| **Wiggins v Hunter** |
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| 2021 NY Slip Op 31488(U) |
| April 15, 2021 |
| Supreme Court, New York County |
| Docket Number: 805306/2017 |
| Judge: Judith N. McMahon |
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# SUPREME COURT OF THE STATE OF NEW YORK
# NEW YORK COUNTY

**PRESENT:** **HON. JUDITH REEVES MCMAHON** **PART** **IAS MOTION 30**

***Justice***

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LINDA WIGGINS, LINDA WIGGINS

Plaintiff,

- v -

ANDREW HUNTER, ADVANTAGE CARE PHYSICIANS MPG,

Defendant.

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**INDEX NO.** 805306/2017

**MOTION DATE** 04/07/2021

**MOTION SEQ. NO.** 002

**DECISION + ORDER ON MOTION**

The following e-filed documents, listed by NYSCEF document number (Motion 002) 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60

were read on this motion to/for JUDGMENT - SUMMARY.

Defendants Andrew Hunter, M.D. ("Dr. Hunter") and Advantage Care Physicians, MPG ("ACP") (collectively "Defendants") move this Court for an Order pursuant to CPLR §3212 granting them summary judgment and dismissing the Complaint in its entirety. The motion is hereby granted.

Plaintiff Linda Wiggins, as Administratrix of the Goods, Chattels and Credits which were of Wilbert Rogers, Deceased, and Linda Rogers Individually ("Plaintiff") commenced this medical malpractice Action on August 8, 2017. According to Plaintiff, Dr. Hunter and ACP negligently failed to diagnose and treat decedent Wilbert Roberts ("Decedent") for atrial fibrillation, which allegedly resulted in a stroke in June 2016. Plaintiff further alleges that in January 2018, Defendants' negligence led to Decedent suffering a weakening of his pulmonary function, respiratory distress, pulmonary embolism and his death on February 9, 2018. Decedent was first evaluated at ACP by Dr. Rutkovsky in February 2008 after he had a surgical resection of his small intestine. Dr. Rutkovsky noted that Decedent had atrial fibrillation, which

was stable on Warfarin, and that Decedent was taking Metoprolol. Decedent was evaluated by cardiologist Dr. Egelman in April 2008 for a pre-operative cardiovascular examination. Since Decedent's echocardiogram was normal, Dr. Egelman recommended Decedent discontinue Coumadin prior to the surgery (to avoid an increased risk of bleeding at the operative site) and increase the Metoprolol.

In July 2008, Dr. Egelman evaluated Decedent for a reoccurrence of atrial fibrillation after a hospital admission and Decedent was prescribed Coumadin and Metoprolol. Plaintiff represents that Decedent was still on Coumadin during an office visit with Dr. Rutkovsky on August 11, 2008. On December 23, 2008, Decedent saw Dr. Lef, who did not practice at ACP, for a medical clearance consultation for an upcoming hemorrhoid surgery. At this appointment, it appears that Dr. Lef discontinued Decedent's Coumadin. Defendants represent that while Decedent was treated at ACP in 2009 for different conditions, including a rotator cuff injury, he showed no signs of atrial fibrillation. During such time, Decedent was taking Metoprolol, but no anticoagulants. After he presented to Dr. Rutkvosky with symptoms of dyspnea, cough, bilateral diffuse coarse rales and wheezing, Decedent was recommended to a cardiologist. Dr. Egelman evaluated Decedent in May 2010 for shortness of breath and Decedent's stress test showed fair exercise tolerance, no chest pain and no evidence of ischemia on EKG. Decedent was noted to have paroxysmal atrial fibrillation and was prescribed Bisoprolol (a beta blocker), but no anticoagulant.

In 2010 and 2011, Decedent continued being treated at ACP for various conditions, including urinary symptoms, benign prostatic hyperplasia and leg/thigh pain. Defendants represent that in December 2014, Decedent was treated for Chronic Obstructive Pulmonary Disease ("COPD") at Lenox Hill Hospital and underwent an EKG that did not reveal any atrial

fibrillation. Decedent was admitted to Lenox Hill Hospital on September 8, 2015 for testicular pain and underwent an EKG, which showed atrial flutter with variable AV block at 89 bpm. Decedent was discharged with instructions to take Bisoprolol for rate control.

Decedent first saw Dr. Hunter at ACP on September 28, 2015 when he presented with complaints of right hip pain. Defendants represent that a physical examination was negative for arrhythmia and Decedent's heart rate was sinus rhythm, showing no signs of atrial fibrillation. Dr. Hunter prescribed pain medication for inflammatory arthritis and referred Decedent to physical therapy. On November 19, 2015 and December 30, 2015, Decedent returned to Dr. Hunter for eczema and eye redness. According to Defendants, Dr. Hunter performed physical examinations on Decedent that revealed no atrial fibrillation.

Defendants also represent that Dr. Hunter was notified when Decedent was admitted to Lenox Hill Hospital from January 4-6, 2016 for abdominal pain and a kidney infection. In June 2016, Decedent suffered a stroke and was evaluated at Lenox Hill Hospital from June 22, 2016 through June 25, 2016. When Decedent returned to Dr. Hunter on July 15, 2016, Dr. Hunter ordered laboratory work and referred Decedent to a cardiologist and neurologist. Decedent saw cardiologist Dr. Malhotra on July 18, 2016, who started Decedent on anticoagulants and continued Bisoprolol for rate control. Dr. Malhotra also noted that Decedent smoked half a pack of cigarettes a day for 37 years until July 2015 and that the Decedent’s EKG showed normal sinus rhythm. In February 2018, Decedent died from a pulmonary embolism and respiratory distress.

In support of their motion for summary judgment, Defendants submit the affirmation of Preston L. Winters, M.D. (“Dr. Winters”) who opines that Defendants did not depart from the standard of care or that any departures alleged by Plaintiff did not proximately cause the

Decedent's injuries and death. According to Dr. Winters, there is no merit in Plaintiff's claim that Dr. Hunter and ACP failed to appreciate notations in Decedent's medical records regarding his history of atrial fibrillation. Dr. Winters states that Dr. Hunter appropriately asked Decedent about his medical history and performed physical examinations at each visit. Dr. Winters opines that Decedent did not present with any signs or symptoms of atrial fibrillation or stroke. Dr. Winters explains that even if Dr. Hunter or ACP were aware of Decedent's history of atrial fibrillation, this does not mean that he was in atrial fibrillation during his visits or that anticoagulant therapy was indicated.

Dr. Winters also finds no merit in Plaintiff's claim that Dr. Hunter and ACP departed from the standard of care by failing to prescribe anticoagulant therapy, as it is within the treating physician's discretion to make such a prescription for a patient with a low annual stroke risk. Dr. Winters opines that ACP appropriately followed the clinical guidelines regarding management of atrial fibrillation and that "anticoagulation therapy was not recommended during the period of alleged negligence (prior to his stroke) based on the annual stroke risk versus the significant bleeding risks of the therapy."[1] Turning to Plaintiff's claim that Decedent should have been placed on an anticoagulant based on his $CHADS_2$ score of "2", Dr. Winters details how risk factors are designated in this scoring schema which is used to assess a patient's stroke risk. The Court notes that both Dr. Winters and Plaintiff's Expert, whose affirmation is discussed below, represent that the $CHADS_2$ score was an accepted and standard scoring schema used to assess a patient's stroke risk. Dr. Winters notes that as of 2014, the updated $CHA_2DS_2$-$VAS_C$ model is recognized by the American College of Cardiology Task Force and is accepted within the medical community. Plaintiff's Expert represents that the updated AHA/ACC/HRS Guidelines

[1] Dr. Winters opines that not only was anticoagulation not indicated for Decedent, but it also might have been unwise in light of his history of gastrointestinal issues due to the risk of gastrointestinal bleeding.

of 2014 recommended that physicians use the $CHA_2DS_2$-$VAS_C$ model to assess a patient's stroke risk. Dr. Winters opines that based upon Decedent's scores under these systems and his presenting symptoms, there was no indication that Dr. Hunter or ACP should have prescribed anticoagulant theory or antiplatelet agents to the Decedent.

Dr. Winters notes that Dr. Markowitz, who saw the Decedent in 2015 and was aware of his history of atrial fibrillation, did not find it necessary to prescribe Decedent an anticoagulant. Dr. Winters further opines that the medical evidence shows that Decedent did not have persistent hypertension, since Decedent's blood pressure readings during 2015 were either within normal limits or low while he was not taking blood pressure medication. In his affirmation, Dr. Winters also addresses Plaintiff's remaining claims and opines that the alleged actions or failures by Defendants were not a proximate cause of Decedent's stroke in 2016 or the related injuries. Dr. Winters refutes Plaintiff's claim that the Decedent's stroke increased his risk to develop a pulmonary embolism, COPD exacerbation or respiratory failure and opines that the pulmonary embolism that led to Decedent's death was more likely than not caused by immobility during his long hospitalization at Mount Sinai and a severe prolonged respiratory illness.

In opposition, Plaintiff submits a redacted expert affidavit by a physician licensed to practice medicine in Louisiana who specializes in internal medicine and cardiology. Plaintiff's Expert disagrees with Dr. Winters and opines that the Decedent was a candidate for anticoagulation therapy once he turned 65 years old in January 2014 and that the standard of care required such anticoagulation. Plaintiff's expert further states that Defendants' failure to prescribe anticoagulation medication directly caused Decedent's embolic stroke in 2016. Plaintiff's Expert disputes Dr. Winter's statement that Decedent was not taking hypertension medication after December 2014 and points to September 2015 Lenox Hill Hospital records that

list "bisoprolol" under Decedent's "home medications." According to Plaintiff's Expert, Decedent should have been prescribed an anticoagulant when he turned 65 based on his paroxysmal atrial fibrillation and his CHADs score of 1, which was based upon being actively treated for hypertension. Plaintiff's expert further states that based upon the updated guidelines in 2014, Decedent should have been prescribed anticoagulant based on his $CHA_2DS_2$-VASc score of "2", which was comprised of 1 point for his age and 1 point for being treated for hypertension.

Turning to Dr. Winters' statement regarding Dr. Markowitz's decision to not prescribe an anticoagulant, Plaintiff's expert states that Dr. Markowitz "was likely deferring to the cardiologist she believed had been actively monitoring this patient at ACP." Plaintiff's Expert states that Dr. Hunter deviated from the standard of care by failing to refer Decedent to a cardiologist or consider the patient's stroke risk in view of his history, age and treatment for hypertension. According to Plaintiff's expert, the cumulative effect of not being on an anticoagulant for eight years significantly increased Decedent's chances of developing a cardioembolic stoke, which he suffered in June 2016. Plaintiff's expert opines that the ACP physicians' collective failure to prescribe anticoagulant for the Decedent between 2008 and 2016 was a direct proximate cause of his 2016 stroke and any neurological sequalae he suffered as a result.

**DISCUSSION**

Summary Judgment Standard

Pursuant to CPLR §3212(b), a motion for summary judgment "shall be granted if, upon all the papers and proof submitted, the cause of action or defense shall be established sufficiently to warrant the Court as a matter of law in directing Judgment in favor of any party." CPLR §3212(b). A party seeking summary judgment must show that there are not material issues of

fact that are in dispute and that it is entitled to judgment as a matter of law. *See Dallas-Stephenson v. Waisman,* 39 AD3d 303, 306 [1st Dept., 2007]. Once a movant makes such a showing, "the burden shifts to the party opposing the motion to produce evidentiary proof in admissible form sufficient to establish the existence of a material issue of fact that precludes summary judgment and requires a trial. *Id.*

"A defendant in a medical malpractice action establishes prima facie entitlement to summary judgment by showing that in treating the plaintiff, he or she did not depart from good and accepted medical practice, or that any such departure was not a proximate cause of the plaintiff's alleged injuries." *Anyie B. v. Bronx Lebanon Hosp.*, 128 AD3d 1, 3 [1st Dept 2015]. (*See Costa v. Columbia Presbyt. Med. Ctr.*, 105 AD3d 525, 525 [1st Dept 2013]). "Once a defendant has established prima facie entitlement to summary judgment, the burden shifts to plaintiff to 'rebut the prima facie showing via medical evidence attesting that the defendant departed from accepted medical practice and that such departure was a proximate cause of the injuries alleged.'" *Ducasse v. New York City Health and Hosps. Corp.*, 148 AD3d 434, 435 [1st Dept 2017] (internal citations omitted). "The opinion of a qualified expert that a plaintiff's injuries were caused by a deviation from relevant industry standards would preclude a grant of summary judgment in favor of the defendants." *Diaz v. New York Downtown Hosp.*, 99 N.Y.2d 542, 544 [2002].

"To defeat summary judgment, the expert's opinion "must demonstrate 'the requisite nexus between the malpractice allegedly committed' and the harm suffered." *Anyie B. v. Bronx Lebanon Hosp.*, 128 AD3d 1, 3 [1st Dept 2015] (internal citations omitted). "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

physician's summary judgment motion." *Alvarez v. Prospect Hosp.*, 68 NY2d 320, 325 [1986]. (*See Otero v. Faierman*, 128 AD3d 499, 500 [1st Dept 2015]. *See generally Cruz v. New York City Health and Hosps. Corp.*, 188 AD3d 592, 593 [1st Dept 2020]; *Henry v. Duncan*, 169 AD3d 421 [1st Dept 2019]). "In order not to be considered speculative or conclusory, expert opinions in opposition should address specific assertions made by the movant's experts, setting forth an explanation of the reasoning and relying on 'specifically cited evidence in the record.'" *Lowe v. Japal*, 170 AD3d 701, 703 [2d Dept 2019]. *See Frye v. Montefiore Med. Ctr.*, 70 AD3d 15, 24 [1st Dept 2009].

Here, the Court finds that based upon the affirmation of Dr. Winters, Defendants sufficiently established prima facie entitlement to summary judgment as a matter of law. Dr. Winters gives a detailed opinion about how ACP and Dr. Hunter did not depart from the standard of care. Dr. Winters also sufficiently explains how Dr. Hunter did not depart from the standard of care in failing to prescribe anticoagulants, specifically since Decedent did not show signs of atrial fibrillation and was at low risk of a stroke. Dr. Winters also sufficiently explains that based upon the $CHA_2DS_2$-VASc score and Decedent's symptoms at the time, there was no indication for Dr. Hunter or ACP to prescribe anticoagulant therapy. Furthermore, Dr. Winters provides a detailed analysis regarding proximate cause and sufficiently opines that Decedent's death was not caused by his stroke or atrial fibrillation, but rather his prolonged pulmonary disease and immobility due to a lengthy hospital stay. Based upon this expert affirmation, this Court finds that Defendants have met their prima facie burden by showing they did not depart from the standard of care and that any departures alleged by Plaintiff did not proximately cause Decedent's injuries and death.

The burden now shifts to Plaintiff to rebut Defendants' prima facie showing via medical evidence and demonstrate that Defendants departed from the standard of care and that such departure was a proximate cause of the Decedent's injuries and death. The Court finds that Plaintiff has failed to meet such burden, as the opinion of Plaintiff's Expert is conclusory and speculative. *See Lyakhovich v. Vernov*, 185 AD3d 566, 569 [2d Dept., 2020]; *Rivera v. New York Pain Care Ctr., P.C.*, 154 AD3d 421, 422 [1st Dept 2017]; *Kaplan v. Karpfen*, 57 AD3d 409 [1st Dept, 2008]. Plaintiff's Expert fails to cite any medical evidence, studies or reports to support his or her opinion that Defendant's failure to prescribe anticoagulant therapy directly caused Decedent's embolic stroke in 2016. *See generally G.L. v. Harawitz*, 146 AD3d 476, 476 [1st Dept 2017]; *Gaudio v. Gonzalez*, 117 AD3d 490, 490-91 [1st Dept 2014]; *Callistro ex rel. Rivera v. Bebbington*, 94 AD3d 408, 411 [1st Dept 2012], *affd sub nom. Callistro v. Bebbington*, 20 NY3d 945 [2012]; *Bullard v. St. Barnabas Hosp.*, 27 AD3d 206 [1st Dept, 2006]. While Plaintiff's expert states that Decedent should have been put on anticoagulant therapy based on his $CHADS_2$ and $CHA_2DS_2$-$VAS_C$ score, the expert did not provide any medical evidence demonstrating that anticoagulant therapy is indicated based on Decedent's scores. Furthermore, the Court finds that several specific statements made by Plaintiff's expert, including those about Dr. Markowitz's decision to not recommend an anticoagulant, to be conclusory and speculative.

Plaintiff's Expert also fails to sufficiently respond to relevant issues raised by Dr. Winters. Specifically, Plaintiff's Expert does not dispute Dr. Winters' findings that Decedent had a low risk for stroke and presented to Dr. Hunter and ACP without symptoms of atrial fibrillation during the relevant time period. *See generally Ruiz v. Reiss*, 180 AD3d 623, 623 [1st Dept 2020]; *Choida v. Schirripa*, 188 AD3d 978, 980 [2d Dept 2020]; *Ahmed v. Pannone*, 116 AD3d 802, 806 [1st Dept, 2014]. Perhaps most significantly, Plaintiff's Expert fails to show a

triable issue of fact exists with regard to proximate cause and demonstrate the requisite nexus between the malpractice allegedly committed and Decedent's injuries and death. Without providing any medical evidence or literature in support of such opinion, Plaintiff's Expert states that the "cumulative effect" of not being on an anticoagulant for eight years "significantly increased" Decedent's changes of having a cardioembolic stroke. Plaintiff's Expert further fails to address Dr. Winters' opinion that the pulmonary embolism that led to Decedent's death was not caused by Defendants' alleged departures, but rather by prolonged pulmonary disease (COPD) and immobility due to Decedent's lengthy hospitalization at Mount Sinai.

Based upon the insufficiencies in Plaintiff's Expert's affidavit and Plaintiff's failure to otherwise show a triable issue of fact, the Court finds that Defendants are entitled to summary judgment dismissal of the Complaint.

Accordingly, it is hereby

**ORDERED** that Defendants' Motion to dismiss Plaintiff's Complaint pursuant to CPLR §3212 is hereby granted in its entirety; and it is further

**ORDERED** that Plaintiff's Complaint is hereby dismissed.

This is the decision and order of the Court.

4/15/2021
DATE

JUDITH REEVES MCMAHON, J.S.C.

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| CHECK ONE: | X | CASE DISPOSED | | | NON-FINAL DISPOSITION | | |
| | X | GRANTED | | DENIED | GRANTED IN PART | | OTHER |
| APPLICATION: | | SETTLE ORDER | | | SUBMIT ORDER | | |
| CHECK IF APPROPRIATE: | | INCLUDES TRANSFER/REASSIGN | | | FIDUCIARY APPOINTMENT | | REFERENCE |