Lilly v Kim
2021 NY Slip Op 31370(U)
April 20, 2021
Supreme Court, Kings County
Docket Number: 507456/2016
Judge: Ellen M. Spodek

At an IAS Term, Part 63 of the Supreme Court of the State of New York, held in and for the County of Kings, at the Courthouse, at Civic Center, Brooklyn, New York, on the 20th day of April, 2021.

P R E S E N T:

HON. ELLEN M. SPODEK,
Justice.

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YVETTE LILLY,

Plaintiff,

- against -

Index No. 507456/2016

Mot. Seq. Nos. 1 and 2

SARAH KIM, N.P., VIVIEN SHIAH, M.D., SUN YOUNG WHANG, N.P., BACK KIM, M.D., JOSEPH RELLA, M.D., BETH ISRAEL MEDICAL CENTER, NEW YORK PRESBYTERIAN HOSPITAL, AND BACK KIM, M.D., P.C.,

Defendants.

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The following e-filed papers read herein:

	NYSCEF Doc Nos.[1]
Notice of Motion/Order to Show Cause/ Petition/Cross Motion and Affidavits (Affirmations) Annexed	29-39 41-54
Opposing Affidavits (Affirmations)	80-89
Reply Affidavits (Affirmations)	93 95
Memorandum of Law in Opposition	90

Upon the foregoing papers, in this medical malpractice action by plaintiff Yvette Lilly (plaintiff), defendants Sun Young Whang, N.P. (Nurse Whang), Back Kim, M.D. (Dr. Kim), and Back Kim, M.D., P.C. (Kim P.C.) move, under motion sequence number

[1]New York State Court Electronic Filing (NYSCEF) Document Numbers

one, and defendants Vivien Shiah, M.D. (Dr. Shiah), Joseph Gerard Rella, M.D., sued herein as Joseph Rella, M.D. (Dr. Rella), and the New York Presbyterian Hospital, sued herein as New York Presbyterian Hospital (NYPH) separately move, under motion sequence number two, pursuant to CPLR 3212, for summary judgment, dismissing all claims as against them, with prejudice, and directing the entry of judgment in their favor.

Facts and Procedural Background

On August 21, 2014, plaintiff underwent a left L4-L5 discectomy performed by nonparty Dr. Kai-Ming Fu at NYPH due to a herniated disc, lumbar back pain, and significant left leg pain. A physical examination of plaintiff following that surgery showed that she had normal pedal pulses. Plaintiff was discharged from NYPH on August 22, 2014. According to plaintiff, her preoperative symptoms resolved following that surgery.

On May 27, 2015, plaintiff, who, at that time, was 51 years old, presented to NYPH's emergency room, complaining of leg pain and leg cramps with her right leg pain and cramping greater than that in her left leg. Plaintiff's cramping and pain started at her groin and radiated down her leg, with the cramping and pain worsening over the previous month. Plaintiff had altered sensation of her toes, and her pain was exacerbated by walking. Plaintiff's pain was recorded as being 10 on a scale of 1 to 10. According to plaintiff, the pain that she was then experiencing was different than her prior back pain for which she had surgery, and she was unable to walk half a block or go upstairs.

After being triaged at 9:14 A.M., plaintiff was evaluated by Dr. Shiah, who was the emergency room attending physician at NYPH and is board certified in emergency medicine. Dr. Shiah's note stated that plaintiff "denie[d] . . . risk factors for PVD [peripheral vascular disease]/intermittent claudication."[2] Dr. Shiah claimed that claudication was ruled out by plaintiff's medical history and her physical examination of plaintiff. Dr. Shiah documented that plaintiff's extremities were non-tender with normal dorsalis pedis and posterior tibialis pulses. Lab tests were performed, which showed that plaintiff was suffering from thrombocytosis (i.e., a high platelet count). Dr. Shiah's assessment was that plaintiff had bilateral leg pain, right greater than left, and leg cramps. Dr. Shiah's discharge diagnoses were that plaintiff had leg cramps and chronic lumbago (i.e., lower back pain) with acute exacerbation. Plaintiff was discharged from NYPH and instructed to follow up with her primary care physician for her abnormal lab studies.

After plaintiff was discharged from NYPH, her daughter, Veronica, spoke to Nurse Whang, who was a friend of hers with whom she had worked in an office, concerning plaintiff's condition. Nurse Whang then spoke directly to plaintiff, who advised her that she had pain when she walked. As a result of this conversation, Nurse Whang scheduled an appointment for plaintiff for June 3, 2015 with Dr. Kim, a vascular specialist who is board certified in cardiovascular disease, at his medical office, Heart

[2]Claudication has been defined as 'limping' or 'walking with difficulty'" (Stedman's Medical Dictionary [Note: online version, database updated Nov. 2014]). Dr. Kim, at his deposition, defined claudication as "pain [in] the leg that [i]s provoked by exertion" (NYSCEF Doc No. 38, Dr. Kim's deposition tr. at 12, lines 23-25). Dr. Kim also testified that "claudication may progress to resting pain or tissue loss" (*id*. at 16, lines 19-20).

Vein NYC Center, where Nurse Whang was then employed. Kim P.C. is Dr. Kim's professional corporation, which does business as Heart Vein NYC Center.[3]

On June 3, 2015, plaintiff went to Dr. Kim's office, where she saw Dr. Kim and Nurse Whang. Plaintiff's chief complaint was recorded as being "severe leg pain, leg cramping, vein consult, [and] claudication." The subjective history listed in plaintiff's medical record stated that plaintiff started having severe pain in both legs, especially her knees downward, about one month ago. It described plaintiff's pain as beginning right when she started moving, and that it was accompanied by severe cramping. The record showed that plaintiff underwent a flow check.

At plaintiff's June 3, 2015 visit, an arterial duplex study was performed of both of plaintiff's legs, which showed moderate to severe stenosis[4] of the bilateral common femoral, superficial femoral, deep femoral, and popliteal arteries. The report of this arterial duplex study described the stenosis for these vessels as being between 50-99%. There was no blood flow visualized in the left posterior tibial artery and distal anterior artery, representing possible occlusions.[5] The report also noted diffuse atheromatous

[3]Nurse Whang, Dr. Kim, and Kim P.C., in their motion for summary judgment, do not raise any arguments for dismissal of plaintiff's complaint as against Kim P.C. that are separate from their arguments with respect to Dr. Kim.

[4]Stenosis is defined as "[a] stricture of any canal or orifice" (Stedman's Medical Dictionary [Note: online version, database updated Nov. 2014]).

[5]Occlusion is "[t]he act of closing or the state of being closed" (Stedman's Medical Dictionary [Note: online version, database updated Nov. 2014]).

plaquing in the bilateral posterior tibial, peroneal, and anterior tibial arteries. The report reflected that essentially all of plaintiff's blood supply to her legs from the groin to her ankle was impaired. According to Dr. Kim, these findings were significant, and could be caused by a blockage due to atherosclerosis or something else, as well as an inflammatory process, but he was unable to determine at that time the cause of plaintiff's condition. No blood tests were performed to determine if plaintiff was suffering from an inflammatory process.

An ankle brachial index (ABI), which is a form of pulse volume recording (PVR) was also performed on plaintiff at her June 3, 2015 visit with Dr. Kim. An ABI is a test in which blood pressure in the arms and legs are measured and compared. It is undisputed that a score of greater than 0.9 is considered acceptable, and less than 0.5 represents severe arterial disease. Plaintiff's ABI score was 0.24 bilaterally, which was a severely depressed ABI and a sign of limb threatening ischemia.[6] According to Dr. Kim, this score signified a reduction of blood flow to plaintiff's ankle.

A physical examination was performed, and Dr. Kim documented symmetric femoral pulses. These pulses were proximal to where the arterial obstructions were visualized, and, therefore, were not indicative of the sufficiency of the blood flow to the more distal segments of plaintiff's legs. Dr. Kim diagnosed plaintiff as suffering from

[6]Ischemia is defined as "[l]ocal loss of blood supply due to mechanical obstruction (mainly arterial narrowing or disruption) of the blood vessel" (Stedman's Medical Dictionary [Note: online version, database updated Nov. 2014]).

intermittent claudication, severe peripheral vascular disease, and peripheral arterial disease. He prescribed aspirin (an antiplatelet), Cilostazol (an antiplatelet and vasodilator), Clopidogrel (Plavix - an antiplatelet), and Simvastatin (Zocor - a statin).

The review of the systems portion of the record indicated that plaintiff was not suffering from dyspnea (shortness of breath) on exertion. However, plaintiff was instructed to return to Dr. Kim's office for an echocardiogram "to assess valve/heart systolic and diastolic function as a cause of [her] symptoms such as dyspnea." Plaintiff was instructed to take the above prescribed medications and return to Dr. Kim's office in one week for follow up.

On June 9, 2015, six days after her visit with Dr. Kim, plaintiff returned to the emergency room at NYPH with her chief complaint being "left leg swelling and pain/arterial blockage." The pain was noted to be 10/10. The triage comments noted that plaintiff had difficulty walking to the triage area due to swelling and pain. Plaintiff was triaged and sent to the urgent care section of the emergency room.

In the emergency room at NYPH, plaintiff was evaluated by Dr. Rella, an attending physician. Dr. Rella, in the history of present illness section of the record, stated that plaintiff had "claudication with peripheral arterial stenosis d[iagnosed] by outside cardiologist (i.e., Dr. Kim)," and that she was there for "chronic pain in the left leg, worse with ambulation but also ha[d] rest pain, not relieved by [A]dvil." Dr. Rella's physical examination of plaintiff showed that her "left leg ha[d] no deformity, no edema, [and was] warm to [the] touch." He further listed that there was "no homans or cord,"

that the dorsalis pedis was faintly palpable, that the posterior tibial was not palpable, and that there was a "cap refill ~ 5 sec."

Under Dr. Rella's assessment and plan, he wrote "peripheral vascular d[isease], followed by outside physician," that plaintiff was "here for leg pain," and that plaintiff was on Plavix and statins, and "seem[ed] well-connected and ha[d] a plan in place." Dr. Rella noted that plaintiff had leg cramps for two weeks, that plaintiff was told that it was due to peripheral vascular disease, that plaintiff was still having pain after taking Plavix and statins, that plaintiff had been taking one Advil per day, and that plaintiff was given Percocet in the emergency department and had "mild relief." Dr. Rella also noted, on plaintiff's list of medications, that she had been taking Percocet for pain, every four to six hours, as needed, with a start date of August 22, 2014. Dr. Rella diagnosed plaintiff with "leg pain" and discharged her home with a prescription for more Percocet and instructions to follow-up with Dr. Kim. Dr. Rella did not speak to Dr. Kim or consult any specialists, nor did he order any tests including blood studies, angiograms, or Doppler studies.

The medical records reflect that Dr. Rella first saw plaintiff at 11:00 p.m. and completed his note at 11:21 p.m. The medical records further reflect that while an ultrasound of plaintiff's lower extremities and blood studies were ordered at 11:04 p.m., they were subsequently canceled before they were performed.

According to Nurse Whang, within a few days after plaintiff's office visit with Dr. Kim, she was contacted by plaintiff's daughter, Veronica, who stated that plaintiff

was still having pain, and she asked if plaintiff could come into Dr. Kim's office for a follow-up visit. Nurse Whang scheduled an appointment for June 11, 2015, at which time plaintiff was seen by Dr. Kim. Nurse Whang was not present at plaintiff's June 11, 2015 office visit.

Dr. Kim, in his note on June 11, 2015, stated that plaintiff was there for abdominal aortic aneurysm and venous ultrasound to assess her leg symptoms. Dr. Kim further stated that plaintiff complained of "acutely worsening leg edema and resting pain below the left knee which started about [one] week ago associated with numbness." He further set forth that plaintiff reported that her "leg edema and numbness g[ot] worse during the nighttime," and that plaintiff was still complaining of "having severe pain [in] both legs (especially both knee[s] down) which started [one] month ago even with taking newly prescribed medications (i.e. Pletal)."

On plaintiff's June 11, 2015 visit with Dr. Kim, an abdominal ultrasound was performed and the findings were insignificant. A left lower extremity venous duplex ultrasound was also performed, which showed no signs of deep vein thrombosis. A left lower extremity arterial duplex ultrasound was performed and confirmed the findings of the study performed on June 3, 2015, namely, that there was severe stenosis of the left common iliac and common femoral arteries, plaintiff's left deep femoral artery was totally occluded, plaintiff had severe stenosis of the left proximal and mid superficial femoral artery, plaintiff had a totally occluded distal left proximal popliteal artery, and there was occlusion of plaintiff's left posterior tibial, peroneal, and anterior tibial arteries.

Dr. Kim noted that plaintiff had acute resting pain in her left leg for one week. He set forth that the lower extremity arterial duplex showed left popliteal artery total occlusion with poor runoffs, and that the lower extremity vein duplex showed negative DVTs/SVTs. He stated that he was sending plaintiff to North Shore University Hospital "for emergent management of p[eripheral arterial disease], incl[uding] endovascular intervention." According to Dr. Kim, the repeat ultrasound of plaintiff's lower extremity arteries demonstrated a progression of her condition from June 3, 2015, and her resting leg pain was a sign of critical limb blood flow compromise that required evaluation at a tertiary care center. Dr. Kim had his staff call an ambulance for plaintiff and she was transported to North Shore University Hospital.

Plaintiff presented to North Shore University Hospital's emergency room in the afternoon of June 11, 2015. Plaintiff's chief complaint was listed as being bilateral calf pain claudication for the past month, which progressed to rest pain of her left foot for the past week. Plaintiff was admitted to North Shore University Hospital at 3:39 p.m. A bilateral lower extremity CT angiogram was performed for plaintiff's "left lower extremity numbness and coolness." It was interpreted as showing "vasculitis involving the bilateral common femoral, superficial femoral and popliteal arteries with long segment severe stenoses along the course of these vessels." There was blood flow "identified below the knees bilaterally with three-vessel runoff to the ankles."

On the evening of June 11, 2015, a vascular surgery consult was called for to "r/o [rule out] threatened foot." A physical examination showed that plaintiff's left foot was

cooler with decreased sensation to the ankle. Only a popliteal artery signal was detectable on a Doppler ultrasound. The assessment was severe vasculitis, and plaintiff was started on Heparin.

On June 12, 2015, the next day, a rheumatology consult was performed. The rheumatologist determined that plaintiff was suffering from large vessel vasculitis, which was most likely giant cell arteritis, and plaintiff was started on steroids. That same day, an arterial duplex ultrasound of the bilateral lower extremities was performed for "vasculitis, cold legs, resting leg pain." The impression was "[d]iffuse arterial luminal narrowing with mural thickening consistent with appearance on CTA [computed tomography angiography] and diagnosis of vasculitis." The impression further stated that "[f]ocal high-grade stenoses [wer]e seen in the proximal superficial femoral arteries bilaterally and in the right popliteal artery." The impression also set forth that there were "occlusions of the left deep femoral artery, the distal right posterior tibial and peroneal arteries and the distal left anterior tibial artery."

On June 13, 2015, plaintiff's sedimentation rate was 120 (normal 0-20) and C-reactive protein was 7.57 (normal 0-0.40). Plaintiff ultimately received Decadron (a steroid), Solumedrol (a steroid), and Cytoxan (a chemotherapy/cytoxic agent), as well as antibiotics. However, plaintiff's condition deteriorated, and on June 22, 2015, plaintiff underwent a left femoral to posterior tibial artery bypass with reverse greater saphenous vein angiogram and fasciotomy in an attempt to salvage her right leg. On June 24, 2015, plaintiff underwent a right femoral to posterior tibial artery bypass with reverse greater

saphenous vein angiogram and vein patch angioplasty of the common femoral artery and fasciotomy. On July 7, 2015, plaintiff underwent a wound debridement of her right leg.

On July 10, 2015, plaintiff underwent a right above the knee amputation and left leg wound debridement and local muscle flap. The preoperative and postoperative diagnoses were vasculitis, gangrene of the right foot, occluded right leg bypass, and infarcted skin in the left leg wound. A pathological evaluation of plaintiff's right leg was consistent with vasculitis. On July 17, 2015, plaintiff was discharged to subacute rehabilitation.

On July 28, 2015, plaintiff returned to North Shore University Hospital due to wound infections in both of her legs. On July 31, 2015, plaintiff underwent a bilateral leg wound debridement and complex wound closure, and left calf muscle flap, and she was discharged on August 7, 2015. On October 30, 2015, plaintiff required further surgery for application of artificial grafts due to non-healing wounds.

Discussion

"The essential elements of a cause of action to recover damages for medical malpractice are a deviation or departure from accepted medical practice and evidence that such departure was a proximate cause of injury" (*Harris v St. Joseph's Med. Ctr.*, 128 AD3d 1010, 1012 [2d Dept 2015]; *see also Joyner v Middletown Med., P.C.*, 183 AD3d 593, 594 [2d Dept 2020]; *Poter v Adams*, 104 AD3d 925, 926 [2d Dept 2013]; *Hayden v Gordon*, 91 AD3d 819, 820 [2d Dept 2012]; *Guzzi v Gewirtz*, 82 AD3d 838, 838 [2d Dept 2011]). "Proximate cause is established where the defendant's conduct was a

'substantial factor' in bringing about the injury" (*King v St. Barnabas Hosp.*, 87 AD3d 238, 245 [1st Dept 2011]; *see also Goldberg v Horowitz*, 73 AD3d 691, 694 [2d Dept 2010]).

In an action sounding in medical malpractice, a defendant moving for summary judgment has the initial burden of making "'a prima facie showing either that there was no departure from accepted medical practice [or the accepted standard of care], or that any departure was not a proximate cause of the patient's injuries'" (*Stucchio v Bikvan*, 155 AD3d 666, 667 [2d Dept 2017], quoting *Matos v Khan*, 119 AD3d 909, 910 [2d Dept 2014]; *see also Larcy v Kamler*, 185 AD3d 564, 564-565 [2d Dept 2020]; *Joyner*, 183 AD3d at 594; *Neyman v Doshi Diagnostic Imaging Servs., P.C.*, 153 AD3d 538, 543 [2d Dept 2017]; *Elmes v Yelon*, 140 AD3d 1009, 1010 [2d Dept 2016]; *Wixted v Schoenwald*, 137 AD3d 1263, 1265 [2d Dept 2016]; *Nisanov v Khulpateea*, 137 AD3d 1091, 1093 [2d Dept 2016]; *Guctas v Pessolano*, 132 AD3d 632, 633 [2d Dept 2015]; *Poter*, 104 AD3d at 926; *Salvia v St. Catherine of Sienna Med. Ctr.*, 84 AD3d 1053, 1053-1054 [2d Dept 2011]; *Heller v Weinberg*, 77 AD3d 622, 622-623 [2d Dept 2010], *lv denied* 16 NY3d 707 [2011]). "The failure to make such [a] prima facie showing requires a denial of the motion, regardless of the sufficiency of the opposing papers" (*Stiso v Berlin*, 176 AD3d 888, 889 [2d Dept 2019]; *see also Winegrad v New York Univ. Med. Ctr.*, 64 NY2d 851, 853 [1985]). Once the defendant has made such a prima facie showing, the burden shifts to the plaintiff to submit, in opposition, "evidentiary facts or materials to rebut the defendant's prima facie showing," and to establish the existence of triable issues of fact,

"but only as to those elements on which the defendant met the prima facie burden" (*Neyman*, 153 AD3d at 543; *see also Alvarez v Prospect Hosp.*, 68 NY2d 320, 324 [1986]; *Keesler v Small*, 140 AD3d 1021, 1023 [2d Dept 2016]; *Elmes*, 140 AD3d at 1010; *Wixted*, 137 AD3d at 1265; *Nisanov*, 137 AD3d at 1093-1094; *Harris*, 128 AD3d at 1012; *Poter*, 104 AD3d at 926; *Stukas v Streiter*, 83 AD3d 18, 25-26 [2d Dept 2011]).

Nurse Whang, Dr. Kim, and Kim P.C.'s Motion for Summary Judgment (Motion Sequence Number One)

As noted above, Dr. Kim was the vascular specialist who examined and treated plaintiff on June 3, 2015 and June 11, 2015 at his office, Heart Vein NYC Center, and Nurse Whang was the nurse practitioner who attended to plaintiff at Heart Vein NYC Center on June 3, 2015. Plaintiff's claim as against Dr. Kim, Kim P.C., and Nurse Whang is that they committed malpractice by an eight-day delay in the diagnosis and treatment of her condition of vasculitis and/or ischemia of her lower extremities from June 3, 2015 to June 11, 2015, which resulted in plaintiff's right above the knee amputation and left leg wound debridement.

In support of their motion, Nurse Whang, Dr. Kim, and Kim P.C. submitted the expert affirmation of Joseph M. Anain, M.D., F.A.C.S. (Dr. Anain), a physician licensed to practice medicine in the State of New York, who is board certified in vascular surgery. Dr. Anain opines, within a reasonable degree of medical certainty, that plaintiff had progressive acute giant cell arteritis (also known as Takayasu arteritis)[7] involving large

[7] Takayasu arteritis is defined as "a progressive obliterative arteritis of unknown origin involving chronic inflammation of the aortic arch with fibrosis and marked luminal narrowing that affects the aorta and its branches,

aortic arterial branches (iliofemoral-popliteal) and subclavian arteries with acute progression in spite of intensive medical management.

Dr. Anain opines that plaintiff's hospitalization was not warranted on June 3, 2015, after plaintiff presented at Dr. Kim's office on June 3, 2015, whereupon an arterial Doppler revealed symptoms of acute swelling and calcification with 50-99% stenosis.

Dr. Anain explains that one week later, on June 11, 2015, plaintiff's condition worsened as she had severe pain when her legs were at rest. He sets forth his opinion that Dr. Kim acted in accordance with good and accepted medical practice by correctly referring plaintiff to North Shore University Hospital for emergent management and possible hospitalization on June 11, 2015. Dr. Anain states that in spite of intensive management with Cytoxan, I.V. Decadron, Solumedrol, antibiotic, and Heparin at North Shore University Hospital, plaintiff's condition progressed to the point of sustaining tissue loss that required her to have emergent surgery and amputation of her right leg on July 10, 2015.

Dr. Anain opines, within a reasonable degree of medical certainty, that there were no diagnostic symptoms or signs of plaintiff's condition that were secondary to Takayasu arteritis at the time that she presented to Heart Vein NYC Center on June 3, 2015 and on June 11, 2015, and was seen by Nurse Whang and/or Dr. Kim. He further opines, within a reasonable degree of medical certainty, that the care provided by Dr. Kim was in accordance with good and accepted medical practice. He explains that the diagnosis of

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often with complete or near complete occlusion of segments of the aorta; more common in females" (Stedman's Medical Dictionary [Note: online version, database updated Nov. 2014]).

Takayasu arteritis was first suspected after the CTA was performed at North Shore University Hospital on June 11, 2015. He sets forth that in spite of 11 days of intensive therapy at North Shore University Hospital, the Takayasu arteritis progressed so as to require bypass surgery, debridement of nearby muscle, and amputation of plaintiff's right leg. Dr. Anain states that if the diagnosis of Takayasu arteritis had been made on June 3, 2015, he does not believe that it would have prevented the progression of this disease.

Dr. Anain sets forth that Nurse Whang saw plaintiff only on June 3, 2015. He asserts that on that date, Nurse Whang, as a nurse practitioner, was under the direction and control of Dr. Kim at Heart Vein NYC Center. He points to the fact that plaintiff's counsel has not made any allegations of departure or negligence against Nurse Whang apart from the allegations made as against Dr. Kim. Dr. Anain opines that, as such, Nurse Whang acted in accordance with good and accepted nursing practice.

Dr. Kim and Nurse Whang also submitted the expert affirmation of Philip M. Gelber, M.D., F.A.C.C. (Dr. Gelber), a physician licensed to practice medicine in the State of New York, who is board certified in internal medicine with a subcertification in cardiovascular disease. Dr. Gelber similarly notes that plaintiff saw Dr. Kim on June 3, 2015 and June 11, 2015, and that Nurse Whang saw plaintiff only on June 3, 2015.

Dr. Gelber points out that plaintiff's allegations, as set forth in her bill of particulars, are that Dr. Kim was negligent in evaluating plaintiff's ischemic lower extremities and not immediately referring her to the hospital. He further points out that plaintiff is alleging that the delay by Dr. Kim resulted in the events that occurred during

her hospitalization at North Shore University Hospital. Dr. Gelber notes that while Nurse Whang did not direct or control plaintiff's treatment, the claims against her are identical to those asserted as against Dr. Kim.

Dr. Gelber explains that the findings in this case regarding plaintiff's medical condition most resemble Takayasu arteritis, which is an extremely rare inflammatory disorder of the large arteries of unknown cause. He states that there is a 9:1 female to male occurrence rate, often in women under 40, and that there is no known cause for this condition.

Dr. Gelber asserts that the treatment of the earliest phases of Takayasu arteritis involves high doses of glucocorticoids, such as prednisone, and immunosuppression. He further asserts that as this disease progresses, occlusive symptoms, such as claudication and ischemic rest pain, develop as they did in plaintiff. He states that aside from plaintiff's leg involvement, there was evidence that plaintiff had this disease from her bilateral axillary and subclavian involvement, as shown by contrast studies.

Dr. Gelber opines, within a reasonable degree of medical certainty, that plaintiff's Takayasu arteritis was of a long duration and that this disease had already progressed by June 3, 2015 when Dr. Kim saw her at his office. Dr. Gelber states that plaintiff had leg pain that had prompted a laminectomy the previous year, which, he states, may, in retrospect, have been an earlier symptom of arterial insufficiency.

Dr. Gelber asserts that it was the development of plaintiff's ischemic rest pain between June 3, 2015 and June 11, 2015 which was an indicator that plaintiff should be

hospitalized. Dr. Gelber opines that Dr. Kim acted in accordance with good and accepted medical practice by referring plaintiff to North Shore University Hospital when she presented to his office on June 11, 2015 because there was a change in her symptoms, namely, the development of leg pain at rest.

Dr. Gelber asserts that plaintiff's presentation to Dr. Kim's office on June 3, 2015 did not warrant a referral to North Shore University Hospital for hospitalization. He further asserts that on June 11, 2015, Dr. Kim properly noted the recent onset of ischemic rest pain and properly made the recommendation for plaintiff's transfer to North Shore University Hospital. He explains that ischemic rest pain is a standard indication for endovascular intervention, unlike claudication.

Dr. Gelber opines, within a reasonable degree of medical certainty, that Dr. Kim did not depart from good and accepted medical practice in his treatment of plaintiff. He sets forth his opinion that Dr. Kim timely and correctly diagnosed the etiology of plaintiff's leg pain and made a prompt referral to North Shore University Hospital.

Dr. Gelber further opines that if Dr. Kim had made the referral for plaintiff's hospitalization on June 3, 2015, the result would have likely been identical. He sets forth that he finds no departure by Dr. Kim with respect to the issue of proximate cause.

Dr. Gelber states that Nurse Whang, as a nurse practitioner, was under the direction and control of Dr. Kim at Heart Vein NYC Center on June 3, 2015. He, like Dr. Anain, notes that plaintiff's counsel has not made any separate allegations of

departure and/or negligence against Nurse Whang. Dr. Gelber states that he finds that Nurse Whang acted in accordance with good and accepted nursing practice.

Plaintiff, in opposition, has submitted the affirmation of her medical expert, a physician licensed to practice medicine in the State of New York who is board certified by the American Board of Surgery and by the American Board of Vascular Surgery. Plaintiff's expert opines, within a reasonable degree of medical certainty, that Nurse Whang and Dr. Kim departed from good and accepted medical practice by failing to properly diagnose plaintiff's condition on June 3, 2015. Plaintiff's expert points to the fact that the arterial ultrasound performed on June 3, 2015 was interpreted as showing that plaintiff had stenosis of the bilateral common femoral, superficial femoral, deep femoral, and popliteal arteries between 50-99%, which indicated a significant stenosis without any explanation as to why plaintiff would have such a significant stenosis since she did not have any risk factors for atherosclerotic disease. Plaintiff's expert notes that the ultrasound demonstrated stenoses from plaintiff's groin to her ankles, and that this distribution of lesions represents tandem stenoses, and included collateral blood flow (deep femoral artery). Plaintiff's expert further explains that at each level, the blood pressure drops, and that by the time the blood flow reaches the foot, the pressure is low enough to cause tissue death. He or she asserts that this was evidenced by plaintiff's abnormally low ABI score of 0.24. He or she emphasizes that an ABI score below 0.4 represents critical disease and that the lower the ABI score, the greater the risk is of limb threatening ischemia.

Plaintiff's expert opines, within a reasonable degree of medical certainty, that given plaintiff's multilevel stenoses, her ABI, her lack of risk factors for atherosclerotic disease, and the rapid onset of her symptoms, it was a departure from good and accepted medical practice for Nurse Whang and Dr. Kim to fail to consider vasculitis on June 3, 2015. Plaintiff's expert further opines, within a reasonable degree of medical certainty, that good and accepted medical practice required that given plaintiff's significant arterial occlusive disease, which was diffuse in nature, an angiogram and/or vascular surgery consult should have been obtained on June 3, 2015, and that the failure to do so was a departure from good and accepted medical practice on the part of Nurse Whang and Dr. Kim. Plaintiff's expert also opines, within a reasonable degree of medical certainty, that it was a departure from good and accepted medical practice on the part of Nurse Whang and Dr. Kim to fail to order blood studies for inflammatory markers, including sedimentation rate and C-Reactive protein since such tests would have provided information that would have resulted in a more timely diagnosis of vasculitis, resulting in plaintiff receiving appropriate treatment in a timely manner. In addition, plaintiff's expert opines, within a reasonable degree of medical certainty, that it was a departure from good and accepted medical practice for Nurse Whang and Dr. Kim to assume that plaintiff's condition was atherosclerotic in nature and prescribe aspirin, Cilostazol, Clopidogrel, and Simvastatin. He or she explains that while these medications are beneficial in the treatment of conditions that are chronic in nature, they were of little or no benefit to plaintiff.

Plaintiff's expert disagrees with Dr. Gelber's opinion that plaintiff's arteritis was of long duration, and that the leg pain of which she complained in 2014 "may have been a symptom of arterial insufficiency in retrospect." Plaintiff's expert states that this opinion by Dr. Gelber constitutes pure speculation since there was no indication that plaintiff was suffering from this condition in 2014. He or she explains that the onset and rapid progression of plaintiff's symptoms starting in May 2015 indicates that it was unlikely that she was suffering from vasculitis in 2014.

Plaintiff's expert notes that Dr. Gelber states that since plaintiff was not suffering from resting leg pain on June 3, 2015, transfer to the hospital was not indicated at that time. Plaintiff's expert states that while he or she agrees that rest pain properly resulted in Dr. Kim transferring plaintiff to the hospital on June 11, 2015, the absence of resting pain did not mean a limb threatening process was not present earlier. Plaintiff's expert explains that given the rapid onset and progression of symptoms with objective findings of reduced arterial blood flow, it would not be prudent or medically acceptable to wait for the development of rest pain before initiating a definitive evaluation of the cause of such pain. He or she asserts that good and accepted medical practice required Nurse Whang and Dr. Kim to perform a more in-depth work-up of plaintiff on June 3, 2015, and they failed to do so.

Plaintiff's expert also disagrees with the opinions of Dr. Anain. He or she notes that Dr. Anain opines that the finding of a left popliteal artery occlusion on June 11, 2015 was a significant change from plaintiff's condition as previously seen on June 3, 2015.

He or she asserts that this opinion by Dr. Anain is speculative since the ultrasound performed on June 3, 2015 was interpreted as showing a 50-99% stenosis in the popliteal artery, which is consistent with a significant and potentially limb threatening stenosis. Plaintiff's expert further disagrees with Dr. Anain's opinion that there was no evidence of giant cell arteritis on June 3, 2015. He or she asserts that plaintiff's tandem stenoses and critically low ABI required that vasculitis be considered and ruled out, and that Nurse Whang and Dr. Kim improperly failed to do so.

Plaintiff's expert strongly disagrees with Dr. Anain's opinion as to a lack of proximate cause. Plaintiff's expert notes that Dr. Anain states that a diagnosis of giant cell arteritis on June 3, 2015 would not have prevented the progression of this disease. Plaintiff's expert states that "[t]his bald statement is without any basis in medicine," and that Dr. Anain has failed to provide any support for it. Plaintiff's expert points out that if this were true, "doctors would never treat giant cell arteritis and would simply let it run its course." He or she further states that "[t]he medical literature supports that early treatment with steroids and chemical agents, such as chemotherapy drugs can decrease and/or arrest the progression of the disease." He or she points out that this is the reason that these medications are administered to patients with this disease and why plaintiff was given these medications at North Shore University Hospital. He or she sets forth that "[i]t is well established that the earlier this condition is treated, the greater opportunity a patient has of being spared ischemia and requiring amputation."

Plaintiff's expert opines, with a reasonable degree of medical certainty, that Nurse Whang, Dr. Kim, and Kim P.C.'s departures from good and accepted practice, singularly and/or in combination with each other, were a proximate cause and a substantial contributing factor of plaintiff's lower extremity ischemia requiring bilateral lower extremity bypass procedures, right above the knee amputation, a bilateral leg wound debridement, complex wound closure, left calf muscle flap, surgery to apply grafts, and the sequalae of such surgeries. He or she specifies that Nurse Whang, Dr. Kim, and Kim P.C.'s departures from good and accepted practice diminished plaintiff's chances of a better outcome and/or the possibility of a better recovery, thereby depriving her of a more favorable prognosis, including complete recovery from her giant cell arteritis without the need to undergo any surgical intervention.

In addressing this motion, the court notes that Dr. Kim has initially established his prima facie entitlement to judgment as a matter of law by submitting the expert affirmations of Dr. Anain and Dr. Gelber, who opine that Dr. Kim did not depart from good and accepted medical practice and that his care and treatment of plaintiff did not proximately cause her injuries. However, "[w]here, as here, the parties adduce conflicting medical expert opinions, summary judgment is not appropriate, as such credibility issues can only be resolved by a jury" (*Bjorke v Rubenstein*, 53 AD3d 519, 520 [2d Dept 2008]; *see also Joyner*, 183 AD3d at 594; *Castillo v Surasi*, 181 AD3d 786, 788-789 [2d Dept 2020]; *M.C. v Huntington Hosp.*, 175 AD3d 578, 581 [2d Dept 2019]; *Mason v Adhikary*, 159 AD3d 1438, 1439 [4th Dept 2018]; *Elmes*, 140 AD3d at 1011;

Nisanov, 137 AD3d at 1094; *Guctas*, 132 AD3d at 633; *Feinberg v Feit*, 23 AD3d 517, 519 [2d Dept 2005]). Here, plaintiff's expert's opinion sharply conflicts with the expert opinions of Dr. Anain and Dr. Gelber. The court finds that plaintiff, through her expert's affirmation, the deposition testimony, and the medical records, has raised triable issues of fact as to whether Dr. Kim departed from good and accepted medical practice by failing to take steps that would have led to an earlier diagnosis of plaintiff's Takayasu arteritis, by failing to timely diagnose her, and by delaying the detection and treatment of it (*see Kiernan v Arevalo-Valencia*, 184 AD3d 727, 728 [2d Dept 2020]; *Feinberg*, 23 AD3d at 519; *Weinberg v Guttman Breast and Diagnostic Inst.*, 254 AD2d 213, 213 [1st Dept 1998]; *Donnelly v Finkel*, 226 AD2d 672, 672 [2d Dept 1996]).

Plaintiff has also raised triable issues of fact as to proximate cause. "To raise a triable issue of fact, a plaintiff need not establish that, but for a defendant doctor's failure to diagnose, the patient would have been cured" (*Neyman*, 153 AD3d at 546). In an action for medical malpractice, "where causation is often a difficult issue," a plaintiff is not required to do any more "than offer sufficient evidence from which a reasonable person might conclude that it was more probable than not that the defendant's deviation was a substantial factor in causing the [plaintiff's] injury" (*Goldberg*, 73 AD3d at 694 [internal quotation marks omitted]; *see also Neyman*, 153 AD3d at 545). The plaintiff's evidence as to causation may be deemed legally sufficient even where his or her expert "cannot quantify the extent to which the defendant's act or omission decreased the plaintiff's chance of a better outcome or increased his [or her] injury," as long as there is

evidence "presented from which the jury may infer that the defendant's conduct diminished the plaintiff's chance of a better outcome or increased his [or her] injury" (*Flaherty v Fromberg*, 46 AD3d 743, 745 [2d Dept 2007]; *see also Goldberg*, 73 AD3d at 694). While the court observes that the delay in between plaintiff's visits with Dr. Kim was short, plaintiff's expert's affirmation, the deposition testimony, and plaintiff's medical records present issues of fact as to proximate cause (*see Joyner*, 183 AD3d at 594). "Whether a diagnostic delay affected a patient's prognosis is typically an issue that should be presented to a jury" (*Polanco v Reed*, 105 AD3d 438, 442 [1st Dept 2013]; *see also Neyman*, 153 AD3d at 546).

As discussed above, plaintiff's expert specifically opines that Dr. Kim's departures from good and accepted medical practice diminished plaintiff's chances of a better outcome and the possibility of a better recovery, thereby depriving her of a more favorable prognosis, including complete recovery from her giant cell arteritis without the need to undergo any surgical intervention. Therefore, a jury could conclude that Dr. Kim's conduct, if found to have constituted a departure from good and accepted medical practice, diminished plaintiff's chance of a better outcome, and that Dr. Kim's departure, resulting in a delay in treatment, was a proximate cause of plaintiff's loss of her leg and other injuries (*see Neyman*, 153 AD3d at 546; *Polanco*, 105 AD3d at 442; *Goldberg*, 73 AD3d at 694; *Flaherty*, 46 AD3d at 74). Thus, Dr. Kim, Kim P.C., and Nurse Whang's motion for summary judgment dismissing plaintiff's complaint must be denied with respect to Dr. Kim and Kim P.C. (*see Kiernan*, 184 AD3d at 728; *Joyner*, 183 AD3d at

594; *Dallas-Stephenson v Waisman*, 39 AD3d 303, 307 [1st Dept 2007]; *McMahon v Badia*, 195 AD2d 445, 446 [2d Dept 1993]).

With respect to Nurse Whang, it is well established that "not every negligent act of a nurse" constitutes medical malpractice; rather, to constitute medical malpractice; there must be "a negligent act or omission by a nurse that constitutes medical treatment or bears a substantial relationship to the rendition of medical treatment by a licensed physician" (*Bleiler v Bodnar*, 65 NY2d 65, 72 [1985]). Plaintiff does not allege that there was any failure by Nurse Whang to elicit all information from plaintiff pertinent to treatment, or to record plaintiff's complaints and to promptly notify Dr. Kim of those complaints (*see id*.; *Abakpa v Martin*, 132 AD3d 924, 927 [2d Dept 2015]). Rather, plaintiff's allegations do not distinguish between Dr. Kim and Nurse Whang with respect to the alleged departures from good and accepted standard of care. Plaintiff claims that Nurse Whang did not properly diagnosis and treat her condition. Notably, there is no expert affirmation from a nurse practitioner alleging that Nurse Whang departed from good and accepted standards of care for a nurse practitioner. Plaintiff does not allege any diagnosis or treatment of her which was made by Nurse Whang, as opposed to Dr. Kim.

Pursuant to Education Law § 6902 (3), nurse practitioners, such as Nurse Whang, may engage in "the diagnosis of illness and physical conditions and the performance of therapeutic and corrective measures within a specialty area of practice, in collaboration with a licensed physician qualified to collaborate in the specialty involved, provided such

services are performed in accordance with a written practice agreement and written practice protocols" (*see also* 8 NYCRR 64.5 [b]; *Ruggiero v Miles*, 125 AD3d 1216, 1217 [3d Dept 2015]). There was no submission of any practice agreement or written practice protocols between Nurse Whang and Dr. Kim. Moreover, Education Law § 6902 (3) further provides that, in the event that a dispute arises with regard to a matter of diagnosis or treatment that is not addressed by written protocols, the physician's opinion, i.e., Dr. Kim's opinion, will prevail. Thus, Nurse Whang was under Dr. Kim's direct supervision or control, and, as shown by the deposition testimony, she did not provide any diagnosis of plaintiff's condition or prescribe plaintiff's treatment (*see* Education Law § 6902 [3]; *Ruggiero*, 125 AD3d at 1217). Rather, it was Dr. Kim who diagnosed and treated plaintiff (NYSCEF Doc No. 37, Nurse Whang's deposition tr at 46, lines 2-6, 12-17; at 47, line 25; at 48, lines 2-4). Nurse Whang also testified that both she and Dr. Kim examined plaintiff at the same time (*id*. at 32, line 21; at 43, line 10). Thus, there is no basis to impose malpractice liability upon Nurse Whang, and summary judgment dismissing plaintiff's complaint as against Nurse Whang is warranted (*see* CPLR 3212 [b]).

Dr. Shiah, Dr. Rella, and NYPH's Motion for Summary Judgment (Motion Sequence Number Two)

Plaintiff alleges that Dr. Shiah and Dr. Rella failed to properly evaluate, timely diagnose, and treat her vasculitis, that they failed to perform appropriate tests and

administer proper medications, and improperly discharged her. Plaintiff asserts that NYPH is vicariously liable for the alleged malpractice of Dr. Shiah and Dr. Rella.

Dr. Shiah and Dr. Rella have submitted the expert affirmation of Larry A. Scher, M.D. (Dr. Scher), a physician duly licensed to practice medicine in the State of New York, who is board certified in vascular surgery. Dr. Scher notes that plaintiff had vasculitis, which is a condition characterized by the inflammation of blood vessels that can cause changes in the vessel walls, such as thickening and narrowing which restrict blood flow. He contrasts vasculitis with peripheral vascular disease due to atherosclerosis or a buildup of plaque on the inner vessel walls, which restricts blood flow. He notes that while medications, such as anticoagulants or antiplatelets, may be used to reduce the risks associated with peripheral vascular disease due to atherosclerosis, these medications are not helpful for patients with vasculitis since there is no plaque buildup in patients with vasculitis.

With respect to plaintiff's presentation to the emergency department at NYPH on May 27, 2015, Dr. Scher opines, to a reasonable degree of medical certainty, that Dr. Shiah obtained a full, complete, and proper medical history of plaintiff to evaluate her complaints of right lower leg pain. He points out that it was documented that plaintiff had previously had spinal surgery and had a history of back pain, that plaintiff had leg cramping that had been worsening with walking for one month, and that plaintiff ambulated with a steady gait. He sets forth that Dr. Shiah performed an examination, which noted no signs of arterial or venous thrombosis and good peripheral pulses (2+).

He further sets forth that there were no skin changes, ulcerations, discoloration, cyanosis or temperature changes that would be suggestive of a vascular problem. He asserts that Dr. Shiah did not ignore plaintiff's signs, symptoms, and complaints, but appropriately evaluated plaintiff's history and presenting signs and symptoms.

Dr. Scher opines, within a reasonable degree of medical certainty, that based upon plaintiff's presenting signs and symptoms, she did not warrant further tests or studies, such as the performance of a Doppler or CT angiogram on May 27, 2015. He asserts that this is because plaintiff's presenting signs and symptoms were not consistent or suggestive of a vascular disease at that time.

Dr. Scher further opines that an in-patient vascular surgery consult and intervention by a vascular surgeon to perform a bypass was not indicated on May 27, 2015. He states that it was proper for Dr. Shiah to have assessed plaintiff's condition as non-emergent and recommend that she follow up with her primary medical doctor or Weill Cornell Internal Medical Associates for further evaluation of her lower extremity pain. He asserts that the reason that this was proper was because plaintiff's condition did not appear to be vascular in nature based on plaintiff's medical history and Dr. Shiah's evaluation of plaintiff.

Dr. Scher notes that plaintiff was found to have an elevated platelet count on her May 27, 2015 visit with Dr. Shiah. However, Dr. Scher opines that this finding did not require further work-up in the emergency department at NYPH, and that it was

appropriate for Dr. Shiah to direct plaintiff to obtain outpatient follow-up for her elevated platelet levels.

With respect to plaintiff's visit with Dr. Rella on June 9, 2015, Dr. Scher opines, within a reasonable degree of medical certainty, that Dr. Rella obtained a full, complete, and proper medical history of plaintiff to evaluate her complaints of left lower extremity pain. Dr. Scher points out that Dr. Rella noted that plaintiff had been evaluated by Dr. Kim, who had diagnosed her with arterial stenosis. He states that Dr. Rella's examination of plaintiff was consistent with plaintiff's reported history of peripheral vascular disease. He opines, within a reasonable degree of medical certainty, that an in-patient vascular consultation or an admission to NYPH was not warranted at that time.

Dr. Scher notes that on June 9, 2015, Dr. Rella's examination showed that plaintiff's capillary refill was five seconds, her dorsalis pedis pulse was faintly palpable, and her posterior tibial pulse was not palpable. He sets forth his opinion that these clinical examination findings were consistent with peripheral vascular disease. He acknowledges that these clinical examination findings were abnormal but asserts that they did not represent an emergent condition. He states that while plaintiff's capillary refill was slightly diminished, she was still exhibiting perfusion of the lower extremity, making it reasonable to discharge plaintiff on June 9, 2015 since she was already scheduled to return to Dr. Kim for a continued work-up for peripheral vascular disease in two days. He also states that further tests and studies, as well as a vascular surgery consult, were not warranted on June 9, 2015 because plaintiff had an outside diagnosis by

Dr. Kim of peripheral vascular disease and Dr. Rella's clinical examination findings were consistent with that diagnosis. He asserts that it was reasonable for Dr. Rella to have plaintiff maintain continuity of care with her outside physician.

Dr. Scher also asserts that the care and treatment rendered to plaintiff by NYPH was, at all times, appropriate and comported with the standard of care. He states that NYPH, including its staff, did not cause or contribute to plaintiff's injuries.

Dr. Scher also opines, within a reasonable degree of medical certainty, that plaintiff's alleged injuries were not the result of any action or inaction by Dr. Shiah, Dr. Rella, or NYPH, but were caused by the natural course of the underlying disease process of giant cell arteritis. He points to the fact that after plaintiff's admission to North Shore University Hospital, she was treated with steroids and Cytoxan to relieve her vascular inflammation, and that plaintiff underwent her first surgical intervention, namely, a left femoral to posterior tibial artery bypass 11 days later. He also points to the fact that two days later, plaintiff developed progressive ischemia of her right lower extremity and underwent a right femoral to posterior tibial artery bypass. He notes that 10 days later, plaintiff's right lower extremity appeared dusky and necrotic muscles were present under her dressing, and that six days later, plaintiff underwent the right above the knee amputation. He asserts that despite the fact that plaintiff was admitted to North Shore University Hospital on June 11, 2015 and was treated with steroids and Cytoxan and underwent bypass procedures, she still required an above the knee amputation on July 10, 2015, about one month after her admission. He opines, within a reasonable degree of

medical certainty, that plaintiff's vasculitis progressed to tissue loss requiring emergent surgery and amputation of her right leg despite intensive management with steroids and Cytoxan and after undergoing revascularization procedures. He further opines that since North Shore University Hospital first treated plaintiff with steroids, if Dr. Rella had treated plaintiff with steroids on June 9, 2015, two days earlier, it would not have altered plaintiff's alleged injuries, which, he states, were due to the progressive nature of her giant cell arteritis or vasculitis.

As to NYPH, Dr. Scher opines, within a reasonable degree of medical certainty, that the care and treatment of plaintiff rendered by NYPH to plaintiff was, at all times, appropriate and comported with the standard of care. Dr. Scher states that there is nothing in the records nor any testimony that suggests that NYPH, including, but not limited to, its physicians, nurses, and other staff, caused and/or contributed to plaintiff's injuries. He sets forth his opinion that plaintiff's claims pertaining to a failure to properly supervise, monitor, review, and evaluate physicians, staff, and other personnel rendering care and treatment is without merit.

In opposition, plaintiff's expert opines that Dr. Shiah departed from good and accepted medical practice in failing to form a proper differential diagnosis during plaintiff's visit to NYPH on May 27, 2015. Plaintiff's expert explains that Dr. Shiah improperly ruled out claudication from her differential diagnosis without a proper basis to do so, and despite the fact that she recognized the serious consequences of untreated claudication, including ischemia and loss of limb. Plaintiff's expert points out that the

leg cramping, of which plaintiff had complained on May 27, 2015, was a sign of restriction of blood flow. Plaintiff's expert further points out that plaintiff's lab results demonstrated thrombocytosis, which was consistent with vasculitis. He or she asserts that in view of plaintiff's symptoms, this required further investigation by Dr. Shiah. He or she states that despite these factors, Dr. Shiah discharged plaintiff without performing any further diagnostic studies or obtaining any consults.

Plaintiff's expert opines, within a reasonable degree of medical certainty, that Dr. Shiah departed from good and accepted medical practice by failing to consider vasculitis in her diagnosis, and by discharging plaintiff from the emergency room without performing proper tests and obtaining a vascular surgery consult. He or she explains that in order to properly evaluate the potential diagnoses of vasculitis and/or arterial insufficiency, good and accepted medical practice required Dr. Shiah to order blood studies for inflammatory markers including sedimentation rate and C-reactive protein, ordering an arterial ultrasound, and obtaining a consult from a vascular surgeon. He or she sets forth his/her opinion that the failure to undertake these studies and obtain this consult from a vascular surgeon constituted departures from good and accepted medical practice. He or she further opines, within a reasonable degree of medical certainty, that had these measures been taken in accordance with good and accepted medical practice, it would have resulted in plaintiff's vasculitis being diagnosed shortly thereafter and would have provided an opportunity for plaintiff to receive appropriate treatment in a more timely fashion.

As to Dr. Rella, plaintiff's expert opines, within a reasonable degree of medical certainty, that Dr. Rella departed from good and accepted medical practice in failing to timely diagnose that plaintiff was suffering from vasculitis and/or critical limb ischemia when she presented to NYPH on June 9, 2015. Plaintiff's expert points to the fact that Dr. Rella's note specifically showed that at that time, plaintiff was suffering from resting leg pain, which is a sign of critical limb blood flow compromise and impending development of gangrene. Plaintiff's expert further points out that plaintiff had reported to Dr. Rella that she had been diagnosed with peripheral arterial stenosis. He or she asserts that based on this, good and accepted medical practice mandated that a vascular surgery consult be obtained and that imaging studies, such as arterial ultrasound, CT angiogram, or MR angiogram of plaintiff's lower extremities be performed. He or she points to the fact that the records show that an ultrasound of plaintiff's lower extremities and blood studies were ordered at 11:04 p.m., but were subsequently canceled without any explanation as to why they were canceled. He or she sets forth his or her opinion that this canceling of the ultrasound was a departure from good and accepted medical practice. He or she asserts that Dr. Rella, at the very least, should have contacted Dr. Kim to obtain further information as to the work-up that he had performed six days earlier. He or she notes that Dr. Rella failed to undertake these steps and opines that his failure to do so was a departure from good and accepted medical practice. Plaintiff's expert opines, within a reasonable degree of medical certainty, that if Dr. Rella had performed these steps on June 9, 2015, plaintiff would have been diagnosed with

vasculitis at that time, two days earlier than when North Shore University Hospital diagnosed her with vasculitis.

Plaintiff's expert also asserts that Dr. Rella failed to perform a physical examination of plaintiff. Specifically, plaintiff's expert notes that plaintiff testified, at her deposition, that Dr. Rella had told her that he was "just there for overtime, "just there to wrap ankles," and "to tell him [her] story (NYCEF Doc No. 86, plaintiff's deposition tr at 102, lines 22-25; at 244, lines 15-17). Plaintiff's expert further notes that plaintiff testified that Dr. Rella did not perform a physical examination on her; plaintiff also testified that Dr. Rella only told her to pull her pant legs up so he could see her legs, but did not touch them (*id*. at 102, lines 7-19; at 244, lines 18-20). Plaintiff's expert also notes that plaintiff testified that Dr. Rella just gave her a prescription for pain medication and told her to follow up with her own doctor (*id*. at 104). Plaintiff's expert asserts that the fact that Dr. Rella did not truly perform a physical examination of plaintiff legs is supported by the fact that he documented that plaintiff's left leg had no edema and was warm to touch. He or she explains that given the findings made by Dr. Kim and at North Shore University Hospital two days later, this "is simply implausible." Plaintiff's expert also points out that one of plaintiff's chief complaints for presenting to NYPH was left leg swelling. Plaintiff's expert asserts that a physical exam of the leg must be performed when a patient complains of pain and swelling, and he or she opines that Dr. Rella's failure to do so was a departure from good and accepted medical practice.

Plaintiff's expert disagrees with Dr. Scher's opinions and notes that Dr. Scher states that plaintiff's signs and symptoms were not suggestive of a vascular problem on May 27, 2015. Plaintiff's expert further opines that plaintiff's symptoms were consistent with claudication, which Dr. Shiah agreed with in her deposition testimony, and that claudication is suggestive of a vascular condition, requiring further studies or a consult from a vascular surgeon to evaluate her complaints. Plaintiff's expert asserts that it is for this reason that he or she disagrees with Dr. Scher's opinion that a vascular surgery consult was not indicated on May 27, 2015.

Plaintiff's expert notes that Dr. Scher admits that limb threatening ischemia, as evidenced by rest pain, is an indication for surgical intervention for chronic lower extremity arterial occlusive disease. Plaintiff's expert asserts that despite this admission by Dr. Scher, and the fact that plaintiff, as documented in the medical record, had resting leg pain on June 9, 2015, Dr. Scher nevertheless opines that it was appropriate for plaintiff to be discharged from NYPH to follow up with her private outside cardiologist.

Plaintiff's expert explains that plaintiff went to NYPH's emergency room seeking medical care from it, and that if she felt that her medical condition could wait until her next appointment with Dr. Kim that was scheduled to take place two days later, she would have stayed home instead of presenting to the emergency room seeking medical treatment. Plaintiff's expert asserts that when treating limb ischemia, "time is of the essence and delay only results in risk of additional tissue death." He or she states that this is "especially true when a patient's symptoms are rapidly progressing, as [plaintiff's

symptoms] were." Plaintiff's expert concludes that for these reasons, it was a departure from good and accepted medical practice for Dr. Rella to discharge plaintiff on June 9, 2015 without a complete and proper work-up simply because she had an upcoming appointment with an outside physician.

Plaintiff's expert disagrees with Dr. Scher's opinion that plaintiff's injuries were "the natural course" of plaintiff's "underlying disease process" of giant cell arteritis, and that there was a lack of proximate cause. Plaintiff's expert explains that an "early treatment of giant cell arteritis provides patients with a greater opportunity to avoid the complications of arterial occlusion," and, therefore, affords them "a better outcome." Plaintiff's expert points out that "[n]ot all patients who are diagnosed with large vessel giant cell arteritis suffer the same dire outcome that [plaintiff] did."

Plaintiff's expert sets forth his or her opinion, within a reasonable degree of medical certainty, that Dr. Shiah, Dr. Rella, and NYPH's departures from good and accepted practice, singularly and/or in combination, were a proximate cause of and/or substantial contributing factor resulting in plaintiff's injuries, including the need to undergo bilateral lower extremity bypass procedures and right above the knee amputation, as well as the other procedures, as set forth above. Plaintiff's expert sets forth that Dr. Shiah, Dr. Rella, and NYPH's departures from good and accepted medical practice significantly diminished plaintiff's chances of a better outcome and/or the possibility of a better recovery.

In reply, Dr. Shiah, Dr. Rella, and NYPH's contend that plaintiff's expert is not qualified to render an opinion because his or her affirmation is silent as to his or her experience actually practicing as a vascular surgeon, and because his or her affirmation also fails to state the date of his or her graduation, the date of his or her completion of a residency or fellowship, and the date that he or she became board certified in surgery and vascular surgery. They argue that plaintiff's expert, therefore, has not shown that he or she is familiar with the standard of care in 2015.

Notably, Dr. Shiah, Dr. Rella, and NYPH's own expert, Dr. Scher, did not provide any such dates in his own affirmation. In addition, Dr. Shiah, Dr. Rella, and NYPH did not seek expert disclosure of this information under CPLR 3101 (d) (1) (i) (*see Kanaly v DeMartino*, 162 AD3d 142, 151 [3d Dept 2018]; *Thomas v Alleyne*, 302 AD2d 36, 37-38 [2d Dept 2002]). Plaintiff's expert is not required to volunteer such specific information, which may tend to reveal his or her identity where it has not been sought in disclosure.

"'[I]t is true that a medical expert is required to be possessed of the requisite skill, training, education, knowledge or experience from which it can be assumed that the opinion rendered is reliable'" (*Samer v Desai*, 179 AD3d 860, 863 [2d Dept 2020], quoting *Postlethwaite v United Health Servs. Hosps.*, 5 AD3d 892, 895 [3d Dept 2004] [internal quotation marks omitted]; *see also Noble v Kingsbrook Jewish Med. Ctr.*, 168 AD3d 1077, 1080 [2d Dept 2019]). Therefore, it has been held that "'where a physician provides an opinion *beyond his or her area of specialization*, a foundation

must be laid tending to support the reliability of the opinion rendered'" (*Samer*, 179 AD3d at 863, quoting *Lavi v NYU Hosps. Ctr.*, 133 AD3d 830, 831 [2d Dept 2015] [emphasis added]; *see also Daniele v Pain Mgt. Ctr. of Long Is.*, 168 AD3d 672, 677 [2d Dept 2019]; *Noble*, 168 AD3d at 1080; *Mustello v Berg*, 44 AD3d 1018, 1019 [2d Dept 2007], *lv denied* 10 NY3d 711 [2008]; *Behar v Coren*, 21 AD3d 1045, 1047 [2d Dept 2005], *lv denied* 6 NY3d 705 [2006]).

Here, plaintiff's expert is not providing an opinion that is "beyond his or her area of specialization" (*Samer*, 179 AD3d at 863; *see also Noble*, 168 AD3d at 1080), and has set forth his or her asserted familiarity with the applicable standard of care. Specifically, plaintiff's expert not only affirms that he or she is board certified by the American Board of Surgery and by the American Board of Vascular Surgery, but also affirms that he or she obtained his or her medical degree from Washington University School of Medicine in St. Louis, Missouri, and completed a residency in surgery, as well as fellowships in critical care surgery and vascular surgery at Mount Sinai Medical Center. He or she further affirms that through his or her "education, training, experience, participating in continuing medical education courses, and review of medical literature," he or she is "fully familiar with the customary obligations, responsibilities and roles of physicians, including those specializing in internal medicine and cardiovascular disease, who attend to and treat patients such as plaintiff," who "present with complaints of lower extremity pain and/or signs and symptoms of claudication and peripheral vascular disease, and *the standard of care for treatment* of

same" (emphasis added). Plaintiff's expert further affirms that all of his or her opinions "are based on [his or her] education, training, experience and review of the medical records and testimony referable to the care and treatment of [plaintiff]." Thus, plaintiff's expert is qualified to render an expert opinion in this action.

Dr. Shiah, Dr. Rella, and NYPH also argue that plaintiff's expert's affirmation is speculative and conclusory. Contrary to this argument, plaintiff's expert's affirmation is not speculative or conclusory, but details the specific departures by Dr. Shiah and Dr. Rella, and is based on the medical records and deposition testimony (*see Carter v Tana*, 68 AD3d 1577, 1580 [3d Dept 2009]).

Dr. Shiah, Dr. Rella, and NYPH also argue that plaintiff's expert ignores plaintiff's prior surgery. This argument is rejected. Plaintiff's expert noted that plaintiff had prior surgery and specifically opined that there was no indication that plaintiff had this condition in 2014, at the time of that surgery. In fact, plaintiff's expert pointed out that the onset and rapid progression of her symptoms, starting in May 2015, indicated that she did not suffer from this condition in 2014.

The court notes that Dr. Shiah and Dr. Rella have initially established their prima facie entitlement to judgment as a matter of law by submitting the expert affirmation of Dr. Scher, who opines that they did not depart from good and accepted medical practice and that their care and treatment of plaintiff did not proximately cause her injuries. However, plaintiff's expert's opinion sharply conflicts with Dr. Scher's expert opinion. The court finds that in view of the conflicting opinions of plaintiff's

expert and Dr. Scher, triable issues of fact exist as to Dr. Shiah and Dr. Rella's alleged departures from good and accepted medical practice which cannot be resolved on this motion for summary judgment (*see Kiernan*, 184 AD3d at 728; *Joyner*, 183 AD3d at 594; *Castillo*, 181 AD3d at 788-789; *M.C.*, 175 AD3d at 581; *Mason*, 159 AD3d at 1439; *Elmes*, 140 AD3d at 1011; *Nisanov*, 137 AD3d at 1094; *Guctas*, 132 AD3d at 633; *Bjorke*, 53 AD3d at 520; *Feinberg*, 23 AD3d at 519). Triable issues of fact are also raised with respect to the issue of whether the alleged malpractice by Dr. Shiah and/or Dr. Rella proximately caused plaintiff's injuries, which mandate the denial of summary judgment as to Dr. Shiah and Dr. Rella with respect to plaintiff's claims of malpractice (*see Neyman*, 153 AD3d at 546; *Polanco*, 105 AD3d at 442; *Goldberg*, 73 AD3d at 694; *Flaherty*, 46 AD3d at 74).

Dr. Shiah, Dr. Rella, and NYPH's arguments in their reply papers, that plaintiff's expert has not raised a triable issue as to proximate cause is devoid of merit. They assert that plaintiff's expert does not indicate whether it was more likely than not that an earlier diagnosis and treatment would have altered plaintiff's outcome. Contrary to this argument, plaintiff's expert has specifically opined that Dr. Shiah, Dr. Rella, and NYPH's departures from good and accepted practice were a proximate cause of and/or substantial contributing factor resulting in plaintiff's injuries, and deprived plaintiff of an opportunity for a better outcome. Thus, summary judgment dismissing plaintiff's first cause of action for malpractice as against Dr. Shiah and Dr. Rella must be denied (*see Contreras v Adeyemi*, 102 AD3d 720, 721 [2d Dept 2013]).

While Dr. Shiah, Dr. Rella, and NYPH's motion seeks summary judgment dismissing plaintiff's complaint as against NYPH, Dr. Shiah testified, at her deposition, that she has been continuously employed by NYPH since 2008 (NYSCEF Doc No. 87, Dr. Shiah's deposition tr at 8, lines 12-19). Dr. Rella testified, at his deposition, that he was employed in 2015 by Cornell (NYSCEF Doc No. 68, Dr. Rella's deposition tr at 15, lines 23-25; at 16, lines 2-9). As stated on NYPH's website, NYPH is home to Weill Cornell Medicine doctors, and Dr. Shiah referred to NYPH as New York Presbyterian-Weill Cornell Medical Center (NYSCEF Doc No. 87, Dr. Shiah's deposition tr at 8, lines 15-16).

"'In general, under the doctrine of respondeat superior, a hospital may be held vicariously liable for the negligence or malpractice of its employees acting within the scope of employment'" (*Fuessel v Chin*, 179 AD3d 899, 901 [2d Dept 2020], quoting *Seiden v Sonstein*, 127 AD3d 1158, 1160 [2d Dept 2015]*; see also Hill v St. Clare's Hosp.*, 67 NY2d 72, 79 [1986]; *Dupree v Westchester County Health Care Corp.*, 164 AD3d 1211, 1213 [2d Dept 2018]). Thus, NYPH may be held vicariously liable for the malpractice of its employees. Plaintiff asserts that both Dr. Shiah and Dr. Rella were employed by NYPH, and NYPH has not shown otherwise.

Furthermore, a hospital may be held vicariously liable for a physician's malpractice even where the physician is not its employee "'where a patient comes to the emergency room seeking treatment from the hospital and not from a particular physician of the patient's choosing'" (*Fuessel*, 179 AD3d at 901, quoting *Muslim v*

Horizon Med. Group, P.C., 118 AD3d 681, 683 [2d Dept 2014]; *see also Mitchell v Goncalves*, 179 AD3d 787, 789 [2d Dept 2020]; *Smolian v Port Auth. of N.Y. & N.J.*, 128 AD3d 796, 801 [2d Dept 2015]; *Tart v New York Bronx Pediatric Medicine, P.C.*, 116 AD3d 515, 516 [1st Dept 2014]; *Gardner v Brookdale Hosp. Med. Ctr.*, 73 AD3d 1124, 1124 [2d Dept 2010]; *Salvatore v Winthrop Univ. Med. Ctr.*, 36 AD3d 887, 888 [2d Dept 2007]; *Orgovan v Bloom*, 7 AD3d 770, 771 [2d Dept 2004]; *Schiavone v Victory Mem. Hosp.*, 292 AD2d 365, 366 [2d Dept 2002]; *Mduba v Benedictine Hosp.*, 52 AD2d 450, 453 [3d Dept 1976]). Here, plaintiff presented to the emergency department of NYPH on May 27, 2015 and June 9, 2015, seeking treatment from NYPH, as opposed to Dr. Shiah or Dr. Rella. Thus, since there are triable issues of fact raised with respect to malpractice by Dr. Shiah and Dr. Rella, summary judgment dismissing plaintiff's complaint as against NYPH must be denied.

To the extent that plaintiff's claims as against NYPH can be construed as asserting a claim for failure to supervise its staff or as imposing liability against NYPH based upon the malpractice of any staff members other than Dr. Shiah and Dr. Rella, plaintiff does not oppose Dr. Shiah, Dr. Rella, and NYPH's motion insofar as it seeks summary judgment dismissing such claims as against NYPH. Summary judgment dismissing any such claims as against NYPH is, therefore, warranted (*see* CPLR 3212 [b]).

Dr. Shiah, Dr. Rella, and NYPH additionally seek summary judgment dismissing plaintiff's second cause of action for lack of informed consent, which

alleges that defendants failed to obtain plaintiff's informed consent to their treatment or lack of treatment of her. Dr. Scher asserts that plaintiff did not undergo any procedure for which informed consent was required. Dr. Kim and Nurse Whang do not raise this issue in their motion.

As provided by Public Health Law § 2805-d (2) (b), "[a] failure to diagnose cannot be the basis of a cause of action for lack of informed consent unless associated with a diagnostic procedure that 'involve[s] invasion or disruption of the integrity of the body'" (*Janeczko v Russell*, 46 AD3d 324, 325 [1st Dept 2007], quoting Public Health Law § 2805-d [2] [b]; *see also Sample v Levada*, 8 AD3d 465, 466-467 [2d Dept 2004]; *Schel v Roth*, 242 AD2d 697, 698 [2d Dept 1997]). Here, plaintiff does not allege that any such procedure was performed. Plaintiff has thus failed to raise any triable issue of fact regarding the issue of lack of informed consent. Indeed, plaintiff's opposition papers fail to address the issue of lack of informed consent at all. Thus, summary judgment dismissing plaintiff's second cause of action for lack of informed consent as against Dr. Shiah, Dr. Rella, and NYPH is warranted (*see* Public Health Law § 2805-d [2] [b]). Upon a search of the record, plaintiff's informed consent claim must also be dismissed as against Dr. Kim, Kim P.C., and Nurse Whang (*see* CPLR 3212 [b]). Plaintiff's complaint as against Nurse Whang is otherwise dismissed.

Conclusion

Accordingly, Nurse Whang, Dr. Kim, and Kim P.C.'s motion for summary judgment: (1) is denied with respect to plaintiff's first cause of action for malpractice as against Dr. Kim and Kim P.C.; and (2) is granted with respect to plaintiff's first cause of action for malpractice as against Nurse Whang. Upon a search of the record, pursuant to CPLR 3212 (b), summary judgment dismissing plaintiff's second cause of action for lack of informed consent as against Nurse Whang, Dr. Kim, and Kim P.C. is granted.

Dr. Shiah, Dr. Rella, and NYPH's motion for summary judgment: (1) is granted insofar as it seeks summary judgment dismissing plaintiff's second cause of action for lack of informed consent as against them; (2) is granted with respect to NYPH solely to the extent that plaintiff's claims can be construed as asserting a claim for failure to supervise its staff or as imposing liability against NYPH based upon the malpractice of any staff members other than Dr. Shiah and Dr. Rella; and (3) is denied in all other respects.

This constitutes the decision and order of the court.

E N T E R,

J. S. C.