Laughtman v Long Is. Jewish Val. Stream
2019 NY Slip Op 34614(U)
March 5, 2019
Supreme Court, Nassau County
Docket Number: Index No. 606154/17
Judge: Jeffrey S. Brown
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SHORT FORM ORDER

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NASSAU

P R E S E N T : HON. JEFFREY S. BROWN
JUSTICE

---X	**TRIAL/IAS PART 11**
ELAINE LAUGHTMAN,	
Plaintiff,	**INDEX # 606154/17**
-against-	
LONG ISLAND JEWISH VALLEY STREAM, a division of LONG ISLAND JEWISH MEDICAL CENTER,	**Mot. Seq. 1** **Mot. Date 1.28.19** **Submit Date 1.28.19**
Defendant.	
---X	

The following papers were read on this motion: E File Docs Numbered

Notice of Motion, Affidavits (Affirmations), Exhibits Annexed	17
Answering Affidavits (Affirmations)	32
Reply Affidavit	36

Defendant Long Island Jewish Valley Stream, a division of Long Island Jewish Medical Center (LIJ) moves by notice of motion for an order granting summary judgment in its favor. For the reasons that follow, the motion must be denied.

In this medical malpractice action, plaintiff Elaine Laughtman contends that the defendant, through its agents and employees, failed to timely diagnose a stroke, ignored the signs, symptoms, and plaintiff's complaints, and failed or neglected to properly treat the plaintiff.

Plaintiff presented to the emergency department at LIJ on October 4, 2016 at approximately 4:29 p.m. with a complaint of slurred speech since 9 a.m. Her medical history was significant for prior CVA, hypertension, bilateral legal blindness, glaucoma, obesity and Type II diabetes. Plaintiff was seen by an attending physician at 4:55 p.m., who initiated a stroke code, recorded the plaintiff's vital signs and ordered a CT scan of the brain, which was performed at 7:44 p.m. The CT scan report revealed mild age-related changes with no intracranial hemorrhage, mass, or acute territorial infarct.

Plaintiff was admitted and evaluated by internal medicine attending Dr. Fozia Jangda, who ordered a neurology consult, a further head CT as well as a brain MRI, an EEG, a TTE and a carotid doppler. Dr. Jangda noted that plaintiff's speech had resolved. Plaintiff was placed on aspirin, and her systolic blood pressure was to be maintained in the range of 140-150. A neurology evaluation was performed by attending neurologist Dr. Angelito Tan, who found that plaintiff's speech had improved, that she had no facial weakness and was able to move all extremities. On October 5, 2016, Dr. Tan again evaluated the plaintiff. A brain MRI was performed at 12:40 p.m., which showed a new small acute infarct in the right posterior frontal periventricular white matter, which signified that the plaintiff had sustained a stroke. She was continued on aspirin and heparin and her vital signs were continuously monitored.

On October 6, 2016 at 5:13 a.m., nurse Sharon Malcolm noted that the plaintiff reported left-sided weakness and notified the physician's assistant on duty. A stroke code was called. At this point, plaintiff was unable to move her left leg and her speech was slowed. A CT scan of the brain showed an acute right basal ganglia infarction and a brain MRI showed an evolving acute infarct extending into the right basal ganglia with no hemorrhage.

On October 7, 2016 at 11:30 a.m., Dr. Tan documented that the plaintiff was awake and alert, in no acute distress. Plaintiff remained on Plavix®, aspirin, and Lovenox®. Physical therapy and occupational therapy services were consulted. The following day, Dr. Tan documented that plaintiff demonstrated left hemiplegia and slurred speech.

By October 11, 106, plaintiff's left hemiplegia persisted but her speech had cleared. She was discharged to the Rusk Institute for acute rehabilitation on October 12, 2016. The discharge notes indicate that the plaintiff was experiencing an evolving acute infarct of the brain.

> It is well established that 'the proponent of a summary judgment motion 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.' (*Alvarez v. Prospect Hosp.*, 68 N.Y.2d 320, 324 [1986]; *see also William J. Jenack Estate Appraisers & Auctioneers, Inc. v. Rabizadeh*, 22 N.Y.3d 470, 475-476 [2013]; CPLR 3212[b]). Once the movant makes the proper showing, 'the burden shifts to the party opposing the motion for summary judgment to produce evidentiary proof in admissible form sufficient to establish the existence of material issues of fact which require a trial of the action' (*Alvarez*, 68 N.Y.2d at 324). The 'facts must be viewed in the light most favorable to the non-moving party' (*Vega v. Restani Constr. Corp.*, 18 N.Y.3d 499, 503 [2012] [internal quotation marks omitted]). However, bald, conclusory assertions or speculation and '[a] shadowy semblance of an issue' are insufficient to defeat summary judgment (*S.J. Capelin Assoc. v. Globe Mfg. Corp.*, 34 N.Y.2d 338, 341 [1974]), as are merely conclusory claims (*Putrino v. Buffalo Athletic Club*, 82 N.Y.2d 779, 781 [1993]).

(*Stonehill Capital Management, LLC v Bank of the West*, 28 N.Y.3d 439 [2016]; *see also*

Fairlane Financial Corp. v Longspaugh, 144 AD3d 858 [2d Dept 2016]; *Phillip v D&D Carting Co., Inc.*, 136 AD3d 18 [2d Dept 2015]).

"In order to establish the liability of a professional health care provider for medical malpractice, a plaintiff must prove that the provider '"departed from accepted community standards of practice, and that such departure was a proximate cause of the plaintiff's injuries."' (*Schmitt v Medford Kidney Ctr.*, 121 AD3d 1088, 1088 [2d Dept 2014] [quoting *DiGeronimo v Fuchs*, 101 AD3d 933, 936 [2d Dept 2012]]; *Fink v DeAngelis*, 117 AD3d 894, 896 [2d Dept 2014]; *Stukas v Streiter*, 83 AD3d 18, 23 [2d Dept 2011]). "A defendant seeking summary judgment in a medical malpractice action bears the initial burden of establishing, *prima facie*, either that there was no departure from the applicable standard of care, or that any alleged departure did not proximately cause the plaintiff's injuries." (*Michel v Long Is. Jewish Med. Ctr.*, 125 AD3d 945, 945 [2d Dept 2015], lv denied, 26 NY3d 905 [2015]; *see also Barrocales v New York Methodist Hosp.*, 122 AD3d 648, 649 [2d Dept 2014]; *Berthen v Bania*, 121 AD3d 732, 732 [2d Dept 2014]; *Trauring v Gendal*, 121 AD3d 1097, 1097 [2d Dept 2014]; *Stukas*, 83 AD3d at 23). "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." (*Gillespie v New York Hosp. Queens*, 96 AD3d 901, 902 [2d Dept 2012]).

"Establishing proximate cause in medical malpractice cases requires a plaintiff to present sufficient medical evidence from which a reasonable person might conclude that it was more probable than not that the defendant's departure was a substantial factor in causing the plaintiff's injury." (*Semel v Guzman*, 84 AD3d 1054, 1056 [2d Dept 2011] [citing *Johnson v Jamaica Hosp. Med. Ctr.*, 21 AD3d 881, 883 [2d Dept 2005]]; *Goldberg v Horowitz*, 73 AD3d 691 [2d Dept 2010]; *see also Skelly–Hand v Lizardi*, 111 AD3d 1187, 1189 [2d Dept 2013]). A plaintiff is not required to eliminate all other possible causes (*Skelly–Hand* at 1189). "'The plaintiff's evidence may be deemed legally sufficient even if [his] expert cannot quantify the extent to which the defendant's act or omission decreased the plaintiff's chance of a better outcome or increased [the] injury, as long as evidence is presented from which the jury may infer that the defendant's conduct diminished the plaintiff's chance of a better outcome or increased [the] injury.'" (*Alicea v Ligouri*, 54 AD3d 784, 786 [2d Dept 2008][quoting *Flaherty v Fromberg*, 46 AD3d 743, 745 [2d Dept 2007]]; *Barbuto v Winthrop Univ. Hosp.*, 305 AD2d 623, 624 [2d Dept 2003]; *Wong v Tang*, 2 AD3d 840, 840-841[2d Dept 2003]; *Jump v Facelle*, 275 AD2d 345, 346 [2d Dept 2000], lv denied 95 NY2d 931 [2002], lv denied 98 NY2d 612 [2002]).

"'[G]eneral allegations that are conclusory and unsupported by competent evidence tending to establish the essential elements of medical malpractice are insufficient to defeat a defendant's motion for summary judgment (citations omitted)'" (*Bendel v Rajpal*, 101 AD3d 662, 663 [2d Dept 2012] [quoting *Bezerman v Bailine*, 95 AD3d 1153, 1154 [2d Dept 2012]]; *see also Savage v Quinn*, 91 AD3d 748, 749 [2d Dept 2012]; *Myers v Ferrara*, 56 AD3d 78, 84 [2d Dept 2008], citing *Alvarez*, 68 NY2d at 325; *Thompson v Orner*, 36 AD3d 791, 792 [2d Dept 2007]; *DiMitri v Monsouri*, 302 AD2d 420, 421 [2d Dept 2003]).

In support of this motion, defendant submits the expert affirmation of neurologist Alan Segal, M.D. Dr. Segal opines that the care and treatment rendered to the plaintiff during her admission from October 4, 2016 to October 12, 2016 was within the accepted standards of care and was not a proximate cause or a substantial factor in bringing about any of the alleged injuries to the plaintiff. In particular, Dr. Segal opines that the plaintiff promptly underwent triage on arrival and that the initiation of a stroke code and plan to monitor the plaintiff while obtaining a CT scan were appropriate. Given her history, clinical presentation and diagnostic tests, she was appropriately admitted for observation and a cardiological workup. Dr. Segal opines that neither neurological intervention nor administration of Tissue Plasminogen Activator (tPA) were indicated. As such, Dr. Segal states that the effects of plaintiff's evolving right basal ganglia stroke, including left sided paralysis, were unavoidable and could not have been prevented during her October 4, 2016 admission to LIJ.

Dr. Segal states that the timing of plaintiff's presentation was relevant to the potential administration of tPA for the treatment of her stroke. He explains that tPA is a medication administered to patients undergoing acute embolic stroke in order to break down clots within the cerebral vasculature and restore blood flow to affected areas of the brain. It may cause excessive intracranial bleeding and its use is guided by a risk/benefit analysis given the risks because, among other things, it is not efficacious in restoring neurological function outside a narrow time window, after which ischemic damage affecting portions of the brain is irreversible. Therefore, the physician assessing a patient for potential use of tPA will review the patient's history and clinical presentation, including the timing of the onset of symptoms to determine whether tPA is appropriate. Dr. Segal states that tPA is not given for hemorrhagic stroke, where the patient's clinical presentation is improving, or where the patient presents for treatment more than four and one-half hours after the onset of symptoms such as slurred speech. Dr. Segal opines that plaintiff's improving stroke symptoms presented a contraindication to the administration of tPA. Further, based on the stable nature of plaintiff's condition on October 5th until the early morning hours of October 6th, Dr. Segal opines that the plan implemented after admission, including blood pressure control and anticoagulation/anti-platelet therapy was the proper course of treatment. He further opines that the diagnostic tests were properly interpreted and acted upon.

Further, Dr. Segal opines that upon the plaintiff's condition change on October 6th, the LIJ staff reacted appropriately as it was determined that the plaintiff was experiencing an evolving acute infarct at the same location as that seen on the October 5th MRI. He opines that the plaintiff's deteriorating neurological condition was the unavoidable consequence of the evolving stroke that occurred prior to plaintiff's presentation to the hospital on October 4th. Accordingly, administration of tPA was contraindicated on October 6th.

In opposition, plaintiff submits her own affidavit and the expert affirmation of Jane Federman, M.D., a specialist in emergency medicine. Plaintiff states that as of the evening of October 4, 2016, she felt well enough to go home but by the following day, she had developed a

severe headache, felt as though boiling water was running down her face, and had difficulty walking. On October 5, 2016, she pushed the call bell to ask to be taken to the bathroom but was told that the nurses were too busy and the call bell was taken away from her. By the time a nurse came to take her to the bathroom, she could not move her left leg or arm. Plaintiff states that she did not see a doctor until daybreak on October 6th.

Dr. Federman contends that contrary to the fifteen minute Northwell Health protocol, the initial CT scan was not performed until almost three hours after the plaintiff presented to the hospital. Dr. Federman further states that risk of a stroke is increased for the 48 hours following a TIA and the stuttering pattern in this patient restarted the clock for the administration of tPA. When promptly administered, tPA can prevent and reduce the long-term effects of a stroke. In addition, contrary to code stroke protocol, the record does not reflect a required neurological assessment every two hours. Rather, despite plaintiff's developing symptoms on October 5, 2016, neurology was not called.

Dr. Federman opines that significant events occurred within the three hour window for the administration of tPA but no meaningful actions were taken throughout the day on October 5th. Indeed, Dr. Federman contends that the manifestation of the plaintiff's symptoms during that afternoon warranted the administration of tPA and there were no absolute contraindications thereto. Dr. Federman concludes that the failure to monitor the plaintiff was a deviation from accepted practice and a substantial factor in her resulting left hemiplegia. Moreover, Dr. Federman opines that the failure to administer tPA during the afternoon of October 5, 2016 deprived the plaintiff of the chance of a better outcome than the left hemiplegia that was diagnosed on October 6, 2016.

In light of the record evidence and conflicting medical affidavits presented, the court finds that there are issues of fact concerning whether the defendant, through its agents and employees, departed from the standards of good and accepted medical practice by failing to properly monitor plaintiff's condition and failing to timely implement interventional therapy. Contrary to defendant's contention, Dr. Federman's affirmation is sufficient to support her qualifications in this case. Nor is Dr. Federman's affirmation wholly conclusory. Instead, she directly contradicts the opinions offered by defendant's expert with respect to the evolution of plaintiff's condition and the administration of tPA. Further, Dr. Federman does take issue with the care administered to the plaintiff prior to October 5th. In short, "[s]ummary judgment is not appropriate in a medical malpractice action where the parties adduce conflicting medical expert opinions." (*Feinberg v Feit*, 23 AD3d 517, 519 [2d Dept 2005]). "Such conflicting expert opinions will raise credibility issues which can only be resolved by a jury [or trier of fact]." (*DiGeronimo v Fuchs,* 101 AD3d 933, 936 [2d Dept 2012]).

For the foregoing reasons, the motion must be **denied**.

This constitutes the decision and order of this court. All applications not specifically addressed herein are denied.

Dated: Mineola, New York
March 5, 2019

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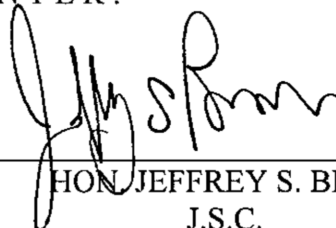

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