Jones v Wong
2020 NY Slip Op 30775(U)
March 11, 2020
Supreme Court, New York County
Docket Number: 805173/13
Judge: Joan A. Madden

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NEW YORK, IAS PART 11

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J. ALETHEA JONES, as Administratrix of the Estate of STELLA IRMA CHARLES, deceased,

Index No.: 805173/13

Plaintiff,

-against-

JAY WONG M.D., LEAH SPINNER, M.D., LOUIS VIZOLI, M.D., ARCHANA ALANKAR, M.D., JESSE SAMMONS, M.D, GARY ZEITLIN, M.D., GERGES SEIFEN, M.D., CAROL ANN LEDERMAN, M.D., BRYAN GREEN, M.D., BETH BERNSTEIN, R.N., CHRINSTA VANATTA, R.N., LAREN WILDRICH, R.N., WHITE PLAINS HOSPITAL MEDICAL CENTER,

Defendants,

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JOAN A. MADDEN, J.:

In this action for medical malpractice, defendants Jay Wong, M.D. ("Dr. Wong"), Archana Alankar, M.D. ("Dr. Alankar"), Jesse Sammons, M.D. ("Dr. Sammons") and Gary Zeitlin, M.D. ("Dr. Zeitlin") and White Plains Hospital Medical Center ("White Plains Hospital")(together "defendants") move for summary judgment dismissing the complaint.[1] Plaintiff opposes the motion.

Background

This action arises out of the care and treatment of plaintiff's decedent, then 78-year old Stella Irma Charles ("Ms. Charles" or "decedent"), during her admission to White Plains Hospital from November 8, 2011 to November 22, 2011, on which date she died.

At her deposition, plaintiff, the daughter of decedent, testified that in 2011, her mother lived alone in an apartment, and was "very active," and was able to bathe, dress, and toilet herself and prepare some of her own meals. (Plaintiff's EBT at 15-19, 162, 164, 165). She also testified that

[1]Pursuant to various stipulations of discontinuance, the action has been discontinued with prejudice as against defendants Bryan Green, M.D., Leah Spinner, M.D., Louis Vizioli, M.D., Carol Ann Lederman, M.D., Gerges Seifen, M.D., Beth Bernstein, R.N., Christina Vanatta, R.N. and Lauren Wildrich, R.N.

while Ms. Charles had an aide to assist her because she was no longer driving, the aide assisted Ms. Charles with going to the senior center and shopping but nothing medical in nature. (Id at 18, 162-164). According to plaintiff, decedent was admitted to the emergency room at White Plains Hospital on November 8, 2011, due to mental status changes over the prior week, weakness and refusal to eat or walk (Id at 73-80, 87).

In this action, plaintiff alleges that defendants departed from the standard of care in failing to properly treat and diagnose the cause of plaintiff's internal bleeding, and that such departure proximately caused Ms. Charles' injuries including anemia and death. Specifically, plaintiff asserts that the decedent's lab results at the time of her admission and during her hospitalization, including her hemoglobin, hematocrit, platelet count, and liver function studies, showed that she was suffering from blood loss which should have triggered defendants to investigate the cause, and would have led to the diagnosis of a lacerated liver.

Dr. Wong, Dr. Alankar and Dr. Sammons are employed by White Plains Hospital and provided care and treatment to Ms. Charles during her hospitalization. Dr. Zeitlin is an infectious disease specialist who provided an infectious disease consult at the request of Dr. Alankar.

Dr. Wong examined decedent and admitted her to the hospital on November 8, 2011, and diagnosed decedent with altered mental status due to metabolic encephalopathy.[2] There was no history of trauma. Dr. Wong ordered the antibiotic Levaquin for possible UTI and pneumonia, and continued IV hydration. The lab worked performed upon admission to the hospital showed that decedent's hemoglobin was 10.1, hematocrit 31.4, and white blood count was elevated at 18.3. Dr. Anakar saw decedent on November 9, 10, and 11, 2011. During this period, decedent's hemoglobin

[2]According to defendants' expert, Elias Sakalis, M.D., "metabolic encephalopathy is a transient or permanent impairment of brain function resulting from physiological insufficiency or aberrant metabolic processes accompanying certain systemic illness." (Sakalis Aff ¶ 9).

decreased from 10.3 on November 10, to 9.2 on November 11. Dr. Alankar next saw the decedent on November 20, 2011.

Dr. Zeitlin was called into the case by Dr. Anakar to assess decedent's elevated white blood cell count and infection, and initially evaluated Ms. Charles on November 10, 2011. Dr. Zeitlin's differential diagnosis was pyelonephritis[3] and/or urinary tract infection. Dr. Zeitlin agreed with the ordering and administration of Levaquin and continued it. Dr. Zeitlin ordered a CT scan of the abdomen to assess for abscess or obstruction of kidney in the setting of a urinary tract infection. (Zetlin EBT at 59). At his deposition, Dr. Zeitlin testified that the CT scan revealed right sided pyelonephritis, with abnormal contour of the kidney suggestive of inflammation (Id at 60). When Dr. Zeitlin saw Ms. Charles on November 16, he continued the same antibiotic.[4] Dr. Wong treated Ms. Charles from November 12, 2011 to November 14, 2011. On November 12, 2011, her hemoglobin was 8.7 (a decrease from 9.2 on the previous day) and on November 13, it was 7.6. Dr. Wong ordered a blood transfusion with one pack of red blood cells, on November 14, her hemoglobin rose to 8.8.

Dr. Sammons treated decedent from November 16 through November 20, 2011. Ms. Charles hemoglobin levels were 9.5 on November 15; 8.6 on November 16; and 8.5. on November 17. period. Dr. Sammons decided no more blood work was needed and no blood work was obtained by the hospital from on November 18, 19 or 20. On November 21, 2011, Ms. Charles was found to be unresponsive after suffering a cardiac arrest and a code was called. She died on November 22, 2011.

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[3]According to defendants' expert Dr. Sakalis, "Pyelonephritis is an inflammation of the kidney due to bacterial infection." (Sakalis Aff. ¶ 15).

[4]Dr. Zeitlin last saw Ms. Charles on November 21 after she suffered cardiac arrest.

An autopsy performed on decedent indicated under the heading "Final Autopsy Diagnosis" "Blunt Force Trauma" and "Laceration of Liver." The cause of death listed is "liver laceration with hematoma and hemoperitoneum.[5]"

Plaintiff commenced this action in 2013. Discovery is complete and the note of issue has been filed.

Defendants now move to summary judgment and submit two affidavits from experts who opine that Ms. Charles did not present any signs or symptoms of a liver laceration and that her abnormal hemoglobin levels were due to her underlying chronic medical conditions as opposed to the internal bleeding from liver laceration.

Defendants' expert, Elias Sakalis, M.D., is licensed to practice medicine in New York and is Board Certified in Internal Medicine, and opines to a reasonable degree of medical certainty upon review of the relevant medical records, pleadings and deposition testimonies, that "decedent did not exhibit any signs or symptoms of a lacerated liver, and that as such, defendants did not deviate from standards of care in failing to diagnose same..[and that] the liver rupture did not occur until November 21, 2011, immediately before decedent coded (which was the sole sign or symptom of same) by which point decedent could not be saved" (Sakalis Aff. ¶ 4).

As for Dr. Wong's admitting diagnosis of altered mental status due to metabolic encephalopathy, Dr. Sakalis opines that:

> Dr. Wong's admitting diagnosis was correct given the history elicited from plaintiff, which included not only decedent's chronic illnesses, but her refusal to eat over the last week, which would account for her dehydration. In addition, upon admission, decedent had an elevated white blood cell count and elevated sodium, creatinine, calcium and potassium levels. Dr. Wong

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[5]According to plaintiff's expert, "[h]emoperitoneum refers to the presence of blood in the abdominal cavity" (Plaintiff's expert Aff ¶ 68).

> testified that, based on these results, his differential diagnosis included urinary tract infection, possible pneumonia and dehydration with resultant hemoconcentration of all cell lines [and]... that based upon the lab values Dr. Wong's differential diagnosis was correct [and that] .Dr. Wong ordered the antibiotic Levaquin for possible UTI and pneumonia, and continued IV hydration, which was appropriate.
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> (Id ¶'s 9-10).

As for Dr. Wong's subsequent care and treatment of decedent, he opines that Dr. Wong provided care and treatment well within standards of care, "[f]rom November 12-14, 2011, Dr. Wong properly responded to a decreased hemoglobin of 7.6 by ordering a blood transfusion, which resulted in an expected and appropriate rise in hemoglobin to 8.8. There were never any signs or symptoms of liver laceration or internal bleeding during the time Dr. Wong cared for decedent. She was awake and alert, her vital signs were stable throughout and her mild lower abdominal pain, which was elicited only on palpation, was due to constipation." He further states that "had decedent had a liver laceration which was causing the decreased hemoglobin at the time of Dr. Wong's treatment, she would have had intense and constant right upper quadrant pain with tachycardia and a low blood pressure [and] [t]his was never the case [and] ... she would not have responded appropriately to the blood transfusion and she would not have been awake and alert and improving clinically with regard to mental status." (Id ¶ 21).

With regard to Dr. Alankar's care and treatment of Ms. Charles, Dr. Sakalis opines that on November 10, 2011 when her "[h]emoglobin was slightly higher than the day before, at 10.3...Dr. Alankar requested an infectious disease consult, which was appropriate due to elevated WBC, and a nephrology consult, which was appropriate due to elevated creatinine, chronic kidney disease and elevated sodium." As for November 11, when Dr. Alankar next saw decedent, whose

hemoglobin had decreased to 9.2, from the previous days 10.3, Dr. Sakalis opines that Dr. Alankar's diagnosis that the decrease was from IV fluids decedent was receiving for hydration, resulting in blood dilution, or her baseline once she was hydrated was within the standard of care "given that decedent was more awake, alert, and improving, with stable vital signs and a CT scan showing no evidence of bleeding with a normal liver" (Id ¶ 17). He also opines that "no work-up was warranted due to the decrease in hemoglobin [and that] Dr. Alankar appropriately ordered another CBC." (Id) As for her treatment of Ms. Charles on November 20, when she was being prepared for discharge, he opines that it was appropriate for Dr. Alankar "to order a CBC and comprehensive metabolic panel [and that]...there were no signs or symptoms of liver laceration on that date" (Id ¶ 18).

As for Dr. Sammons, who treated Ms. Charles from November 16, 2011 to November 20, 2011, Dr. Sakalis opines that Dr. Sammons correctly testified that "increase of hemoglobin to 9.5 [on November 15] was a laboratory error since hemoglobin would not increase to such a degree after only one unit of packed blood (Id ¶ 22). He states that:

> Such an increase would not occur and it was reasonable to attribute the 9.5 result following the transfusion of one unit of blood to laboratory error. As such, four days of blood testing following the blood transfusion showed stable hemoglobin levels of November 14 (8.8), November 15 (9.5), November 16 (8.6) and November 17 (8.5). In addition to improvement in decedent's condition and stable and normal vital signs, Dr. Sammons exercised his independent medical judgment and made a determination that decedent was ready for discharge and decided to no longer monitor hemoglobin levels [and that] ...this was an appropriate exercise of medical judgment.

(Id).

With respect to the decedent's hemoglobin levels during the subject hospitalization, he opines that to a reasonable degree of medical certainty, that:

> hemoglobin in the 8.5-9.0 range was consistent with anemia of chronic

> disease given decedent's multiple co-morbidities. Decedent, a 78 year old female, had a long and complicated medical history. She had abnormal renal function since 2009 and was diagnosed with proteinuria, hypertension, chronic kidney disease, and anemia of renal failure. The fact that decedent had chronic kidney disease and was in known renal failure alone would explain her below normal hemoglobin for a healthy person. Her medical history also included breast cancer and bilateral mastectomy in the 1970s, sarcoidosis, seizure disorder post intracerebral bleed, hyperlipidemia, colonic polyp, pancreatitis, a metal plate in her head in 1985, cerebral aneurysm in 1985, stroke, multiple trans-ischemic attacks (TIAs, or "mini" strokes) and dementia since 2007 of vascular etiology, as well as Alzheimer's Disease. Decedent also had elevated ferritin levels, which is an indication of chronic inflammation, resulting in anemia of chronic disease
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> (Id ¶ 23).

He further opines, to a reasonable degree of medical certainty with respect to decedent's low hemoglobin levels that :

> decedent suffered from anemia of chronic disease, otherwise known as normocytic anemia, due to her underlying, chronic, medical conditions. This accounted for decedent's below normal hemoglobin levels, with normal vital signs, but elevated ferritin levels. Elevated ferritin levels are caused by chronic diseases, which results in chronic inflammation throughout the body. The body will store iron in order to make it unavailable and prevent bacteria from gaining access to it, since bacteria depend on iron and multiply. Therefore, when chronic disease is present, the body sequesters iron within its cells, resulting in elevated ferritin levels, but decreased hemoglobin. It is my opinion, to a reasonable degree of medical certainty, that when decedent was admitted to the hospital, the drop in hemoglobin which required blood transfusion was due to dilution of the blood as a result of IV hydration. The transfusion of one pack of red blood cells on November 13 resulted in the expected and appropriate response of an elevation of hemoglobin in the 8.5-9.0 range over the next four days. Decedent's below normal hemoglobin levels during the hospitalization were not indicative of a liver laceration or other internal organ injury where she was losing blood given her vital signs, physical examination findings and the CT scan done which was entirely normal. There was no indication prior to the decedent's cardiac arrest on November 21, 2011 of any internal injury either by history, clinical exam, or on CT scan.

(Id ¶ 24).

As to the liver laceration, Dr. Sakalis also opines that "[i]t is my opinion, to a reasonable degree of medical certainty, that what likely occurred is that decedent, who was under the care of a home health aide, suffered a blunt injury to the liver prior to her presentation to the hospital. This history was unknown to the medical providers at the hospital [and that] there were no signs or symptoms of same until decedent experienced a sudden rupture of a hepatic subcapsular hematoma from a liver laceration, causing shock and cardiac arrest..[and that] such delayed bleeding and rupture occurs in 1 -3% of patients with a liver laceration and can occur from three days and up to six weeks following trauma" (Id ¶ 25). He further opines that [s]ince there were no signs or symptoms of the impending rupture prior to its occurrence, it is my opinion, to a reasonable degree of medical certainty, that there was nothing the medical providers in this case should have or could have done to prevent decedent's sudden and unexpected death due to same" (Id ¶ 26).

Defendants also submit the affidavit of Bruce E. Hirsch, an infectious disease doctor who is licensed to practice medicine in New York who states his opinions to a reasonable degree of medical certainty. After noting Dr. Zeitlin's deposition testimony that he was called in to provide treatment to Ms. Charles as an infectious disease consultant and that his role was limited to assisting in managing her urinary tract infection, and that he was not monitoring her hemoglobin levels (Zeitlin EBT at 58), Dr. Hirsch opines that "Dr. Zeitlin's role and duty was to target his treatment to the cure of decedent's urinary tract infection [and not] to monitor decedent's hemoglobin levels, and this was appropriately left to the other physicians treating the decedent." (Hirsch Aff ¶ 10). He also opines that "the hemoglobin levels in this case were being appropriately monitored by the hospitalists and,

given Dr. Zeitlin's limited role as an infectious disease consult[6], since these values were not pertinent to the care he was rendering, it would not be his duty to monitor them. This was appropriately left to the hospitalists managing decedent's overall care, who would be in a better position to formulate a diagnosis for same." (Id ¶ 15).

He also opines that:

> decedent suffered from anemia of chronic disease due to her underlying, chronic, medical conditions. This accounted for decedent's. below- normal hemoglobin levels, with normal vital signs. When decedent was admitted to the hospital, the drop in hemoglobin which required blood transfusion was due to dilution of the blood as a result of IV hydration. The transfusion of one pack of red blood cells on November 13 resulted in the expected and appropriate response of an elevation of hemoglobin in the 8.5-9.0 range over the next four days. Decedent's below normal hemoglobin levels during the hospitalization were not indicative of a liver laceration or
> other internal organ injury where she was losing blood given her vital signs physical examination findings and the CT scan done, which was entirely normal. There was no indication prior to the decedent's cardiac arrest on November 21, 2011 of any internal injury either by history, clinical exam, or-on CT scan.

(Id ¶ 16)

As for causation, he opines that "there were no signs or symptoms of the impending rupture prior to its occurrence there was nothing the medical providers in this case should have or could have done to prevent decedent's sudden and unexpected death due to same [and that] Dr. Zeitlin's treatment, which was. limited to an infectious disease consult and treating an infection did not proximately cause death or injury to decedent." (Id ¶'s 17, 18).

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[6]Dr. Hirsch also opines as the appropriateness of Dr. Zeitlin's treatment of decedent for the urinary tract infection and his physical examination of treatment without a rectal exam. However, as plaintiff's expert does not address any departures in this regard, they are considered abandoned, and are not addressed here.

Plaintiff opposes the motion, arguing that defendants have not made a prima facie showing entitling them to summary judgment since their experts do not specify the applicable standard of care or make a sufficient showing with regard to proximate cause but, instead, speculate as to the cause of decedent's liver rapture, and ignore evidence of internal bleeding before decedent coded on November 21, 2011.

Alternatively, plaintiff argues that there are triable issues of fact as whether defendants deviated from accepted standards of medical care and whether such deviations proximately caused Ms. Charles' injuries. In support of this argument, plaintiff submits the affirmation of a physician, whose identity is redacted, and who is licensed to practice medicine in New York State and is board certified in internal medicine, endochronology/metabolism and emergency medicine, and who opines to a reasonable degree of medical certainty.

Plaintiff's expert opines that "[i]n 2011, when a hospitalized patient was deemed anemic, the standard of care required the physicians following that patient to perform an adequate workup to determine the cause of the anemia so that it could be appropriately treated....required the physicians treating the patient to closely monitor the patient's lab work and particularly the hemoglobin, hematocrit, and platelet count [and that] [d]aily monitoring of these blood levels is required for an anemic hospitalized patient and is particularly indicated if a patient is so anemic that the he or she must be transfused. " (Id at ¶'s 64, 65, 66). The expert further opines that "[i]n 2011, if a hospitalized anemic patient presented with repeated decreases in hemoglobin, hematocrit, and platelet count (particularly after transfusion), the standard of care required physicians following that patient to rule out internal bleeding via continued, daily monitoring of lab work and imaging such as a CT and other diagnostic testing." (Id ¶ 67).

In the case of Ms. Charles, the plaintiff's expert states that while during the first several days at the hospital, "Ms. Charles had stable (and in fact slightly increasing) hemoglobin and hematocrit levels and platelet counts... on November 11, 2011, Ms. Charles' hemoglobin, hematocrit, and platelet counts started steadily decreasing." (Id ¶ 69). The expert opines that "the physicians following Ms. Charles deviated from accepted standards of care in failing to continue to monitor, assess, and document her hemoglobin, hematocrit, and platelet count on November 18, 2011, November 19, 2011, and November 20, 2011 [and]...in failing to heed and appreciate Ms. Charles' abnormal liver tests [beginning on November 11][and that] Ms. Charles' elevated ALT, ALKP, and AST tests were indicative of potential liver damage and the Defendants failed to heed and appreciate that the abnormal liver function tests, in conjunction with the low blood counts, could indicate a bleed from the liver." (Id ¶'s 75-76)

Plaintiff's expert further opines that "Defendants deviated from accepted standards of medical care in failing to heed and appreciate the persistent abdominal pain/tenderness that Ms. Charles had throughout her hospitalization [and that] [h]er persistent abdominal pain/tenderness in the context of her anemia and elevated liver function studies was consistent with an abdominal bleed." (Id ¶77).

The expert also opines that:

> Defendants' failure to obtain diagnostic imaging between November 13, 2011 and November 21, 2011 to rule out an internal bleed was a deviation from accepted standards of medical care. In light of Ms. Charles' anemia of unknown origin, abnormal liver function tests, and persistent abdominal pain/tenderness, an abdominal CT with contrast was indicated in order to rule out a bleed in the abdomen. Although an abdominal CT was performed on November 10, 2011, that CT was performed without contrast and the report noted that "evaluation [was] limited due to artifact from bilateral upper extremities." Accordingly, the November 10, 2011 abdominal CT was not

> diagnostic. The Defendants' experts assert that "had decedent been losing blood resulting in decreased hemoglobin it would have been present on the CT scan." However, Ms. Charles' hemoglobin was not yet in decline on November 10, 2011. Another abdominal CT (with contrast) was indicated as of November 13, 2011 (after three days of downward trending hemoglobin) to determine the source of Ms. Charles' anemia which required her to be transfused and remained indicated until the time of the code because of her persistent abdominal pain/tenderness and her decreasing hemoglobin after the transfusion.

(Id ¶ 78).

Plaintiff's expert additionally opines that defendants deviated from the standard of care "in administering subcutaneous heparin to Ms. Charles throughout her hospitalization [and that] [a]s an anticoagulant, heparin prevents clotting and can cause or exacerbate bleeding. In light of Ms. Charles' anemia, heparin was not indicated for her, particularly in light of the fact that the Defendants failed to rule out an internal bleed source. (Id ¶ 79).

As for defendants' expert opinion that Ms. Charles' drop in hemoglobin following the transfusion was due to dilution of blood following IV hydration, plaintiff's experts rejects this opinion, stating that:

> First, even if a patient is dehydrated and hemoconcentrated, they equilibrate within twenty-four hours of receiving intravenous hydration...receiving hydration on the evening of November 8, 2011 is without basis. Second, this theory is patently belied by the medical records. Dr. Wong testified that all three of Ms. Charles' cell lines decreased as a result of hydration, but they did not. In fact, after she received hydration, Ms. Charles' hemoglobin remained relatively stable (with slight increases) and her platelet count increased. Then, between November 11, 2011 and November 13, 2011, her white blood count, hemoglobin, and platelets all progressively decreased requiring a blood transfusion, which is consistent with a bleed. Moreover, if Ms. Charles had been hemoconcentrated and dehydrated on admission, her sodium levels would have steadily decreased within the first twenty-four hours of receiving hydration. They did not. Accordingly, Defendants' hemoconcentration theory is without basis...[and] Defendants deviated from accepted standards of care in failing to perform an adequate work up for Ms. Charles to timely identify and treat the source of her anemia.

(Id ¶ 74).

As for Dr. Hirsch's opinion that the infectious disease specialist, Dr. Zeitlin did not owe a duty to monitor Ms. Charles hemoglobin levels because he performed infectious disease consults for Ms. Charles," plaintiff's expert notes Dr. Zeitlin testimony that he is an internal medicine and infectious disease physician (Zeitlin, p. 53). and that in 2011, he not only provided infectious disease consults for patients in White Plains Hospital; he was also a primary care physician at a private practice, and that monitoring and assessing hemoglobin levels and treating anemia are within the scope of his practice as a doctor of internal medicine (Zeitlin, pp. 18-21, 39, 53-55). In addition, plaintiff's expert opines that "[a]s a physician treating and following Ms. Charles at White Plains Hospital (and particularly as a physician who is also an internist), Dr. Zeitlin unquestionably had a duty to monitor and assess all of Ms. Charles' lab work, including her hemoglobin levels." (Id ¶ 80).

With respect to causation, plaintiff's expert opines that:

> the Defendants' departures from accepted standards of care proximately caused Ms. Charles' injuries including her cardiac arrest. I opine to a reasonable degree of medical certainty that internal bleeding from Ms. Charles' liver caused her to go into cardiac arrest on the morning of November 21, 2011. This is based on the fact that her red blood cell count, hemoglobin, and hematocrit were all extremely low just after the arrest and the fact that her ALT and AST were very high just after the arrest (facts which the Defendants and their experts ignore). Moreover, the autopsy reports reveal that Ms. Charles had hemoperitoneum (approximately 1000cc) at the time of her death. The Defendants' experts speculate that just before the code Ms. Charles "experienced a sudden rupture of a hepatic subcapsular hematoma from a liver laceration, causing shock and cardiac arrest" and that such "delayed bleeding and rupture occurs in 1-3% of patients with a liver laceration and can occur from three days and up to six weeks following trauma." I reject the Defendants' conclusory theory that Ms. Charles' internal bleeding did not begin until immediately before the code on November 21, 2011 because it ignores all of the aforementioned signs of internal bleeding between November 11, 2011 and November 21, 2011 that the Defendants failed to investigate — a marked, unexplained drop in hemoglobin which required transfusion, elevated ALT and AST values which corresponded to the drop in hemoglobin, a decrease in hemoglobin after transfusion, and persistent abdominal pain/tenderness.

(Plaintiff's Expert Aff. ¶ 81).

Discussion

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 the proximate cause of the injuries alleged." Roques v. Nobel, 73 AD3d 204, 206 (1st Dep't 2010). To satisfy this burden, a defendant must present expert opinion testimony that is supported by the facts in the record and addresses the essential allegations in the Bill of Particulars. Id The expert opinion relied on by defendant must be based on the facts in the record or those personally known to the expert. Defense expert opinion should specify "in what way" a patient's treatment was proper and "elucidate the standard of care." Ocasio-Gary v. Lawrence Hosp., 69 AD3d 403, 404 (1st Dep't 2010). A defendant's expert opinion must also "explain what defendant did and why." Id. (quoting Wasserman v. Carella, 307 AD2d 225, 226 [1st Dept 2003]).

Here, contrary to plaintiff's position, the court finds that defendants' experts made a prima facie showing that defendants did not deviate from the standard of care in their care and treatment of Ms. Charles and that her below normal hemoglobin during her hospitalization was not indicative of internal injuries but of various other factors including underlying chronic conditions and dilution of her blood due to IV hydration.

Accordingly, the burden shifts to plaintiff "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 v. Prospect Hosp., 68 N.Y.2d 320, 324-325 (1986). Specifically, in a medical malpractice action, this requires that a plaintiff opposing a defendant's summary judgment motion "submit evidentiary facts or materials to rebut the prima facie showing by the defendant physician that he was

not negligent in treating plaintiff so as to demonstrate the existence of a triable issue of fact... General allegations of medical malpractice, merely conclusory and unsupported by competent evidence tending to establish the essential elements of medical malpractice, are insufficient to defeat defendant['s]... summary judgment motion." Id.

In addition, a plaintiff's expert's opinion "must demonstrate the requisite nexus between the malpractice allegedly committed and the harm suffered." Dallas-Stephenson v. Waisman, 39 A.D.3d 303, 307 (1st Dep't 2007) (internal citations and quotations omitted). If "the expert's ultimate assertions are speculative or unsupported by any evidentiary foundation... the opinion should be given no probative force and is insufficient to withstand summary judgment." Diaz v. Downtown Hospital, 99 N.Y.2d 542, 544 (2002). On the other hand, "[t]he law is well settled that when competing experts present adequately supported but differing opinions on the propriety of the medical care, summary judgment is not proper." (See Rojas v. Palese, 94 A.D.3d 557 (1st Dep't 2012)).

As for whether Dr. Zeitlin owed a duty of care to monitor Ms. Charles' hemoglobin levels, the court notes that "[w]hether a duty is owed in the first instance is a question for the court, and generally not an appropriate subject for expert opinion" Dallas-Stephenson v Waisman, 39 AD3d at 307 (internal citations omitted). "[T]he duty of a physician may be limited to those medical functions undertaken by the physician and relied upon by the patient...the question is whether the physician owes a duty under the circumstances of a particular scenario." Burtman v. Brown, 97 AD3d 156, 161-162 (1st Dept 2012)(internal citations and quotations omitted).

Here, the record shows that, although Dr. Zeitlin is an internist, he was involved in decedent's care and treatment as an infectious disease consultant, and in that role he treated

decedent's urinary tract infection and ordered a CT scan to confirm the infection, and did not undertake a duty to monitor decedent's hemoglobin levels or to treat her anemia. See O'Toole v. Goodman, 170 AD3d 615, 616 (1st Dept 2019)(affirming grant of summary judgment in favor of defendant surgeon who had no duty to manage patient's medication in intensive care unit and "properly relied on the ICU staff and other specialists to treat and manage the patient's non-surgical issue"); compare Tierney v. Girardi, 86 AD3d 447, 448 (1st Dept 2011) (rejecting argument of physician performing cardiocatheterization that he did not owe a duty of care to patient following the procedure based on evidence that "he consulted with her, her family, and the cardiologist concerning her treatment ... and continued to monitor her condition"). As the record is devoid of evidence that he was responsible for, or controlled the care and treatment that allegedly led to decedent's injuries and death, summary judgment in his favor is warranted.

As for the remaining defendants, for the reasons below, plaintiff's expert opinion is sufficient to raise a triable issue of fact as whether these defendants deviated from the standard of care in their treatment of Ms. Charles and whether such deviations were a proximate cause of her injuries and death. In particular, plaintiff's expert raises issues of fact as to whether defendants' deviated from the standard of care (a) in failing to do a workup, including a further CT scan, to determine the reasons for Ms. Charles' low levels of hemoglobin and anemia, including after receiving a transfusion on November 14; (b) by administering subcutaneous heparin to Ms. Charles throughout her hospitalization..[which] prevents clotting and can cause or exacerbate bleeding; (c) in incorrectly attributing Ms. Charles' drop in hemoglobin following the transfusion to dilution of blood following IV hydration; (d) in failing to continue to monitor, assess, and document decedent's hemoglobin, hematocrit, and platelet count from November 18-20; and (e) in failing to heed and appreciate that

Ms. Charles' abnormal liver tests and continued abdominal tenderness as attributable to a potential bleed from the liver.

In addition, plaintiff has raised triable issues of fact as to whether these deviations were a proximate cause of Ms. Charles' injuries and death based on her expert's opinion that Ms. Charles' untreated internal bleeding from her liver caused her injuries and death.

Next, contrary to defendants' argument, plaintiff's expert has raise a triable issue of fact as to whether Dr. Wong, Dr. Alankar and Dr. Sammons are each potentially liable to plaintiff based on their involvement in Ms Charles' care and treatment. Specifically, with respect to Dr. Wong, plaintiff's expert opines that, during the period of his treatment of Ms. Charles, in addition to having low hemoglobin levels, Ms. Charles had abnormal liver function tests (beginning on November 11) and abdominal tenderness should have triggered a further work up as signs of potentially internal bleeding, and that these signs and symptoms continued during Dr. Alankar's and Dr. Sammons' subsequent care and treatment of Ms. Charles. In addition, with regard to Dr. Alankar, plaintiff's expert opines that her attributing Ms. Charles' drop in hemoglobin following the transfusion to dilution of blood following IV hydration was a deviation from the standard of care. With respect to Dr. Sammons, plaintiff's expert opines that he also deviated from the standard of care when he discontinued blood testing to assess and document Ms. Charles hemoglobin, hematocrit, and platelet count.

Accordingly, defendants' motion for summary judgment is granted only to the extent of dismissing the complaint against Dr. Zeitlin.

Conclusion

In view of the above, it is

ORDERED that defendants' motion for summary judgment is granted to the extent of dismissing the complaint and any cross claims against defendant Gary Zeitlin, M.D.; and it is further

ORDERED that based on this dismissal of the complaint and any cross claims against Gary Zeitlin, M.D. and the various stipulations discontinuing the action against defendants Bryan Green, M.D., Leah Spinner, M.D., Louis Vizioli, M.D., Carol Ann Lederman, M.D., Gerges Seifen, M.D., Beth Bernstein, R.N., Christina Vanatta, R.N. and Lauren Wildrich, R.N. the caption is amended to remove these defendants from the caption; and it is further

ORDERED that the caption as amended shall read as follows:

J. ALTHEA JONES, as Administratrix of the Estate of STELLA IRMA CHARLES, Deceased,

Plaintiff

-against-

JAY WONG, M.D., ARCHANA ALANKAR, M.D., JESSE SAMMONS, M.D., and WHITE PLAINS HOSPITAL MEDICAL CENTER,

Defendants.

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and it is further

ORDERED, that within 15 days of the efiling of this order, defendant Gary Zeitlin, M.D. shall serve a copy of this order with notice of entry on the Clerk of the General Clerk's Office (Room 119) and the County Clerk (room 141B), who are directed to mark the court records to reflect the removal of defendants Gary Zeitlin, M.D., Bryan Green, M.D., Leah Spinner, M.D., Louis Vizioli, M.D., Carol Ann Lederman, M.D., Gerges Seifen, M.D., Beth Bernstein, R.N., Christina Vanatta, R.N. and Lauren Wildrich, R.N. from the caption; and it is further

ORDERED that such service upon the General Clerk's Office and the County Clerk shall be made in accordance with the procedures set forth in the Protocol on Courthouse and County Clerk Procedures for Electronically Filed Cases (accessible at the "E-Filing" page and on the court's website at the address (www.nycourts.gov/supctmanh); and it is further

ORDERED that the remaining parties shall appear for a pre-trial conference on April 9, 2020 at noon in Part 11, room 351, 60 Centre Street, New York, NY.

DATED: March 11, 2020

J.S.C.

HON. JOAN A. MADDEN
J.S.C.