Kitt v Okonta
2015 NY Slip Op 31899(U)
September 25, 2015
Supreme Court, Bronx County
Docket Number: 300414/10
Judge: Stanley B. Green
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[* 1] FILED Sep 30 2015 Bronx County Clerk

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF BRONX: IA-6M
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PATRINA KITT, as Administratrix of the Estate of
CHMAAR KITT SCOTT, deceased,

INDEX No. 300414/10

Plaintiff(s),

- against-

BENJAMIN OKONTA, M.D., BROOKHAVEN
REHABILITATION & HEALTH CARE CENTER,
SENIOR CARE EMERGENCY MEDICAL SERVICES
and ST. JOHN'S EPISCOPAL HOSPITAL,

Defendant(s)

DECISION

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HON. STANLEY GREEN:

The motion by Benjamin Okonta, M.D. for summary judgment dismissing the complaint is hereby consolidated with the motions for summary judgment by Brookhaven Rehabilitation & Health Care Center (Brookhaven) and Episcopal Health Services, Inc. s/h/a St. John's Episcopal Hospital (St. John's) and upon consolidation, the motion by St. John's and the motion by Dr. Okonta are granted. The motion by Brookhaven is denied.

Plaintiff commenced this action to recover damages for personal injuries and death, allegedly due to defendants' failure to timely diagnose and treat deep vein thrombosis (DVT), pulmonary embolism (PE) and cardiac arrest.

On March 18, 2008, decedent, age 26 and weighing 509.6 lbs, was admitted to Brookhaven from Halifax Hospital in Florida to participate in a weight loss program offered by the facility. Decedent had been admitted to Halifax Hospital on March 4, 2008 with complaints of shortness of breath. After undergoing tests, including tests to rule out DVT/PE, decedent was

discharged from Halifax Hospital on March 14, 2008 and with a principal diagnosis of congestive heart failure and secondary diagnoses of cardiomyopathy, morbid obesity, chronic bronchitis and hypertension.

On admission to Brookhaven on March 18, 2008, decedent was alert, ambulatory and independent in all activities of daily living. However, he complained of bilateral lower leg pain. Dr. Khanina, an attending physician at Brookhaven, was notified and issued a telephone order for Percocet for pain, as needed. On March 20, 2008, Dr. Khanina performed a physical examination of decedent, ordered an EKG and daily blood pressure and oxygen saturation readings. Decedent's course at Brookhaven was uneventful through March 28, 2008, except for occasional complaints of pain in his legs, which resolved with medication.

On March 28, 2008, decedent developed nausea, vomiting, shortness of breath, diarrhea and dizziness. On March 29, 2008, at approximately 5:10 a.m., a nurse found decedent kneeling on the floor, facing the bedside table. He said he was kneeling down because it was comfortable for him to vomit in that position. Decedent was assisted back into bed. The attending physician was contacted and ordered oxygen 2-3L by nasal cannula, as needed, for shortness of breath.

At 9:45 a.m., a nurse noted that decedent was in bed and alert, but felt nauseated and dizzy when he moved. He was given ice chips for the nausea and instructed not to get out of bed. At 10:00 a.m., the attending physician was paged. At 10:30 a.m., decedent was found sitting on the floor at the foot of his bed, gagging and retching. He complained of nausea and dizziness and had no recollection of how he ended up on the floor. Nurses transferred him back to bed and called Dr. Khanina, who ordered decedent transferred to St. John's for evaluation.

Senior Care Emergency Medical Services arrived to take decedent to the hospital, but as

they were loading him into the ambulance, the stretcher collapsed and decedent rolled off the stretcher onto the sidewalk. Nurses responded and decedent was transferred back onto the stretcher and taken to the hospital. Decedent arrived at St. John's at approximately 11:59 a.m. A Brookhaven nurse's note indicates that at 12:10 p.m. St. John's was contacted to inform them of decedent's fall.

On arrival at St. John's decedent was triaged by Nurse McLeod. She noted that decedent's only complaint was that he had been dropped by the EMTs and that he denied pain, loss of consciousness or injury. Nurse McLeod requested a bariatric bed, took decedent's vital signs, started an IV, and obtained a past medical history. She observed that decedent appeared to be in moderate respiratory distress and placed him on 100% oxygen via a non-rebreather mask. She categorized decedent as category "1", the most urgent category.

At approximately 1:00 p.m., a speciality bed was brought to the emergency department. As decedent was being transferred from the Senior Care stretcher to the bed, he became unresponsive. EMT's began to perform CPR and a code was called. Dr. Okonta, the cardiac arrest team leader, responded to the code. Despite all efforts to resuscitate him, decedent did not respond and was pronounced dead by Dr. Okonta at 2:04 p.m. The Medical Examiner determined that the cause of death was "pulmonary embolism due to deep vein thrombosis of leg due to morbid obesity."

Brookhaven, SJEH and Dr. Okonta seek dismissal of the complaint on the ground that the care and treatment they provided to decedent was within accepted standards of medical care and was not a proximate cause of decedent's claimed injuries or death.

In support of its motion, Brookhaven submits the affirmation of Dr. Chideckel, a board

certified surgeon in private practice as a vascular surgeon. Dr. Chideckel opines that Brookhaven did not depart from accepted standards of medical care in its care and treatment of decedent, that there is no causal link between the care provided by Brookhaven and the claimed injuries, and that decedent's underlying deterioration and poor prognosis given his morbid obesity was the proximate cause of his injuries and death.

Dr. Chideckel notes that at the time decedent was admitted to Brookhaven, he was ambulatory and Brookhaven possessed documents from Halifax Health Systems, dated March 7, 2008, which "detailed that he had no evidence of deep vein thrombosis (DVT) or pulmonary embolism (PE)." He also notes that a D-dimer test was performed at Halifax that specifically ruled out DVT. Dr. Chideckel acknowledges that morbidly obese residents, such as decedent, are at greater risk for DVT or PE, but states that: "it is not within accepted standards of medical care to maintain residents on a prolonged course of blood thinners and it is in fact more detrimental to the long term health of the resident." Dr. Chideckel notes that decedent had complaints of bilateral leg pain on March 18, 26 and 27, but opines that there was "no evidence in the records of signs or symptoms that would have indicated a pulmonary thromboembolism exclusively."

Dr. Chideckel notes that on March 29th, when decedent was found sitting on the floor complaining of nausea and dizziness, Brookhaven staff notified the attending physician and oxygen was ordered for shortness of breath. He opines that based on decedent's vital signs at that time, there was no indication that he was suffering from a DVT or PE. He also opines that at 10:30 a.m., when decedent was found on the floor of his room, complaining of nausea and dizziness, consistent with good and accepted standards of medical practice, the attending physician was notified and an order was implemented to transfer decedent to the hospital.

In support of its motion, St. John's submits the affirmation of Dr. Elias Sakalis, who is board certified in Internal Medicine. Dr. Sakalis opines that the care and treatment rendered to decedent at St. John's was at all times proper and in conformity with the applicable standard of care. Dr. Sakalis notes that Nurse McLeod testified that when decedent arrived at St. John's ER, she immediately triaged him, took his vital signs and started an IV, then later entered the information in the electronic record at 12:47 p.m. Dr. Sakalis opines that decedent's presenting signs, symptoms and complaints were "unlikely indicative" of a DVT or PE. He explains that patients with a DVT can present with pain to one or both legs and/or with swelling or warmth to the leg and patients with a PE generally present with shortness of breath, sharp chest pain, tachycardia or rapid breathing and other than shortness of breath and that decedent did not have any signs or symptoms that would be suggestive of a DVT or PE. Dr. Sakalis also notes that shortness of breath could have been caused by an exacerbation of any of decedent's other medical conditions, including congestive heart failure or chronic bronchitis.

Dr. Sakalis acknowledges that there are times when patients present with signs and symptoms that are highly indicative of a DVT or PE and in such cases, the immediate use of thrombolytics, without blood work or imaging studies may be warranted, but he opines that this is only if the patient is hemodynamically unstable, which was not the case here as decedent's vital signs were stable and he did not make any complaint of pain, including chest pain, to Nurse McLeod. Dr. Sakalis also opines that administration of thrombolytics to decedent without any work-up would have been contraindicated and a departure in this case because decedent had suffered a trauma.

Dr. Sakalis opines that the relevant standard of care did not dictate that SJEH had to

administer fibrinolytic agents or use presumptive fibrinolysis in the face of DVT because fibrinolysis is the process of dissolving blood clots and is not used to treat DVT's in the acute emergency room setting. He opines that since decedent was at SJEH at most an hour prior going into cardiac arrest, there was no indication to immediately administer fibrinolytic agents for a DVT or PE. As to plaintiff's claim that various laboratory studies and imaging studies should have been performed on decedent's arrival, Dr. Sakalis opines that even if such studies and labs had been done, the results could not have been available in time to start anticoagulation for decedent to obtain the therapeutic effects of same prior to his cardiac arrest. Dr. Sakalis also opines that decedent's cardiac arrest was properly managed in accordance with the standard of care.

In support of his motion, Dr. Okonta submits the affirmation of Dr. Gregory Mazarin, who is board certified in Emergency Medicine. Dr. Mazarin opines that Dr. Okonta complied with the standard of care when providing basic and advanced life support by immediately establishing an airway, obtaining IV access and administering epinephrine, nasal saline and atropine, and by use of Dopamine when a faint pulse was detected. He opines that patients in cardiac arrest are too unstable to undergo diagnostic testing and because the mortality rate is so high once cardiac arrest occurs, PE is the last on the list of responses to the pulseless electrical activity (PEA) that was occurring in this case. Dr. Mazarin also opines that any treatment given by Dr. Okonta was not a substantial factor in causing the claimed injuries because decedent was already coding at the time of Dr. Okonta's arrival and given the presence of multiple thromboemboli in decedent's lung, it was not a condition amenable to treatment once decedent's heart stopped because the clots interfered with the normal perfusion and oxygenation of his

blood. Thus, he opines that decedent would have died irrespective of any care rendered by Dr. Okonta.

Plaintiff contends that Brookhaven and St. John's failed to meet their prima facie burden on the motion because: (1) their experts do not practice in the specialties of pulmonology, emergency medicine or critical care medicine; (2) Dr. Sakalis failed to review the depositions of the EMT's and ambulance report; (3) Dr. Chideckel's opinion is based on facts not supported by the records, i.e., that Halifax records showed "no evidence of deep vein thrombosis or pulmonary embolism" when DVT could not be ruled out due to the quality of the Doppler studies and decedent's size; (4) there is no indication in the Brookhaven record that Dr. Khanina reviewed the Halifax chart; and (5) Dr. Sakalis' assertion that Nurse McLeod triaged decedent "immediately" is contrary to the testimony of the EMT's. Plaintiff also contends that Dr. Mazarin's opinion is insufficient because he did not address the issue of delay in treating decedent at St. John's and did not review all of the EMT reports and records.

In opposition to the motion, plaintiff submits the affirmation of Dr. Schwartz, who is Board Certified in Neurocritical Care, Critical Care Medicine and Pulmonary Medicine.

Dr. Schwartz opines that defendants were negligent in failing to timely diagnose and treat decedent's pulmonary embolism and failing to timely administer a bolus of heparin for a diagnosed or suspected PE and as a result, deprived decedent of any chance of survival and caused his death.

Dr. Schwartz notes that the Halifax records indicate that decedent's D-dimer test was markedly elevated at 3718 Ng/Ml, where normal would be less than 250Ng/Ml, and opines that this warranted further VTE (venous thromboembolism) work up because although a normal D-

dimer would rule out a DVT within a 95% negative probability, such a high reading did not eliminate the suspicion of a DVT. He also notes that the doppler ultrasound of March 4, 2008 was a "limited examination due to patient's significant body size" and specifically noted that there was "non-visualization of the mid and distal portions of the femoral vein due to the patients body size" and the CT scan was limited as well, in that: "The examination of the small branches is limited secondary to the patient's size." Also, followup CT scan was recommended by the radiologist that performed the CT angiogram.

Dr. Schwartz opines the staff and physicians, who were aware of the suspected DVT at Halifax and inconclusive test results, should have performed further testing to rule out a DVT or provided a prophylactic course of heparin since decedent was "virtually bedridden" and unable to ambulate without assistance. He also notes that decedent was seen by a physician only once during his admission to Brookhaven and his complaints of shortness of breath was treated with prednisone and inhalers and pain in his legs was treated with Percocet. He opines that Brookhaven staff and physicians, who were aware of the suspected DVT at Halifax and the inconclusive testing for DVT/PE, should have performed further investigation and testing to rule out a DVT, or provided a prophylactic course of heparin since decedent was "virtually bedridden" and unable to ambulate without assistance. Dr. Schwartz also opines that treatment of decedent's continued pain in the legs, altered mental state and shortness of breath with pain medication, asthma medication and psychotropic drugs, instead of being considered as symptoms of DVT/PE, led to a failure to consider prophylactic anticoagulation treatment and that these multiple deviations led to decedent's death from PE.

Dr. Schwartz also opines that on March 29, 2008, in the early morning on March 29th, the

signs and symptoms were highly suggestive of PE and that there was at least a 2.5 hour period during which time decedent was not in shock or cardiac arrest and if he had been appropriately treated with therapeutic Heparin, his chances of survival would have been approximately 95%. However, during this time, at neither facility was decedent seen or evaluated by a physician and no diagnostic studies were performed. He opines that these were deviations from the standard of care that led to decedent's death.

Dr. Schwartz opines that St. John's emergency room had the last chance to save decedent if they had acted promptly in assessing and treating DVT/PE. He opines that anticoagulation was mandatory at this juncture and time was wasted in the emergency room and that the failure to administer an appropriate dose of heparin during the time when decedent was not in shock was a gross deviation from the standard of care and led to his death.

In reply, Brookhaven contends that Dr. Schwartz' entire theory that Brookhaven should have prophylactically put decedent on a course of heparin is based on the incorrect premise that decedent was immobile, when he was ambulatory and, per Dr. Chideckel, prophylactic anticoagulation treatment was not appropriate for him. Brookhaven also contends that Dr. Schwartz' affirmation contains other factual misstatements, including that the facility "blinly [sic] treated decedent's pain with percocet," when this was done after a physical evaluation by Dr. Khanina, and that "Chideckel does not address the fact that an[sic] physical examination was never performed at Brookhaven nor was there any consideration of prophylactic anticoagulants," when the record shows that Dr. Khanina as well as the nursing staff and the physical therapy department performed examinations of decedent. Brookhaven contends that plaintiff's expert's opinion is based upon hindsight, when decedent was suffering from multiple co-morbidities that

could have caused the symptoms that he presented with.

St. John's contends that Dr. Schwartz fails to assert the relevant standard of care applicable in the Emergency Room in 2008, mistakenly combines the opposition to all defendants and attempts to rely on information that could not have been known by the staff in the emergency department at St. John's, such as the records from Halifax and the autopsy report. St. John's also contends that plaintiff fails to show how the availability of a bariatric bed would have changed decedent's overall course and that Dr. Schwartz failed to rebut Dr. Sakalis' opinion that Heparin was not indicated on arrival because decedent's complaints of leg pain was a chronic complaint and his shortness of breath could have been caused by an exacerbation of any of his chronic medical conditions. St. John's also notes that Dr. Schwartz talks about "the golden hour" during which Heparin should have been administered, yet also opines that Brookhaven should have anti-coagulated decedent during his entire admission and identifies a 2.5 hour period where he opines Brookhaven should have intervened and transferred decedent to St. John's.

In a medical malpractice action, a defendant physician establishes prima facie entitlement to summary judgment when he establishes that in treating the plaintiff there was no departure from good and accepted medical practice or that any departure was not the proximate cause of the injuries alleged (Roques v. Noble, 73 AD3d 204). Once the defendant has met his prima facie burden, the burden shifts to the plaintiff to present competent evidence sufficient to show that the defendant departed from accepted standards of practice and that such departure was a proximate cause of the plaintiff's injuries (Kafka v. New York Hospital, 228 AD2d 332).

In order to sustain this burden, a plaintiff must submit the affidavit of a physician attesting to a departure from good and accepted practice and that the alleged departure was a

competent producing cause of the plaintiff's injuries(Berger v. Becker, 272 AD2d 565). The expert's opinion must be based on facts in the record or personal knowledge (Cassano v. Hagstrom (5 NY2d 643).

Initially, it is noted that plaintiff has not opposed defendants' motions insofar as they seek dismissal of the cause of action for lack of informed consent. Accordingly, the cause of action for lack of informed consent is dismissed. It is also noted that the fact that Dr. Chideckel and Dr. Sakalis are not specialists in pulmonary, critical care or emergency medicine does not render their opinions insufficient as there is no requirement that a medical expert be a specialist in a particular field if he possesses the requisite knowledge necessary to make a determination on the issues presented (Joswick v. Lenox hill Hospital, 161 ADd2d 352, citing Fuller v. Preis, 35 NY2d 425).

While Brookhaven has presented the affirmation of an expert who opines that the care and treatment provided by Brookhaven was in accordance with good and accepted standards of medical practice and did not proximately cause the claimed injuries, Dr. Schwartz' affirmation raises triable issues of fact as to whether, in light of the inconclusive tests for DVT performed at Halifax Hospital, decedent's high risk for DVT/PE, his complaints of shortness of breath and continuing complaints of leg pain, it was a departure for Brookhaven staff to fail to evaluate and further investigate decedent's complaints of leg pain or administer prophylactic anticoagulation therapy and to fail to have decedent seen by a physician more than once and if so, whether this was a substantial factor in causing the claimed injuries and death.

It is noted that Dr. Schwartz' opinion is based, in part, upon his characterization of decedent as "virtually bedridden" and immobile, while the Brookhaven records indicate that he

was ambulatory. However, the Brookhaven records also indicate that decedent was had difficulty with balance and that he required a one-person assist on transfer. Also, while there are progress notes which indicate that decedent was out of bed, there are other days when there is no mention of whether or not he was out of bed. As the court's task is issue finding rather than issue determination (Sillman v. Twentieth Century-Fox Film Corp., 3 NY2d 395), viewing the evidence in the light most favorable to plaintiff and giving her the benefit of every reasonable inference (Boyce v. Vazquez, 249 AD2d 724), triable issues of fact exist which preclude a grant of summary judgment. Accordingly, Brookhaven's motion for summary judgment is denied.

As to St. John's, while plaintiff's expert opines that St. John's emergency room "had the last chance to save" decedent if they had acted promptly in assessing and treating DVT/PE, his opinion is insufficient to raise a material issue of fact because he fails to address Dr.Sakalis' opinion that decedent did not present with any signs or symptoms that would be suggestive of a DVT or PE, such as pain in his legs, sharp chest pain, tachycardia or rapid breathing, that decedent's vital signs were stable, and that his shortness of breath could have been caused by an exacerbation of any of his chronic medical conditions, including congestive heart failure or chronic bronchitis. He also fails to rebut Dr. Sakalis' opinion that because decedent had suffered a potential trauma, thrombolytics would be contraindicated without the confirmation of a PE and that, even if the tests and laboratory studies had been performed immediately on decedent's arrival, the result could not have been available in time to start anticoagulation for decedent to obtain the therapeutic effects of same prior to his cardiac arrest. This renders Dr. Schwartz' opinion that St. John's departed from the standard of care and caused the claimed injuries conclusory and insufficient to raise a material issue of fact (Abalola v. Flower Hospital;, 44

AD3d 522; Ramirez v. Columbia-Presbyterian Medical Center, 16 AD3d 238). Accordingly, the motion for summary judgment by St. John's is granted.

It is noted that plaintiff's expert notes discrepancies in the St. John's records regarding the timing of the code, decedent's time of death, etc. However, these discrepancies are explained by the testimony of Nurse McLeod and the addendums to the records, which show that the entries are timed at the time they were made and, due to the need to treat the patient, the entries were made after the fact.

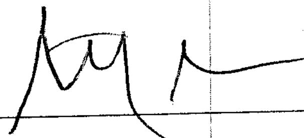
As to Dr. Okonta, the evidence presented establishes, prima facie, that the care and treatment rendered to decedent by Dr. Okonta was within good and accepted standards of medical treatment and that no act or omission by him was a substantial factor in causing the claimed injuries. Thus, the burden shifted to plaintiff to present competent evidence sufficient to raise a material issue of fact (Zuckerman v. City of New York, 49 NY2d 557). She has failed to meet this burden. While Dr. Schwartz contends that St. John's had the last opportunity to save decedent, he does not offer an opinion regarding the treatment by Dr. Okonta nor does he address Dr. Mazarin's opinion that Dr. Okonta's duty was to render emergent care to decedent solely for cardiac arrest, that cardiac care took immediate priority over an examination for PE/DVT, and that, due to the presence of multiple thromboembolisms in his lung, decedent would have died regardless of any treatment by Dr. Okonta. Thus, the evidence presented is insufficient to raise a material issue of fact to defeat Dr. Okonta's motion. Accordingly, Dr. Okonta is entitled to summary judgment dismissing the complaint.

This constitutes the decision and order of the court.

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 as against Benjamin Okonta, M.D. and St. John's Episcopal Hospital.

Dated: September 25, 2015



STANLEY GREEN, J.S.C.