, *supra*).

In opposition, plaintiff submits, among other things, a separate affirmation by her expert, as stated above.⁵ The expert disagrees with Dr. Kleiner's conclusion that Dr. Stewart did not depart from accepted standards of medical care. The expert opines that Dr. Stewart and Dr. Kaskel, both attending nephrologists for the plaintiff, should have controlled the unstable blood pressures by increasing the dosages of the prescribed medication and removing more fluid during dialysis. She states that such a failure contributed to the hypertensive episode the plaintiff suffered on December 25 and 26 which resulted in a cerebral hemorrhage. The court finds that there is an issue of credibility, precluding summary judgment (*see Viti v Franklin Gen. Hosp.*, 190 AD2d 790, *supra*). Accordingly, the motion by the defendant, Public Administrator of Suffolk is denied.

Turning to the motion for summary judgment by Siddhartha Sharma, M.D., this defendant submits, among other things, the bill of particulars, the examination before trial transcripts of Frederick Kaskel, M.D., Musarrat Hussain, M.D., Beth Bailey, M.D. and defendant Sharma. In the bill of particulars, plaintiff alleges that Dr. Sharma departed from accepted standards of care in failing to properly monitor and treat the plaintiff's blood pressure on the evening of December 25, 1997. As a result, plaintiff alleges that Dr. Sharma's departures proximately caused the plaintiff's cerebral hemorrhage and residual injuries. Dr. Kaskel testified to the effect that he was an attending physician in pediatrics, the Director of the division of pediatric nephrology service and worked closely with Dr. Stewart, also a pediatrics attending physician. He stated that when the plaintiff was admitted to Stony Brook, she was in acute and chronic renal failure. When he was on call for Dr. Stewart, he worked closely with the nephrology fellow, Dr. Hussain. On December 25, while on call for Dr. Stewart, Dr. Kaskel and Dr. Hussain agreed to continue the current medications and diet after Dr. Hussain's assessment revealed that she was medically stable. At approximately 3:00 a.m. he received a call from the neurology attending and learned that the plaintiff was going to the operating room to remove bleeding in the brain. He then stated that he called Dr. Hussain and learned that the blood pressures were initially low, requiring that the medications be held, however the blood pressure suddenly rose. Dr. Kaskel agreed with Dr. Hussain's decision to hold the medications. He also spoke with Dr. Bailey, but did not speak

⁵ The Court has conducted an in-camera inspection of the original unredacted affirmation and finds it to be identical in every way to the redacted affirmation in plaintiff's opposition papers with the exception of the redacted expert's name. In addition, the Court has returned the unredacted affirmation to the plaintiff's attorney.

with Dr. Sharma.

Dr. Hussain testified to the effect that he was a fellow in pediatric nephrology. He stated that the ultimate decisions regarding the plaintiff's care were made by the pediatric attending physician, except for changes in the antihypertensive medications which would be decided by the pediatric nephrology attending. He recalled writing a plan on December 25 after examining the plaintiff which was approved by Dr. Kaskel. Later in the day he received a call from Dr. Sharma regarding the plaintiff's blood pressure. He stated that the initial pressure, 92/67 was normal for this patient and that the medications should be given. However when the pressure fell to 72/40 at 7:30 p.m., he told Dr. Sharma to hold the medications and check the blood pressure every thirty minutes. Dr. Hussain was aware that Dr. Sharma was working under Dr. Bailey, a senior resident who would decide when to resume the medications. He received a call from Dr. Bailey later in the evening while a chromotomographic ("CT") scan of the brain was being performed upon the plaintiff. He then drove to the hospital to evaluate the plaintiff.

Dr. Bailey testified that she worked under the direct supervision of the attending physicians and she assisted in the patient care for children admitted to Stony Brook or brought to the clinics. She was also responsible for teaching first and second year residents and medical students. She stated that she had limited involvement in this plaintiff's care and all the orders that she wrote were under the direction of the pediatric nephrologist. On December 25, 1997, she assessed the plaintiff in the morning and was later told by staff that the plaintiff had a headache. Dr. Bailey checked the blood pressure with a manual blood pressure cuff and noted the pressure was 70/40. She assessed the plaintiff and noted that she was alert, awake and neurologically normal. She began to take the blood pressures every fifteen to thirty minutes and held all medicines until the blood pressure returned to normal as directed by Dr. Hussain. The nursing staff and Dr. Sharma also took the frequent blood pressures. The plaintiff was given tylenol for her headache which later resolved. She had several conversations with Dr. Hussain and at 12:00 a.m., when the blood pressure rose, she was told by Dr. Hussain to give the medications that were previously withheld. When the plaintiff became unresponsive at 1:00 a.m., Dr. Bailey called Dr. Mansfield, the attending for the pediatric intensive care unit and arranged for the emergency brain CT scan.

Dr. Sharma testified that he was employed at Stony Brook as a first-year resident in emergency medicine. He worked the over night call on the evening of December 25 with Dr. Bailey, the senior resident. He stated that the orders that he wrote in the plaintiff's chart were written under the direction of the nephrology fellow, Dr. Hussain. On the evening of December 25 he notified Dr. Hussain at the direction of Dr. Bailey when the plaintiff's blood pressure dropped. He stated that although he wrote the order to hold the medication he knew that any decision to resume the medication would be made by Hussain or Bailey. He participated in taking the plaintiff's frequent blood pressures. He was later called into the plaintiff's room at approximately 1:15 a.m. and noted that she was unresponsive. He assisted Dr. Bailey by calling the intensive care resident.

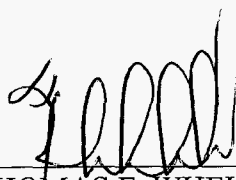
Phyllis Dunn Weiner, M.D. affirms that she is board certified in pediatric medicine. She opines that the plaintiff's abnormal laboratory results and renal ultrasound indicate that her kidneys were not functioning upon her December 1997 admission to Stony Brook. She states that Dr. Sharma was advised by the nephrology fellow, Hussain, to withhold the medication due to low blood pressure and it was appropriate to do so. She opines that any action or inaction by Dr. Sharma was at the direction of either Dr. Bailey or Dr. Hussain and was not clearly contraindicated by the standard of care. She also states that the cerebral bleed

sustained by the plaintiff was an unpredictable and sudden event unrelated to the care and treatment provided by Dr. Sharma. This evidence is sufficient to demonstrate Dr. Sharma's prima facie entitlement to judgment as a matter of law in that he demonstrated that he acted only at the direction of more senior physicians, such as the fellow, second-year resident and the attendings (*see Cerny v Williams*, 32 AD3d 881, *supra*).

In opposition, plaintiff submits a separate affirmation of her expert, as stated above.⁶ The court finds that plaintiff fails to raise an issue of fact inasmuch as the expert fails to state how Dr. Sharma acted independently of his senior resident, fellow and attending physician and departed from accepted standards of care (*see Petty v Pilgrim*, 22 AD2d 478, *supra*). In addition, the expert's opinion that Sharma failed to monitor the blood pressures is not supported by the medical record wherein the nursing staff charted that they would continue to monitor the plaintiff's blood pressures and a review of the frequent vital signs sheet demonstrates that the blood pressures were frequently monitored (*see, Alvarez v Prospect Hosp.*, 68 NY2d 320, *supra*). Accordingly, the motion for summary judgment by Dr. Sharma is granted.

Accordingly, the motions for summary judgment by the Sisters of Charity defendants, Dr. Fink, and The Public Administrator are denied. The motion for summary judgment by Dr. Sharma dismissing the action is granted.

DATED: 6/27/08



THOMAS F. WHELAN, J.S.C.

⁶ The Court has conducted an in-camera inspection of the original unredacted affirmation and finds it to be identical in every way to the redacted affirmation in plaintiff's opposition papers with the exception of the redacted expert's name. In addition, the Court has returned the unredacted affirmation to the plaintiff's attorney.