Irizarry v St. Barnabas Hosp.
2015 NY Slip Op 30365(U)
March 20, 2015
Supreme Court, Bronx County
Docket Number: 20626/09
Judge: Stanley B. Green
Cases posted with a "30000" identifier, i.e., 2013 NY Slip Op 30001(U), are republished from various state and local government websites. These include the New York State Unified Court System's E-Courts Service, and the Bronx County Clerk's office.
This opinion is uncorrected and not selected for official publication.

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF BRONX: IA-6M

----------X

JULIA IRIZARRY, INDEX No. 20626/09

Plaintiff(s),

- against-

ST. BARNABAS HOSPITAL, ST. BARNABAS COMMUNITY ENTERPRISES, INC., GEORGE PICCORELLI, M.D., QUISUKMADE ADEKUHLEDO, M.D., FRANCISCO SOLIS, D.O. and KENNETH SCHWARTZ, M.D.,

Defendant(s) DECISION

----------X

HON. STANLEY GREEN:

The motion by St. Barnabas Hospital, St. Barnabas Community Enterprises, Inc. (SBH), Olusunmade Adekunle, M.D. i/s/h/a Dr. Ouisukmade Adekuhledo, M.D. and Francisco Solis, D.O. for summary judgment dismissing the complaint is granted.

Plaintiff claims that following femoral popliteal bypass surgery on her left leg on October 16, 2007, defendants discharged her from SBH prematurely, with an impaired gait and without adequate discharge planning and as a result, she was unable to keep her follow up medical appointment, refill her prescription for Coumadin and receive timely VNS care and physical therapy, which caused her bypass to become occluded, necessitating additional surgery and ultimately necessitating an above the knee amputation of her left leg.

Plaintiff was admitted to SBH on October 16, 2007, to undergo a femoral popliteal bypass to her left leg. The surgery was performed by Dr. Piccorelli. From October 18 to 24, plaintiff received physical therapy and had a rehabilitative consultation. On October 22, 2007, plaintiff was interviewed by a hospital social worker, Mark Black, with the assistance of a

Spanish interpreter. Black's notes indicate that plaintiff was alert and oriented, she resided alone at 2000 Davidson Avenue, Apt. 5A, Bronx, NY and her emergency contact was her son, Jesus Rosas, who resided in Apt. 1D of the same building, and included Rosas' telephone number. Black's notes also indicate that plaintiff would require assistance at home and a plan was made to refer her to the Visiting Nurse Service (VNS), a home health care agency, for post-hospital care. On October 24, 2007, plaintiff was discharged from SBH in the company of her son, Jesus Rosas, with a five day supply of Coumadin and instructions to follow up with her primary care physician on October 26, 2007 and the vascular surgery clinic on November 14, 2007.

VNS records show that starting on October 25, 2007 (the day after plaintiff was discharged) and continuing through October 29, 2007, VNS providers attempted to see plaintiff at her residence, but they were unable to gain entry to the building. When they called the emergency contact number that was provided to reach plaintiff's son, the person who answered denied knowing plaintiff or Jesus Rosas. SBH was first informed of the difficulty in seeing plaintiff on October 29, 2007. At that time, another contact telephone number to reach plaintiff's son was provided through the office of plaintiff's physician and arrangements were made for a neighbor to let VNS into plaintiff's building. That day, VNS noted that plaintiff had no telephone and the bell downstairs was not working.

On November 14, 2007, plaintiff presented to the vascular clinic for a wound check. It was noted that she was healing well and she was told to return in two months. The nature of her treatment on the 14th was not discussed in this motion. However, on November 30, 2007, plaintiff went to SBH Emergency Room complaining of numbness behind the left knee. She was diagnosed with an occluded femoral-popliteal bypass.

On December 2, 2007, Dr. Schwartz performed a left ilio-popliteal artery bypass and a left common femoral artery endarterection. Post operatively, the blood flow to plaintiff's left extremity was poor, gangrene set in and plaintiff's leg had to be amputated above the knee on December 21, 2007.

SBH and Drs. Adekunle and Solis seek dismissal of the complaint on the ground that the care and treatment they rendered to plaintiff was at all times proper and no act or omission by them was a proximate cause or substantial factor in causing the claimed injuries. In support of the motion, SBH and Drs. Adekunle and Solis submit the affirmation of Dr. George Brief, who is Board Certified in Internal Medicine, the affidavit of Cynthia Collins, a registered nurse, and the affidavit of Margaret McCabe, a physical therapist.

Dr. Brief opines that the care and treatment rendered by SBH staff, including Dr. Adekunle, Dr. Solis, Mr. Black, and other staff members was at all times proper and within good and accepted standards of medical practice and no act or omission by them was a proximate cause or substantial factor in causing the claimed injuries. Dr. Brief notes that hospitals do not make medical judgments and that hospital residents are "essentially trainees" who work under the direction and supervision of attending physicians. He explains that while residents may document a patient's history and complaints, perform a physical examination and discuss the case with the supervising attending physician, they do not have the authority to discharge or admit a patient, order a patient's transfer to another institution, order medication, or otherwise create a plan of care independent of the attending physician, as that is the responsibility of the attending physician.

Dr. Brief states that the attending physician is responsible for performing his own

evaluations of the patients and formulating a plan of care, which may include discharge. He opines that Dr. Adekunle, Dr. Solis and other St. Barnabas Hospital staff involved in plaintiff's care clearly and appropriately documented her history, symptoms, clinical findings and progress, providing Drs. Piccorelli and Schwartz all of the pertinent information necessary to make an informed disposition with regard to plaintiff. He also opines that all of the attending physicians' orders and instructions were implemented and that none of Dr. Piccorelli's or Dr. Schwartz's actions were such as to require Dr. Adekunle, Dr. Solis or any other resident to countermand their decisions and to exercise independent judgment in the care and treatment of plaintiff.

Nurse Collins opines that SBH staff who participated in plaintiff's discharge planning acted within the applicable standard of care and that nothing they did or failed to do was a proximate cause or a substantial factor in plaintiff's outcome. She notes that prior to being discharged, plaintiff was interviewed by Mr. Black through a Spanish interpreter. She also notes that plaintiff informed Mr. Black that she resided alone at 2000 Davidson Avenue, Apt. 5A, Bronx, New York, that her son (and emergency contact) Jesus Rosas, resided in apartment 1D of the same building and a telephone number for Rosas was provided. Nurse Collins notes that during her interview with Mr. Black, plaintiff never verbalized any concerns about her ability to allow VNS personnel entry into her home or go to her medical appointment.

Nurse Collins explains that the decision of whether or not to discharge a patient is made by the patient's attending physicians and the role of nurses and hospital staff in discharging a patient is to document the patient's information and provide the patient with discharge instructions. She opines that the discharge planner is not required to independently investigate the truth of the information provided by the patient or to question her about whether the bell in

her apartment is working, where the patient does not verbalize any problems or concerns. Nurse Collins opines that SBH staff acted within the standard of care by giving plaintiff appropriate discharge instructions and arranging for VNS to come to her residence.

The affidavit of Margaret Mc Cabe, P.T. shows that plaintiff's treatment by the physical therapists at SBH was within the applicable standard of care and that none of their acts or omissions is a cause or substantial factor in plaintiff's outcome. McCabe explains that the physical therapist does not decide whether or not to discharge a patient, that this decision is made by the patient's attending physicians and physical therapists have no authority to countermand it. She opines that SBH physical therapists fulfilled their functions in their treatment of plaintiff. She opines that attempting stairs is not crucial for a patient who was able to climb to her fifth-floor apartment prior to the surgery, at a time when she complained of pain and numbness in her legs, because "As long as the attending physician deemed the patient ready for discharge, the patient's improved circulation and post-operative pain relief should have made it tolerable for her to climb up and down stairs."

Dr. Piccorelli takes no position with regard to the propriety of the discharge, but submits opposition "only to clarify" that the claimed departures pertaining to the discharge would be the responsibility of the hospital staff and employed doctors and not his responsibility. In support of this contention, Dr. Piccorelli submits the affirmation of William Suggs, M.D., a Board Certified Vascular Surgeon. Dr. Suggs opines that the care and treatment Dr. Piccorelli provided with regard to the surgery and plaintiff's discharge in all ways met the standard of care. He opines that the role of the Vascular Surgeon with regard to the discharge of a patient such as plaintiff is "merely to determine whether the patient is fit for discharge from a surgical standpoint" and that

issues regarding the patient's living accommodations, access to communication and the like are the Hospital's employees' responsibility, not the vascular surgeon's. Dr. Suggs opines that although Dr. Piccorelli "authenticated" the resident's Discharge Summary, "this was done in reliance on the resident, social worker, physical therapist, nurses and others" for whom the hospital is responsible. He also opines that if plaintiff's living accommodations, ability to communicate and/or similar issues were not properly considered, this is the hospital's fault.

Plaintiff contends that SBH and Drs. Adekunle and Solis have failed to meet their prima facie burden because they failed to address the deposition testimony of the discharge planning team (such as, it is important to consider a patient's ability to walk if she underwent surgery on her leg) and the testimony of plaintiff's son, Jesus Rosas, that he told people in the hospital prior to his mother's discharge, that she was "not stable for discharge." Thus, plaintiff contends that Nurse Collins' opinion is not based on the facts when she states that Rosas did not voice concerns regarding his mother's living conditions and this renders defendants' experts' opinions speculative and inadmissible.

In opposition to the motion, plaintiff submits the affidavit of a board certified vascular surgeon who notes that plaintiff was discharged with 5 mg of Coumadin because she was to receive follow up care from her primary care doctor two days post discharge, but she missed her medical appointment, did not refill her prescription for Coumadin, and was not seen by a physician until November 14, 2007. Thus, she did not have her blood levels for Coumadin taken post discharge through readmission to SBH.

Plaintiff's medical expert notes that Nurse Butler opines that Ms. Irizarry was not stable for discharge to her home on October 24, 2007 and that it was unsafe and improper to discharge

her to her home on that date. The expert also notes that Nurse Butler opines that the social workers and "team" that coordinated plaintiff's discharge planning (including resident physicians, nursing, social workers, and physical therapists) departed from the standard of care by failing to notify the attending physician, Dr. Piccorelli, that plaintiff was "not stable" for discharge to her home and that it was unsafe and improper to discharge her to home on that date and that these departures were substantial factors in causing plaintiff to miss her October 26, 2007 medical appointment, to not be seen by a physician until November 14, 2007, to not have her blood levels for Coumadin taken post discharge through readmission to SBH, to not receive timely refill of Coumadin prescription, and to not receive physical therapy post-discharge until November 5, 2007 and VNS care until October 31, 2007.

Plaintiff's medical expert opines that: "If the attending physician, Dr. Piccorelli, had been told that plaintiff was "not stable" for discharge, then accepted standards of care would have required that he not discharge her at that time and if keeping plaintiff in the hospital was not an option, then accepted standards of care required that she be transferred to another facility or hospital." The expert also opines that if plaintiff was not stable and Dr. Piccorelli still decided to discharge her home, then accepted standards of care would have required that hospital medical staff capable of countermanding the order, such as the senior resident physician on the team, do so and failure to take such action would have constituted a deviation. Plaintiff's medical expert concludes that based on his review of the material, including Nurse Butler's affidavit, plaintiff's discharge from the hospital on October 24, 2007 was premature and that this was a substantial factor in causing her to miss her medical appointment and suffer the claimed injuries.

Nurse Butler opines that "while the attending doctor, Dr. Piccorelli, would have the

ultimate authority and decision-making regarding whether to discharge Ms. Irizarry from the hospital," accepted standards of care required that the "team" coordinating the discharge planning, who would be providing Dr. Piccorelli with the information pertaining to the above decision, provide information that is accurate and would not omit information pertinent and relevant to that decision. She notes that Drs. Solis and Adekunle (first year residents) involved in plaintiff's care testified that the social worker would tell the surgical team if there was a problem regarding discharge planning, and that this communication would take place prior to the attending physician giving the instruction to discharge the patient. She also notes that there is no indication that the residents or medical staff were notified by the social workers of any problems or concerns regarding plaintiff's post-discharge planning and that Dr. Piccorelli "testified that he did not know at that time that plaintiff resided on the fifth floor of an apartment building having a broken elevator." Nurse Butler refers to Mr. Black's testimony that it was an oversight on his part to not indicate whether plaintiff resided in an elevator building or a walk-up building, because he probably assumed that it was an "elevated" building.

Nurse Butler also notes that there is "no indication that Mr. Black spoke with any of plaintiff's sons or other family members about whether she resided in an elevator building" and no indication that any social worker notified the discharge nursing staff, or Visiting Nurse Service, prior to plaintiff's discharge, that there was no working contact phone number (emergency or otherwise) for this patient.

Nurse Butler opines that SBH social workers departed from the standard of care by failing to timely and properly determine whether plaintiff resided in an elevator or non-elevator building, failing to notify the "team" whether she had to climb or descend stairs to get to her

medical appointments, failing to obtain working contact phone numbers to reach her or her family, failing to note proper information about her living conditions, failing to give family contact info for VNS and by failing to notify the team of these problems and allowing the team, including surgery, medicine and PT, to deem her "stable " for discharge. She opines that these departures caused plaintiff to miss her medical appointment, to not refill of her prescription for Coumadin and to not be seen by a physician until November 14, 2007. She opines that these departures were substantial factors in causing the claimed injuries. Nurse Butler disagrees with Nurse Collins' opinions and notes that Nurse Collins does not address the testimony of Black or his "admission that he deviated from accepted standards of care."

On a motion for summary judgment, it is the burden of the summary judgment proponent to demonstrate prima facie entitlement to judgment as a matter of law with evidence sufficient to eliminate any material issue of fact; failure to do so requires denial of the motion regardless of the sufficiency of the opposing papers (Alvarez v. Prospect Hosp., 68 NY2d 320; Winegrad v. New York Univ. Med. Ctr., 64 NY2d 851). The burden then shifts to the party opposing the motion to demonstrate by evidentiary proof in admissible form that a triable issue of fact exists (Zuckerman v. City of New York, 49 NY2d 557). A court's task is issue finding rather than issue determination (Sillman v. Twentieth Century-Fox Film Corp., 3 NY2d 395) and the court must view the evidence in the light most favorable to the party opposing the motion, giving that party the benefit of every reasonable inference and ascertaining whether there exists any triable issue of fact (Boyce v. Vazquez, 249 AD2d 724).

Despite plaintiff's assertions to the contrary, the evidence presented is sufficient to establish, prima facie, SBH's, Dr. Solis' and Dr. Adekunle's entitlement to judgment as a matter

of law. Thus, the burden shifted to plaintiff to present competent evidence sufficient to raise a material issue of fact. She has failed to meet this burden.

While plaintiff has submitted the affidavit of a vascular surgeon who opines that plaintiff's discharge from the hospital on October 24, 2007 was "premature" and a substantial factor in causing her to miss her October 26, 2007 medical appointment, his opinion is based, in part, upon hypothethicals and not on the facts. This renders his opinion insufficient to raise a triable issue of fact (Shapiro v. Health Ins. Plan of Greater New York, 7 NY2d 56). It is also noted that plaintiff's medical expert's opinion is based, in part, upon the opinion of Nurse Butler, that plaintiff was not "stable" for discharge to her home. However, Nurse Butler is not competent to render an opinion as to whether plaintiff was medically stable for discharge, nor is she competent to render an opinion regarding other health care specialties, such as physical therapists (Geffner v. North Shore Univ. Hosp., 57 AD3d 839).

As to Nurse Butlers' assertion that Drs. Solis and Adekunle and SBH staff departed from the standards of care by failing to inform the attending physician of pertinent information, it is undisputed that plaintiff's chart contained the physical therapists' and social workers' notes and that Dr. Piccorelli was responsible for deciding whether plaintiff should be discharged. Therefore, the pertinent information as to plaintiff's physical therapy plan was available to him to consider in deciding whether to discharge plaintiff. Insofar as Nurse Butler opines that SBH staff departed from the standard of care by failing to indicate in the record that social workers asked plaintiff or any of her family about her living conditions, she fails to set forth the standard of care that the health care provider should have followed and many of the alleged failures to document are not supported by the evidence. For example, she claims that defendants failed to ascertain

whether plaintiff had any children, when the note lists the name of one of her sons. The absence of a note in the record is not proof of a departure from the standard of care (Rivera v. Jothianandan, 100 AD3d 542). Nurse Butler not only fails to address the patient's responsibility to provide the hospital with accurate information regarding her living conditions and contact information, but also fails to set forth the standard of care that social workers are supposed to follow in a case such as plaintiff's (Grzelecki v. Sipperly, 2 AD3d 939). This renders her affidavit lacking in probative value and insufficient to raise a material issue of fact.

As to Nurse Butler's opinion that SBH staff departed from the standard of care by failing to advise the "team" and Dr. Piccorelli that plaintiff resided on the fifth floor of a building with a broken elevator, the evidence shows that plaintiff did not report any concerns regarding getting to her appointments and there was no reason to question the truth of the information she provided. Nor is there evidence that the elevator was broken on the day of plaintiff's follow up medical appointment. Notably, there is no affidavit from the plaintiff or excerpts from her deposition testimony to support any claim that she did not have a phone, that she could not get to her appointment because the elevator was not working or that she could not refill her Coumadin prescription. Thus, plaintiff has failed to establish that the alleged departure was a proximate cause of the claimed injuries.

As to Dr. Piccorelli, Dr. Suggs does not contradict Dr. Brief's opinion that it was Dr. Piccorelli's responsibility to review the chart and determine whether plaintiff was physically cleared to return to her home or whether she required further rehabilitation or physical therapy before going home. Here, it was Dr. Piccorelli's decision to discharge plaintiff and the chart was contained the physical therapist's note as well as the social workers' notes and the information

provided by plaintiff. Therefore, he had the pertinent information to decide whether plaintiff was "stable" for discharge to her home or, if she should be discharged to a rehab facility.

As to plaintiff's contention that Mr. Black's testimony contains admissions of negligence, a review of his testimony shows that he was responding to hypothetical situations that have not been established in this case. Finally, plaintiff's medical expert does not address the fact that plaintiff went to the vascular clinic on November 14, 2007, was examined and told to return in two months. It was noted that plaintiff was ambulating with a walker and had finished her Coumadin. No further medications, including Coumadin, were prescribed and no complications were observed. Plaintiff's medical expert does not opine when the occlusion first occurred, whether before or after the November 14th visit, and thus cannot establish a connection between any alleged deficits in the discharge planning and the occlusion. Accordingly, the motion by SBH, Dr. Solis and Dr. Adekunle for summary judgment dismissing the complaint is granted.

Movants shall serve a copy of this order with notice of entry on the Clerk of the Court who shall enter judgment dismissing the complaint.

This constitutes the decision and order of the court.

Dated: February 20, 2015

STANLEY GREEN, J.S.C.