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SHORT FORM ORDER

INDEX No. 08-40239
CAL. No. 13-02118MM

SUPREME COURT - STATE OF NEW YORK
I.A.S. PART 33 - SUFFOLK COUNTY



***PRESENT:***

Hon. THOMAS F. WHELAN
Justice of the Supreme Court

MOTION DATE 4-15-14
ADJ. DATE 6-23-14
Mot. Seq. # 002 - MotD
CDISP: No

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RACHEL LEONARDI,

Plaintiff,

- against -

JASON A. WINSLOW, M.D., RONALD DVORKIN, M.D., and GOOD SAMARITAN HOSPITAL MEDICAL CENTER,

Defendants.

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Upon the following papers numbered 1 to 21 read on this motion for summary judgment; Notice of Motion/ Order to Show Cause and supporting papers 1-16; Notice of Cross Motion and supporting papers_; Answering Affidavits and supporting papers 17-19; Replying Affidavits and supporting papers 20-21; Other __; (~~and after hearing counsel in support and opposed to the motion~~) it is,

***ORDERED*** that this motion (002) by defendants, Jason A. Winslow, M.D., Ronald Dvorkin, M.D. and Good Samaritan Hospital Medical Center, pursuant to CPLR 3212 for summary judgment dismissing the complaint is granted to the extent indicated below.

In this medical malpractice action, plaintiff Rachel Leonardi alleges that the defendants negligently departed from the standard of care on or about February 17, 2007, when she was seen as a patient in the emergency room at Good Samaritan Hospital by defendants, Jason Winslow, M.D. and Ronald Dvorkin, M.D., and hospital employees, and that they failed to provide informed consent concerning her care and treatment for an allergic reaction to medication she was taking and for septic shock. In addition, the plaintiff alleges that the defendants failed to properly consider her medical history, failed to timely and properly diagnose and treat her, failed to admit her to the hospital, and failed to advise her of the risks and complications concerning her care and treatment. Due to these and other alleged departures from accepted standards of medical care and treatment, the plaintiff claims to have suffered acute renal failure, fever, anaphylactic shock, septic shock, severe oliguria,

or

pulmonary embolism, unconsciousness, weight loss, muscle atrophy, atrial fibrillation with rapid ventricular response, the need for intravenous antibiotics, intubation, Foley catheter, spinal catheter and loss of enjoyment and quality of life.

In the complaint served, two causes of action are advanced. The First cause of action sounds in medical malpractice against all defendants but it also includes a claim of negligence against the hospital in the hiring and training of its personnel. The second cause of action sounds in a lack of informed consent.

By the instant motion, the defendants seek summary judgment dismissing the plaintiff's complaint. In support thereof, the defendants submitted, inter alia, an attorney's affirmation; the affidavit of James D. Ryan, M.D.; copies of the pleadings; transcripts of the examinations before trial of Rachel Leonardi, Jason A, Winslow, M.D., Ronald Dvorkin, M.D., and non-party witnesses Victoria Shields and John Shields; and certified copies of the Good Samaritan Hospital and St. Joseph Hospital records. Defense counsel contends that the claims sounding in negligent hire against the hospital and those in the Second cause of action for lack of informed consent are legally insufficient an/or otherwise lacking in merit and defendants' expert, James G. Ryan, M.D., opines that there were no deviations in the care and treatment rendered by the defendants to the plaintiff.

The plaintiff's expert, Dr. Ryan, stated, the medical records he reviewed indicate that the 35 year old plaintiff was diagnosed with lupus in 2006 and was placed on Plaquenil and Prednisone. She had been receiving Methotrexate, an immune suppressant drug, for a few months prior to presenting to the emergency room at Good Samaritan Hospital in February 2007. Dr. Ryan avers that the lupus, when it flared, caused the plaintiff to suffer swelling, pain, and stiffness in her joints, particularly in her feet, ankles, wrists, and hands, and flushing in her cheeks. She was previously diagnosed with Factor V Leiden mutation, which her doctors advised could cause or contribute to blood clotting. She was also previously diagnosed with Epstein-Barr virus, irritable bowel syndrome since she was in her twenties, hypothyroidism, and she has had heart palpitations since 1989. She experienced about three to four respiratory infections per year in the past, and took Levaquin for respiratory infections without any allergic reaction in 2006. She had known allergies to mosquito bites, latex, and sulfa-based medications.

Dr. Ryan avers that on February 6, 2007, plaintiff presented to her private medical doctor, Elena Stybel, M.D., for upper respiratory symptoms of runny nose, congestion, and low grade fever for one week, for which Dr. Stybel placed her on Levaquin. She also placed the plaintiff on Diflucan for oral thrush, which medication she had never taken previously. That evening, about one and a half hours after taking Diflucan, she felt very restless, feverish, shaky, sweaty, clammy, her heart was racing, and she felt like she was going to pass out. She called her private doctor and was instructed to stop the Diflucan and to take Benadryl. Sometime after midnight, the plaintiff's mother, Mrs. Shields, noted Rachael's face was very flush and red all over, she was groggy and lethargic, not completely coherent, and mumbling her words. She was having diarrhea and vomiting, was cold and clammy to touch, and was experiencing itching of her tongue and swelling in her face. The following morning she awoke with terrible joint pains, her face was swollen, and she felt very weak. She presented to the emergency room at Good Samaritan Hospital where she was admitted from February 8 to February 10, 2007, to rule out sepsis. She was placed on an intravenous antibiotic, Rocephin.

Dr. Ryan described the tests and consults called, including an infectious disease consult. A sonogram ruled out hydronephrosis. As she was hemodynamically stable on February 10, 2007, she was discharged home by Dr. Ionescu, with instructions to follow up with Dr. Stybel in one week, and to not take Diflucan due to the allergic reaction to it. Thereafter, the plaintiff returned to work, followed up with Dr. Stybel, and remained without any symptoms through February 16, 2007. She continued the Levaquin, and stopped the Diflucan.

Dr. Ryan avers that on the evening of February 16, 2007, the plaintiff experienced feeling very hot within 15 to 20 minutes, her eyes became blurry and red, she felt itching in her mouth, and had what looked like a heat rash on her body. He father took her to the emergency room at Good Samaritan Hospital on February 17, 2007 at 8:26 a.m., where she was seen by Dr. Winslow, who after taking a history and examining the plaintiff, indicated that the plaintiff was in no acute distress and was presenting with allergy symptoms related to oral Levaquin. Dr. Ryan set forth the testing and treatment provided to the plaintiff, including intramuscular Benadryl. Dr. Winslow observed that the plaintiff had no respiratory distress, retractions, or nasal flaring, and that her breath sounds were clear bilaterally. He further noted that she had diffused urticarial eruptions on her face and trunk, with no involvement of her palms, soles, or mucous membranes. She was instructed to discontinue the Levaquin and to see her primary medical doctor in two days for evaluation, and to hydrate. She was given a prescription for Benadryl three times a day, and was advised that the Levaquin would take 24 hours to get out of her blood. Dr. Ryan stated that Dr. Winslow was aware Levaquin could cause skin problems, diarrhea, vomiting or upset stomach, and itching eyes and skin. He instructed the plaintiff to return if she developed swelling of the lips or tongue, difficulty breathing, and advised her of the other symptoms to watch for.

Dr. Ryan states that the plaintiff testified she did not feel her symptoms resolved before she left the hospital on February 17, 2007, and advised her father that she did not think she should be going home. Dr. Ryan continued that if she had told that to Dr. Winslow, Dr. Winslow indicated that he would have re-evaluated her again. After the plaintiff arrived at home, she experienced shaking, vomiting, sweating, her heart was racing, and she had chills. By early evening, she became delirious and collapsed to the floor. She was taken by ambulance to New Island Hospital on February 18, 2007 at 12:03 a.m., with a temperature of 106.4 degrees. Dr. Ryan described the medical care and treatment, and that the plaintiff was diagnosed with septic shock, with fever from an unknown cause. Multiple tests were performed, including a CT scan of the lungs which revealed small bilateral pleural effusions with atelectasis, positive for pulmonary embolus in the right lower lobe. She was taken to the critical care unit, intubated, and placed on a mechanical ventilator. Dr. Ryan continued to describe her care and treatment, noting gradual improvement on a daily basis by February 20, 2007. However, on February 22, 2007, atrial fibrillation was noted and arrangements were made to transfer her to St. Francis Hospital for further cardiac work-up on February 27, 2007.

Dr. Ryan set forth his opinion that the defendants comported with the standard of care in that Dr. Winslow diagnosed the plaintiff with a mild allergic reaction to Levaquin within minutes of her presentation to Good Samaritan Hospital's emergency room on February 17, 2007. In assessing the severity of an allergic reaction, signs and symptoms are considered, which include hypotension, syncope, respiratory distress, dysphoria, wheezes, and low oxygen saturation, and that she had none of these symptoms. Therefore, the appropriate treatment involves the use of antihistamines, such as

Benadryl, and the use of an H2 blocker such as Pepcid, both of which were ordered by Dr. Winslow. Blood tests and x-rays were not indicated for the minor allergic reaction while she was present at the emergency room on February 17, 2007 between 8:26 a.m. and 10:09 a.m. and the treatment and discharge instructions were appropriate. Dr. Ryan opined that Dr. Winslow and the staff at Good Samaritan Hospital timely and appropriately diagnosed and treated the plaintiff within the standard of care. They heeded her complaints, noting that she had no fever and her blood work was normal. She was provided proper treatment based upon her presentation. She was discharged without any signs of hemodynamic instability, and the defendants properly stabilized her condition. Dr. Ryan continued that there is no objective evidence to support any claim that the plaintiff did not improve while in the emergency room. Her condition at that time did not warrant admission to the hospital. The plaintiff was already taking Prednisone, a steroid, which is beneficial to treating allergic reactions, and an increased dose of Prednisone was not warranted.

Dr. Ryan states that after the plaintiff was discharged from the emergency room on February 17, 2007, she felt badly and feverish that evening, but she did not recall taking her temperature or calling any medical provider about her symptoms becoming more intense or about becoming delirious until she collapsed to the floor. Dr. Ryan opined that because the plaintiff's condition worsened on February 17, 2007, with severe symptoms arising in the late afternoon to the early evening, that there were no acts or omissions by the defendants that caused the plaintiff's condition to worsen or deteriorate. She was taken by ambulance to New Island Hospital, nearly fourteen hours after being discharged from Good Samaritan Hospital's emergency room. When she presented to New Island Hospital, her lungs were clear to auscultation bilaterally, her heart had a regular rhythm, and she had no edema. She was diagnosed with septic shock and not with an allergic reaction or anaphylactic shock. She was kept on the ventilator on February 18, 2007 and part of February 19th, at which time she was extubated. She clinically improved, and by February 21, 2007, antibiotics to treat sepsis were discontinued. Dr. Ryan opined that plaintiff was not treated for an allergic reaction which she alleges the defendants failed to properly diagnose and treat.

Dr. Ryan stated that the only reference to Dr. Ronald Dvorkin is a note that he reviewed the patient's chart for her visit of February 8, 2007 at 7:44 a.m. Dr. Winslow testified that he did not know how Dr. Dvorkin's name appeared on the chart as he did not speak to him. Dr. Dvorkin did not recall seeing the plaintiff, nor did the plaintiff recall any contact with Dr. Dvorkin on February 17, 2007. There is no indication that Dr. Dvorkin had any role in the plaintiff's care and treatment. It is Dr. Ryan's opinion, within a reasonable degree of medical certainty, that none of the defendants deviated from the accepted standard of care in the care and treatment rendered to the plaintiff, and that they did not proximately cause the injuries claimed by her. Upon this affirmation and the other proof attached to the moving papers, the defendants seek summary judgment dismissing the complaint in its entirety as to all defendants.

The plaintiff opposes and relies upon an affirmation of her counsel and the affirmation of her expert physician. The plaintiff's expert stated that defendants, Jason A. Winslow, M.D. and Good Samaritan Hospital, deviated from the accepted standards of care in rendering medical care and treatment to Rachael Leonardi on February 17, 2007, and that said deviations from the standard of care were a substantial factor and proximate cause in Rachael Leonardi suffering acute renal failure, septic shock, and pulmonary embolism.

The plaintiff's expert set forth the plaintiff's medical history and noted her presentation to Good Samaritan Hospital on February 8, 2007, where she was admitted to the hospital to rule out sepsis. He described her care and treatment and that she was discharged on February 10, 2007. During the ensuing week, until February 17, 2007, the plaintiff experienced minor weakness and fatigue. On the morning of February 17, 2007, she took Levaquin for flu-like symptoms, and within 15 to 20 minutes, began to feel very hot, dizzy, shaky, and had blurred vision and blood shot eyes and an itchy mouth. Her father took her back to Good Samaritan Hospital's emergency room where the plaintiff stated she felt badly, was having trouble speaking, and experienced a bout of diarrhea. She was not admitted, and her father was told it would take 24 hours for the Levaquin to leave her system and that she should take Benadryl, regularly. She returned home, and continued the Benadryl, but began to experience sweating, racing heart, chills and fever, eventually became delirious and collapsed late that night. She was taken to New Island Hospital where she was intubated and diagnosed with septic shock and pulmonary embolism and with a secondary diagnosis of renal and respiratory failures. She remained hospitalized until February 27, 2007, and then transferred to St. Francis hospital for further work-up.

Plaintiff's expert opined that Dr. Winslow and/or the staff at Good Samaritan Hospital Medical Center deviated from the acceptable standards of care in failing, on February 17, 2006 to take an adequate and comprehensive history of the plaintiff which would have revealed that she was suffering from systemic lupus erythematosus. He states that Dr. Winslow failed to review the prior hospital admission record of the plaintiff from February 8 through 10, 2007, and that he should have pursued a differential diagnosis. He does not state what that differential diagnosis should have been, or that the failure to establish a differential diagnosis was the proximate cause of plaintiff's eventual diagnosis of septic shock. However, he states, that Dr, Winslow's reliance upon the plaintiff self-diagnosis as to having an allergic reaction to Levaquin was improper because her statements did not mean that she was actually suffering from such an allergic reaction. Rather, a CBC and metabolic profile should have been ordered because of the systemic lupus and flu-like symptoms she presented. Had Dr. Winslow taken such a profile, a high white blood cell count clearly indicating infection and sepsis would have been revealed.

Upon its review of the submissions of the parties, and for the reasons stated below, the motion, is granted in its entirety with respect to defendant, Dvorak and it is granted as to the Second cause of action with respect to the defendants, Winslow and the hospital. The motion is further granted as to the hospital with respect to the claim of negligent hiring and training that is advanced in the First cause of action. It is, however, denied with respect defendants, Winslow and the hospital, as to the remaining portions of the First cause of action which sound in medical malpractice.

"'In order to establish the liability of a physician for medical malpractice, a plaintiff must prove that the physician deviated or departed from accepted community standards of practice, and that such departure was a proximate cause of the plaintiff's injuries'" (***Fink v DeAngelis***, 117 AD3d 894, 986 NYS2d 212 [2d Dept 2014] *quoting* ***DiGeronimo v Fuchs***, 101 AD3d 933, 936, 957 NYS2d 167 [2d Dept 2012], *quoting* ***Stukas v Streiter***, 83 AD3d 18, 23, 918 NYS2d 176 [2d Dept 2011]). "Accordingly, '[a] physician moving for summary judgment dismissing a complaint alleging medical malpractice must establish, prima facie, either that there was no departure or that any departure was not a proximate cause of the plaintiff's injuries'" (***Fink v DeAngelis***, 117 AD3d 894, *supra*, *quoting*

***Gillespie v New York Hosp. Queens***, 96 AD3d 901, 902, 947 NYS2d 148 [2d Dept 2012]). "Once a defendant physician 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" (***Matos v Khan***, 119 AD3d 909, 2014 WL 3732819 [2d Dept 2014]; *see* ***Stukas v Streiter***, 83 AD3d 18 at 30, *supra*). "Summary judgment is not appropriate in a medical malpractice action where the parties adduce conflicting medical expert opinions" (***Fink v DeAngelis***, 117 AD3d 894, *supra*; ***Feinberg v Feit***, 23 AD3d 517, 519, 806 NYS2d 661 [2d Dept2005]), as "such conflicting expert opinions will raise credibility issues which can only be resolved by a jury" (***Fink v DeAngelis***, 117 AD3d 894, *supra*; ***DiGeronimo v Fuchs***, 101 AD3d at 936, 957 NYS2d 167 [2d Dept 2012]).

A claim of a "lack of informed consent" is a distinct cause of action for medical malpractice which requires proof of facts not contemplated by an action based merely on allegations of negligence" (***Walker v Saint Vincent Catholic Med. Ctrs.***, 114 AD3d 669, 979 NYS2d 697 [2d Dept 2014]). A cause of action premised on a lack of informed consent "is meant to redress a 'failure of the person providing the professional treatment or diagnosis to disclose to the patient such alternatives thereto and the reasonably foreseeable risks and benefits involved as a reasonable medical ... practitioner under similar circumstances would have disclosed, in a manner permitting the patient to make a knowledgeable evaluation'" (***Karlin v IVF Am., Inc.***, 93 NY2d 282, 292, 690 NYS2d 495 [1999]; *quoting* Public Health Law § 2805–d [1]). For the claim to be actionable, the defendant must have engaged in a "non-emergency treatment, procedure or surgery" or "a diagnostic procedure which involved invasion or disruption of the integrity of the body" (Public Health Law § 2805–d [2]). To establish a cause of action to recover damages for malpractice based on lack of informed consent, a plaintiff must prove: (1) that the person providing the professional treatment failed to disclose alternatives thereto and failed to inform the patient of reasonably foreseeable risks associated with the treatment, procedure, surgery or qualifying diagnostic procedure and the alternatives, that a reasonable medical practitioner would have disclosed in the same circumstances; (2) that a reasonably prudent patient in the same position would not have undergone the treatment if he or she had been fully informed; and (3) that the lack of informed consent is a proximate cause of the injury (*see* ***Walker v Saint Vincent Catholic Med. Ctrs.***, 114 AD3d 669, *supra*; ***Khosrova v Westermann***, 109 AD3d 965, 966, 971 NYS2d 565 [2d Dept 2013]; ***Spano v Bertocci***, 299 AD2d 335, 337, 749 NYS2d 275 [2d Dept 2002]).

Claims against a hospital in which it is charged with negligently hiring, training, supervising and/or monitoring its employees are not actionable "where the employee is acting within the scope of his or her employment, thereby rendering the employer liable for damages caused by the employee's negligence under the alternative theory of respondeat superior" (***Drisdom v Niagara Falls Mem. Med. Ctr.***, 53 AD3d 1142, 861 NYS2d 919 [4th Dept 2008]; *see also* ***Segal v St. John's Univ.***, 69 AD3d 702, 893 NYS2d 221 [2s Dept 2010]). An act is considered to be within the scope of employment if it is performed while the employee is engaged generally in the business of his [or her] employer, or if his [or her] act may be reasonably said to be necessary or incidental to such employment (*see* ***Wood v State***, 119 AD3d 672, 990 NYS2d 76 [2d Dept 2014]).

Here, the moving papers of the defendants established a prima facie entitlement to summary judgment dismissing all claims against defendant Dvorkin and the plaintiff's opposing papers failed

to demonstrate any question of fact on the issue of his liability under any of the causes of action set forth in the complaint. Summary judgment dismissing the complaint is thus awarded to defendant Dvorkin. The moving papers further established that the plaintiff's Second cause of action, which sounds in lack of informed consent, are without merit since the plaintiff's malpractice claims relate to alleged failures to diagnose and treat the condition of the plaintiff rather to any procedure or treatment within the purview of Public Health Law § 2805–d that was engaged in by the defendants (*see* Public Health Law § 2805–d[2]; ***Deutsch v Chaglassian***, 71 AD3d 718, 719–720, *supra*;). Summary judgment dismissing the Second cause of action set forth in the complaint is thus awarded to defendants, Winslow and the hospital. The defendant hospital is further awarded summary judgment dismissing so much of the plaintiff's First cause of action which charges the hospital with negligence in the hiring, training, or supervision of its staff, as such claims are not actionable under the circumstances of this case (*see* ***Drisdom v Niagara Falls Mem. Med. Ctr.***, 53 AD3d 1142, *supra*).

The court further finds that the defendants' submissions established, prima facie, that none of the defendants departed from good and acceptable standards of care and treatment in the community. In addition, the proof adduced in support of the motion established prima facie that the defendants care and treatment did not cause plaintiff's condition to worsen and progress nor otherwise cause the injuries which plaintiff alleges to have suffered. However, the plaintiff's submissions in opposition sufficiently demonstrated the existence of genuine questions of fact regarding whether Dr. Winslow departed from good and acceptable medical practice by failing to diagnose and treat the condition the plaintiff presented on February 17, 2007, and if so whether any such departures were a proximate cause of the plaintiff's injuries. The motion is thus denied with respect to the medical malpractice claims advanced against defendants Winslow and the hospital in the First cause of action.

Dated: August 22 2014

THOMAS F. WHELAN, J.S.C.