SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF BRONX

----------X

YANYCE DENAI CULLER, as Administrator of the Estate of DARLENE SUMLIN, Deceased,

Plaintiff,

-against-

ROBIN J. DIBNER, M.D., STEVEN D. MEED, M.D., LENOX HILL COMMUNITY MEDICAL GROUP, LENOX HILL PRIMARY CARE CENTER, LHHN MEDICAL, P.C. d/b/a/ MANHATTAN'S PHYSICIAN GROUP, P.C., LENOX HILL HOSPITAL, MT. SINAI MEICAL CENTER, ST. LUKE'S-ROOSEVELT HOSPITAL CENTER, and HANDS-ON PHYSICAL THERAPY, P.C.,

Defendants.

----------X

MEMORANDUM DECISION

Index No. 300617/10

HON. ROBERT T. JOHNSON:

The respective motions of defendants Robin J. Dibner, M.D. and Lenox Hill Hospital (s/h/a Lenox Hill Hospital and Lenox Hill Primary Care Center); Steven D. Meed, M.D. and LHHN Medical, P.C.; Mt. Sinai Medical Center; and St. Luke's-Roosevelt Hospital Center seeking summary judgment are decided as follows.

This medical malpractice action stems from the alleged failure to timely diagnose and treat pernicious anemia and a Vitamin B12 deficiency experienced by the decedent Darlene Sumlin ("decedent') from February 2006 through February 2008. On January 28, 2008 the decedent suffered cardiac arrest and anoxic brain damage as a result of the alleged delay in diagnosis, and she ultimately died on April 19, 2014.

The decedent was a patient at the Lenox Hill Community Medical Group ("LHCMG") in 2007. This group provided primary care as well as specialty care. The decedent was referred to Dr. Dibner for a rheumatology consult and she was seen on March 22, 2007. Dr. Dibner documented that

the decedent did not have lupus but that she had a strange constellation of symptoms, that were consistent with the presence of macrocytic anemia, as evidenced by a CBC study done earlier that month. Dr. Dibner documented that she was concerned with B12 or folate deficiency. Her plan was to start B12 supplementation, then follow with B12 correction and to give folic acid. Notably, this plan was not implemented.

The decedent returned to LHCMG for follow up care and was seen by rheumatologist Dr. Meed from March 27 through October 2, 2007. On March 27th, the decedent complained of hand numbness further described as carpal tunnel symptoms. An exam was significant for alopecia, swollen wrists, positive Tinel and Phalen signs and a weak grip. An impression of mild SLE (systemic lupus erythematosus) was noted, and Prednisone and Plaquenil were prescribed.

On March 30, 2007, the decedent was seen at LHCMG for severe joint pain. It was documented in the records that the decedent had been diagnosed with SLE and carpal tunnel syndrome, and was prescribed Prednisone. On April 5, 2007 and April 17, 2007, Dr. Meed noted that the decedent's condition had improved slightly but continued to complain of severe pain. On May 27, 2007, Dr. Meed documented the results of an EMG, which demonstrated improving carpal tunnel syndrome. On June 14, 2007, Dr. Meed noted the decedent continued to complain of hand and foot numbness. He noted that the decedent's SLE was not in remission and he increased her Prednisone dose, maintained her on Plaquenil, and started her on Methotrexate (also for lupus). On July 17, 2007, Dr. Meed increased her dose of Methotrexate. She was also given Folate.

On August 16, 2007, Dr. Meed noted the decedent was feeling stronger and could return to light duty at work. The decedent reported feeling stronger. A musculoskeletal exam demonstrated that the decedent had lupus with wrist involvement as well as carpel tunnel syndrome secondary to

use of a sorting machine. Dr. Meed concluded that the lupus was stable with medication, and the wrists were fairly normal. Blood labs were performed again and revealed nothing of significance. On September 6, 2007, Dr. Meed documented some improvement of the decedent's lupus but there were complaints of fatigue. Dr. Meed testified that the blood tests showed that the decedent did not have B12 deficiency anemia. Dr. Meed increased the decedent's Methotrexate dose and recommended a cardiology evaluation and echocardiogram.

On November 28, 2007, the decedent presented to defendant St. Luke-Roosevelt's Emergency Department complaining of intermittent weakness, dizziness, and shortness of breath. The impression was arthropathy and secondarily with lupus. She was discharged and told to follow up with her private physician/clinic.

On January 12, 2008, the decedent was taken to Lenox Hill Hospital by ambulance. Her chief complaints were noted to be depression and stress as well as a history of lupus and bilateral leg pain for one week with questionable swelling. A Doppler study was interpreted as negative for DVT (deep vein thrombosis). The decedent underwent a psychiatric assessment, which noted that she had bilateral numbness for two hours, three months' duration shortness of breath, and an increase in heart rate and palpitations. She was discharged with prolonged depression and referred for outpatient treatment. At discharge, Naprosyn was prescribed.

The decedent presented to the St. Luke's Emergency Department on January 13, 2009 with complaints of headaches, confusion, slurred speech and increasing anxiety with paranoid thoughts. The decedent was diagnosed with adjustment disorder and mixed anxiety and depressed mood; the plan was for her to follow up in outpatient psychotherapy. She was discharged with instructions to follow up with her lupus doctor.

Later that day, on January 13, the decedent presented to the Mt. Sinai Emergency Department with a two-day history of dizziness. She was treated and released for "anxiety." Her CBC result was significant for anemia. She was medicated with Ativan and discharged with an appointment to follow up with outpatient psychiatry.

The next day she presented to St. Luke's and was again discharged with a diagnosis of "anxiety."

On Janaury 15, the decedent was brought by ambulance to St. Luke's. She stated she wanted to hurt herself. She was prescribed medication consistent with a diagnosis of psychosis. Her blood work continued to reflect anemia. The next day the impression was psychosis. Tests revealed that the decedent did not have lupus. Significantly, on January 18, a Vitamin B12 deficiency was noted in the treatment plan and she was started on Vitamin B12. On January 19, she was transferred from the psychiatric floor to the medicine floor and she was noted to have pernicious anemia, hypertension and depression. She was febrile and bactremic.

Early on the morning of January 20, the decedent went to the bathroom and suffered an episode of shortness of breath, followed by a sudden collapse and cardiac arrest. A code was called, and she was intubated and transferred to the MICU. At some point in the MICU, it was noted that the decedent had a low probability of pulmonary embolism, but was treated prophylactically for the same. Later that day, after suffering additional cardiac arrests and other complications, the decedent was put on a ventilator and tube feedings were started. On February 1, 2008, a tracheostomy was performed. Her neurological status remained unchanged throughout the remainder of the admission and she was discharged on February 12, 2008 to St. Barnabas Nursing Home, where she remained ventilator-dependent until her death on April 19, 2014.

The proponent of a motion for summary judgment must make a prima facie showing of entitlement to judgment as a matter of law, tendering sufficient evidence to demonstrate the absence of any material issues of fact. *See Alvarez v. Prospect Hosp.*, 68 NY2d 320, 324 (1986); *Zuckerman v. City of New York*, 49 NY2d 557, 562 (1980). The failure to make such a showing requires denial of the motion, regardless of the sufficiency of the opposing papers. *See Winegrad v. New York University Medical Center*, 64 NY2d 851, 853 (1985). Once the moving party has demonstrated its entitlement to summary judgment, the party opposing the motion must demonstrate by admissible evidence the existence of a factual issue requiring the trial of the action. *See Zuckerman v. City of New York*, 49 NY2d at 562. When considering a motion for summary judgment, the court must view the evidence in the light most favorable to the party opposing the motion. *See Lau v. Margaret E. Pescatore Parking, Inc.*, 30 NY3d 1025 (2017).

A defendant moving for summary judgment in a medical malpractice action must make a prima facie showing of entitlement to judgment as a matter of law by showing that in treating the plaintiff there was no departure from good and accepted medical practice or that any departure was not a proximate cause of the injuries alleged. *See Roques v. Nobel*, 73 AD3d 204, 206 (1st Dep't 2010). To satisfy the burden, a defendant must present expert opinion that is supported by the facts in the record, and that opinion must address the essential allegations in the bill of particulars. *Id.* If the defendant makes a prima facie showing, the burden shifts to the plaintiff to produce evidentiary proof in admissible form sufficient to establish the existence of material issues of fact. *Id.*

The moving defendants essentially argue that their treatment was in accordance with good and accepted medical practice; that a causal link cannot be established between vitamin B12 deficiency and the decedent's cardiorespiratory arrest; nor can plaintiff establish the decedent's arrest

was caused by a pulmonary embolism. In the absence of proof that the arrest was caused by either condition, defendants argue that plaintiff cannot, as a matter of law, establish that the care rendered by the moving defendants was a substantial factor in causing the decedent's arrest, subsequent neurological injuries, or death. The moving defendants' arguments are supported by numerous expert affirmations, including the affirmation of Dr. Mark R. Burns, a board-certified internist and rheumatologist; Dr. Louis Tiger, a board certified internist and rheumatologist; Dr. Thomas Kwiatkowski, board certified in internal and emergency medicine; and Dr. Kenneth N. Sable, board certified in emergency medicine (submitted on Reply by Mt. Sinai),

In opposition, plaintiff argues with support from her two experts, one board certified in emergency medicine, and the other board certified in rheumatology, that had appropriate care been provided at any of the emergency room visits to St. Luke's-Roosevelt, Mt. Sinai, or Lenox Hill, the continued observation of decedent and work-ups would have led to an earlier diagnosis of the B12 deficiency, and an earlier diagnosis of the homocysteinemia,[1] which put the decedent at high risk for thrombotic events. The experts further opine that the pulmonary embolism that caused the decedent's cardiac arrests was a direct result of the failure of the physicians at LHCMG, including Dr. Meed, Dr. Dibner and Lenox Hill Hospital internal medicine physicians, to properly diagnose and treat the B12 deficiency in 2007. They explain that failure of the physicians treating the decedent during the inpatient admission to St. Luke's Roosevelt to properly work-up the decedent for the numerous potentially life-threatening symptoms she presented with, resulted in an inordinate delay in the diagnosis of her B12 deficiency and pulmonary embolism, most certainly contributed to the

[1]Homocysteinemia is the elevation of the homocysteine level in blood plasma; such elevation can be caused by a vitamin B12 deficiency. Homocysteinemia is a risk factor for cardiovascular disease and thrombosis.

continued thromboembolic events leading to the clot in the lungs, which resulted in the cardiopulmonary arrests that ultimately led to her demise.

In view of the record on these motions, even assuming that defendants established their entitlement to judgment as a matter of law, plaintiff has demonstrated the existence of material issues of fact. Plaintiff's experts have sufficiently raised issues of fact with regard to the appropriateness of the care provided by the moving defendants; whether appropriate care would have led to an earlier diagnosis of the B12 deficiency and an earlier diagnosis of the homocysteinemia; and whether an earlier diagnosis of the B12 deficiency would have led to earlier treatment and earlier correction of the homocysteinemia. The plaintiff's experts' opinions that the pulmonary arrests were a direct result of the moving defendants' failures to properly diagnose and treat the B12 deficiency, and failure to work-up the decedent for the numerous potentially life threatening symptoms she presented with, creates issues of fact and summary judgment must therefore be denied.

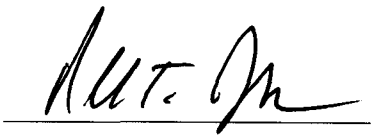
This court has considered the defendants' reply arguments and find that they do not warrant granting summary judgment.

Accordingly, defendants' motions are denied.

This constitutes the Decision and Order of the Court.

Date: May 21, 2018

Bronx, New York



ROBERT T. JOHNSON, J.S.C.