

**Weber v Sharma**

2021 NY Slip Op 33220(U)

March 8, 2021

Supreme Court, Orange County

Docket Number: Index No. EF004176-2018

Judge: Sandra B. Sciortino

Cases posted with a "30000" identifier, i.e., 2013 NY Slip Op 30001(U), are republished from various New York State and local government sources, including the New York State Unified Court System's eCourts Service.

This opinion is uncorrected and not selected for official publication.

To commence the statutory time for appeals as of right (CPLR 5513 [a]), you are advised to serve a copy of this order, with notice of entry, upon all parties.

SUPREME COURT OF THE STATE OF NEW YORK  
COUNTY OF ORANGE

-----X  
**BRIAN WEBER, Executor for the Estate of  
AMANDA WEBER, Deceased, and  
BRIAN WEBER, Individually,**

Plaintiffs,

-against-

**PUJA SHARMA, M.D., VIRAL RAS SHETH, M.D.  
and CRYSTAL RUN HEALTHCARE,**

Defendants.

-----X  
**SCIORTINO, J.**

**DECISION AND ORDER**

**Index No.: EF004176-2018**

**Motion Date: 12/28/2020**

**Sequence No. 2**

The following papers numbered 1 to 36 were considered with this motion by defendants for an order granting summary judgment and dismissal of the complaint:

<u>PAPERS</u>	<u>NUMBERED</u>
Notice of Motion/Affirmation (Horner)/ Physician's Affirmation (Sharma)/ Physician's Affirmation (Ras Sheth) Exhibits A-CC	1-33
Affirmation in Opposition (Smith)/ Physician's Affirmation	34-35
Affirmation in Reply (Horner)	36

**BACKGROUND**

This action for medical malpractice and wrongful death arises out of medical treatment rendered to plaintiff's wife, Amber Weber (the decedent) at Crystal Run Healthcare's Urgent Care ("Crystal Run"). On January 18, 2018, The decedent presented to Crystal Run complaining of atypical chest pain. The decedent was initially assessed by defendant Dr. Sharma and then referred

to defendant Dr. Sheth. Plaintiff claims that, as a result of defendants' negligence, the decedent was discharged from their care and died later that night from a myocardial infraction from atherosclerotic cardiovascular disease.

This matter was commenced by filing of a Summons and Verified Complaint on April 16, 2018. (Exhibit A) A Verified Answer was filed on June 18, 2018. (Exhibit B) The Examination before Trial of defendant Puja Sharma, M.D. was taken on December 19, 2019. The Examination before Trial of defendant Viral Ras Sheth, M.D. was taken on December 19, 2019. The Examination before Trial of defendant Crystal Run by Debra Mack, R.N. was taken pursuant to court order on December 19, 2019. Note of Issue was filed on September 9, 2020.

Verified Bills of Particulars were filed for each of the three defendants. Each bill specified the allegations of malpractice asserted.

Defendant Sharma's negligence is alleged to be, *inter alia*:

In failing to act in accordance with generally accepted standards of medical treatment, examination and evaluation, medical examination and evaluation and recognition and the appropriate, adequate and timely diagnosis of the ischemic heart disease and near-occlusive and symptomatic atherosclerosis cardiac and/or coronary vessel disease with angina and cardiac symptoms;

In negligently failing to timely, adequately, correctly and appropriately evaluate, diagnose and treat the plaintiff decedent who was suffering from signs and symptoms of occlusive coronary disease;

In the failure to act and perform in accordance with the generally accepted standards of medical evaluation, assessment, diagnosis, referral and treatment;

In negligently failing to evaluate, assess, diagnose, refer and treating a patient;

In negligently failing to take the necessary care and caution to prevent the subsequent injuries and death to/of the plaintiff-decedent.

(Exhibit H[1])

Defendant Sheth's alleged negligence is the same as allegations against Dr Sharma with the addition of references to cardiology:

In failing to act in accordance with generally accepted standards of medical and **cardiology** treatment, examination and evaluation, cardiology examination and evaluation and recognition and the appropriate, adequate and timely diagnosis of the

ischemic heart disease and near-occlusive and symptomatic atherosclerosis cardiac and/or coronary vessel disease with angina and cardiac symptoms;

In negligently failing to timely, adequately, correctly and appropriately evaluate, diagnose and treat the plaintiff decedent who was suffering from signs and symptoms of occlusive coronary disease;

In the failure to act and perform in accordance with the generally accepted standards of medical and **cardiology** evaluation, assessment, diagnosis, referral and treatment;

In negligently failing to evaluate, assess, diagnose, refer and treating a patient;

In negligently failing to use the proper medical and cardiology practice skills and judgment in treating the plaintiff.

(Exhibit H[2])

Defendant Crystal Run's negligence is alleged to be, *inter alia*:

In negligently failing to supervise, monitor, manage, educate and control those health care providers including physicians, physician's assistants, nurses, nurse practitioners and/or other health care providers and workers under this defendant's employ, control, care and/or supervision.

(Exhibit H[3])

#### Dr. Sharma Deposition

Dr. Sharma testified the decedent presented with heartburn, indigestion, nausea and chest pain. The decedent was concerned she had the flu. The decedent was receptive and responsive to questioning. Upon questioning, the decedent indicated she was experiencing bilateral upper extremity tightness, primarily on her left side. She had experienced jaw tightness, although not at the time of the examination. Dr. Sharma noted these symptoms as atypical chest pain. The decedent reported taking antacids for indigestion with no relief, and reported a family history of cardiac disease. Dr. Sharma ordered a flu test and an EKG. Concerned with the decedent's symptoms and family history, Dr. Sharma referred her to Dr. Sheth, a cardiologist in the same building, to rule out the possibility of a cardiac issue. Dr. Sharma spent approximately one half hour with the decedent.

#### Dr. Sheth Deposition

Dr. Sheth testified he saw the decedent at approximately 5:45 p.m. on January 18, 2018, after referral by Dr. Sharma. The decedent complained of substernal chest discomfort, which had begun suddenly and had lasted for approximately four hours. Dr. Sheth's differential diagnosis was that the chest pain was cardiac-related. Dr. Sheth prescribed Norvasc to address the decedent's hypertension and coronary spasm and ordered aspirin for the possibility of a cardiac occlusive event.

Dr. Sheth was unable to perform an echocardiogram in the Crystal Run office; the echocardiographers leave the office at 4:00 p.m. Troponin testing could not be performed in the office setting; serial testing needs to be done approximately eight hours apart. Dr. Sheth advised the decedent of the circumstances and recommended she be transferred to the emergency room by ambulance or car. An echocardiogram and troponin testing could be done at the hospital to make sure she was not having a heart attack. The decedent refused to go to the emergency room. The decedent was given a dose of nitroglycerine, which provided no relief.

Dr. Sheth asked Debra Mack, head cardiac nurse, to convince the decedent to go to the emergency room. As she was convinced her symptoms were not related to her heart, the decedent again refused to go to the emergency room.

Dr. Sheth told the decedent that she may have severe narrowing of her heart and was at risk of dying if she went home. Although she did not sign an against medical advice ("AMA") discharge form, the decedent was discharged against medical advice. Dr. Sheth testified that he was not aware the Crystal Run office had AMA forms available.

#### Deborah Mack Deposition

Ms. Mack testified that she saw the decedent after her visit with Dr. Sheth. Dr. Sheth directed Ms. Mack to give the decedent nitroglycerine and try to convince her to go to the hospital. Dr. Sheth then signed and locked his electronic notes on the visit.

The decedent described experiencing mid-sternal epigastric, jaw and bilateral arm pain. Ms. Mack administered the nitroglycerine; no relief resulted. Ms. Mack tried to convince the decedent to go to the hospital. She offered to make a phone call to family for transfer to the hospital as the decedent did not want to go by ambulance. The decedent indicated that she had to go home.

Ms. Mack reported to Dr. Sheth that the nitroglycerine did not provide relief. Dr. Sheth, though still wanting the decedent to go to the hospital, ordered an echocardiogram for the next morning. Ms. Mack again told the decedent to go to the emergency room. As the decedent did not want to go, Ms. Mack made an appointment for the next morning for an echocardiogram in the Crystal Run office.

Ms. Mack spent approximately 20 minutes with Ms. Weber. She confirmed that the decedent did not sign an against medical advice form; Ms. Mack did not know the form was available until several days later. Ms. Mack testified that, in the Crystal Run office, she had never had patients sign or initial anything indicating that they were leaving against medical advice.

Ms. Mack testified the Crystal Run notes are generated by the nurse and signed by the doctor. Once the notes are closed by the doctor, changes cannot be made. After Ms. Weber's visit with Dr. Sheth, Dr. Sheth signed his notes, preventing Ms. Weber's access. Dr. Sharma, however, had not yet signed her notes. After Ms. Weber's visit, Ms. Mack left the office to pick up her son. The following morning, Ms. Mack entered her notes into Dr. Sharma's unlocked portion of the chart. She subsequently learned of the Ms. Weber's death.

### **Motion for Summary Judgment**

Based upon the medical records; the deposition testimony; the affidavits of Dr. Sharma and Dr. Sheth, and the pleadings of this matter, defendants assert they have established entitlement to summary judgment.

Defendants submit the affidavit of defendant Dr. Sharma. Dr. Sharma, duly licensed to practice medicine in New York State, is Board certified in Family Medicine. Dr. Sharma avers the patient presented with atypical chest pain. Strongly suspecting a cardiac issue and extremely concerned, the patient was immediately referred to Dr. Sheth, a board-certified cardiologist in the same office. The patient was escorted to Dr. Sheth's office by a staff member. Dr. Sharma opines, to a reasonable degree of medical certainty, that all of the decisions she made in this case were medically appropriate, were made in accordance with good and accepted family medicine practice, and were not the proximate cause of the decedent's later myocardial infarction and death.

Defendants submit the affidavit of defendant Dr. Sheth, a physician duly licensed to practice medicine in the State of New York at the time of this incident, and board certified in cardiology. Dr. Sheth's differential diagnosis was that the decedent's chest pain was cardiac-related. He recommended transfer to the emergency room by ambulance or car and an echocardiogram and troponin testing.

Dr. Sheth had Debra Mack, the head cardiac nurse, give the decedent a dose of nitroglycerin and try to convince her to go to the emergency room. Dr. Sheth warned the decedent that it was possible that she had severe narrowing of an artery; if she did not go to the hospital, she may die. The decedent was discharged against medical advice.

Dr. Sheth opines, to a reasonable degree of medical certainty, that all of the decisions he made in this case were medically appropriate, were made in accordance with good and accepted cardiology practice and were not the proximate cause of the decedent's later myocardial infarction and death. Dr. Sheth opines the proximate cause of death was the refusal to follow his repeated advice to transfer to the emergency room for further treatment.

Based upon the medical records; the deposition testimony; the affidavits of defendants Dr.

Sharma and Dr. Sheth, and the pleadings of this matter, defendants assert they have established entitlement to summary judgment.

### Opposition

Plaintiff first argues that defendants' motion is supported by their own self-serving affirmations based entirely on their own versions of the events and hearsay. There is a complete lack of objective evidence to support the defendants' contentions. No independent expert affirmation is appended.

Plaintiff further argues that the Dead Man's Statute requires defendants' testimony with respect to what the decedent allegedly said during her visit to Crystal Run be disregarded as hearsay. Plaintiff essentially denies the decedent was referred to an emergency room, that defendants offered to call an ambulance, and that the decedent left against medical advice. The decedent was not asked to sign an AMA form or initial any records or documents indicating that she was refusing to follow recommendations or directives from defendants with respect to her healthcare.

With respect to the medical records, plaintiff argues the only entry in the records which support the argument that the decedent refused medical advice is defendant Sheth's note indicating "Pt declines transfer to ER for Trops."

Plaintiff argues that, although Dr. Sheth's notes aspirin was "ordered," there is no indication that aspirin was given. Plaintiff, therefore, concludes defendants did not give the decedent aspirin. The Crystal Run records indicate only that nitroglycerine sublingual was given by Ms. Mack. There is also no reference in Dr. Sheth's notes of the effect of nitroglycerine as Dr. Sheth had logged out of the computer system. Therefore, but for Ms. Mack's note written the following morning, there is no proof that Dr. Sheth was aware of or appreciated the fact that the decedent experienced no relief from the nitroglycerine.

The record is devoid of any indication that “continued refusals” were made by the decedent; only a single note was made indicating “pt declines transfer to ER for Trops.” Defendants’ failure to use the available AMA form suggests that the decedent was not made aware of the serious and life-threatening nature of her condition.

With respect to Ms. Mack’s notes, plaintiff argues that these notes were generated the following morning, after defendants had received notice of Ms. Weber’s death. Furthermore, Ms. Mack waited nearly one month to enter and/or sign the note of the decedent’s encounters with Dr. Sharma, Dr. Sheth, and herself. Plaintiff argues that Ms. Mack, though not a party to the action, is an interested witness.

Plaintiff argues that defendants have failed to meet their burden. As such, plaintiff does not need to put forth an expert affirmation to oppose the motion. Regardless, in opposition to the motion for summary judgment, plaintiff submits an affirmation of a board certified physician (hereinafter “Dr. X”). Dr. X, a physician licensed to practice in the State of Connecticut, is board certified in Internal Medicine, Cardiovascular Disease, and Interventional Cardiology. All opinions were presented within a reasonable degree of medical certainty.

Dr. X opines that the defendants failed to adequately and appropriately evaluate, assess and treat the plaintiff. The defendants failed to appreciate the lack of any decrease in Ms. Weber’s chest pain after being given nitroglycerine and that failure represented a deviation and departure from good and accepted practice of medicine.

Dr. X further asserts that the failure to facilitate the transfer of the decedent to a hospital was the proximate cause of her death. Death would have been prevented had she been treated in the hospital. The note “pt declines transfer to ER for Trops” indicates that the decedent was purportedly refusing transfer to the ER for blood tests and does not indicate she was advised she faced a risk of

death if she went home or that she was experiencing a life-threatening cardiac event.

Dr. Sheth testified that he did not discuss the issue of cardiac catheterization or angioplasty to address a possible life-threatening coronary occlusion with the decedent. Dr. X opines that the decedent was required to be provided with this information so that she could make the appropriate informed decision about a transfer to the hospital as she required urgent and immediate transfer. The failure to advise her that she faced a risk of death if she went home or that she was experiencing a life-threatening cardiac event was a deviation and departure from good and accepted practice of medicine and was the proximate cause of death.

### Reply

Defendants argue the Dead Man's Statute is inapplicable here. When a summary judgment motion is supported by certified medical records, it is proper to consider the movants' testimony about conversations with the decedent or mentally ill person. (*Butler v. Cayuga Med. Ctr.*, 158 AD3d 868 [3d Dept 2018]) Defendants argue Dr. Sharma's, Dr. Sheth's, and Debra Mack's deposition testimony is consistent with the Crystal Run records which document both the ER referral and Weber's refusal to transfer to the ER by any means. Therefore, the Court may consider their testimony and opinions in support of the motion. Despite plaintiff's contention, a medical provider may make out a *prima facie* case on summary judgment through the defendants' own opinions.

With respect to plaintiff's assertion that there is no evidence in the "Procedure & Counseling" section of the medical records that the decedent was counseled, defendants argue plaintiff ignores Dr. Sheth's affidavit and Ms. Mack's testimony that considerable time was spent counseling the decedent about her condition and the need to address it. Defendants argue the absence of a particular notation in a hospital record, if explained, does not mean the information was not elicited or an action not taken. (*citing Topel v. Long Island Jewish Med. Cent.*, 55 NY2d 682

[1981]) Defendants further argue that the decedent's refusal was noted in Ms. Mack's note: "MD advised again to go to ER, pt refusing." Though not generated immediately after her meeting with the decedent, the note could not be immediately signed because Dr. Sheth had already electronically signed his note. Finally, there was no testimony that any chart entry was colored by Ms. Mack's knowledge of the decedent's death.

With respect to plaintiff's expert affirmation, defendants argue the affidavit should not be considered as it is in inadmissible form. No proof has been provided that an unredacted affirmation was submitted to the Court, and the notarial venue, "State of New York, County of Woodmere," does not exist. If the affidavit was executed in New York, the notarization is defective. If the affidavit was executed in Connecticut, it is inadmissible as the stated venue is "State of New York" and the affidavit lacks the certificate of conformity required by CPLR 2309(c).

Dr. X's affirmation also does not state whether the cardiology practice has been in a hospital or office setting or whether he is still practicing or is retired. Defendants argue the practice setting distinction is significant as Dr. Sheth has demonstrated that protocols differ depending on the setting. Therefore, plaintiff has failed to sufficiently set forth the expert's qualifications. Even if the court does not reject Dr. X's affidavit, defendants argue plaintiff's expert affirmation is contradicted by the record and, therefore, is insufficient to defeat summary judgment.

Dr. X does not differentiate a single specific departure from the standard of care made by Dr. Sharma. His failure to identify specific departures by Dr. Sharma constitutes a partial default in opposing summary judgment. Similarly, no specific acts of negligence are asserted against Crystal Run.

Defendants argue Dr. X also claims multiple unpleaded departures: failure to take steps to facilitate Ms. Weber's transfer; failure to give her aspirin though prescribed; failing to advise the

decedent that she faced a risk of death if she went home; failing to notify her husband and her family of her refusal to agree to transfer to the emergency room; and failing to call 911 or an ambulance to transfer her. These unpleaded claims are based on the speculation that the decedent would have changed her mind if defendants would have continued to persuade her. Defendants argue the decedent's express refusal to accept the treatment plan was her right.

### Discussion

Summary judgment is a drastic remedy, appropriate only when there is a clear demonstration of the absence of any triable issue of fact. (*Piccirillo v. Piccirillo*, 156 AD2d 748 [2d Dept. 1989], citing *Andre v. Pomeroy*, 35 NY2d 361 [1974]). The function of the Court on such a motion is issue finding, and not issue determination. (*Sillman v. Twentieth Century-Fox Film Corp.*, 3 NY2d 395 [1957]) The function of the Court is not to resolve issues of fact or to determine credibility, but merely to determine whether such issues exist. (*Kolivas v. Kirchoff*, 14 AD3d 493 [2d Dept. 2005]) In doing so, the Court is obliged to draw all reasonable inferences in favor of the non-moving party. (*Rizzo v. Lincoln Diner Corp.*, 215 AD2d 546 [2d Dept. 1995]) Where there is any doubt about the existence of a material and triable issue of fact, summary judgment must not be granted. (*Anyanwu v. Johnson*, 276 AD2d 572 [2d Dept. 2000]) However, summary judgment shall be granted where, upon all the papers and proofs submitted, the cause of action or defense is sufficiently established to warrant the court as a matter of law, in directing judgment in favor of any party. (*Zuckerman v. City of New York*, 49 NY 2d 557, 52 [1980]) "Evidentiary proof must be in admissible form, and cannot be 'mere conclusions, expressions of hope or unsubstantiated allegations or assertions.'" (*Javaherei v. Old Cedar Development Corp.*, 84 AD3d 881, 887 [2d Dept. 2011]).

In a medical malpractice action, plaintiff must prove that the physician deviated or departed from accepted community standards of practice, and that this departure was the proximate cause of plaintiff's injuries. (*Stukas v. Streiter*, 83 AD3d 18 [2d Dept. 2011]) A defendant physician seeking

summary judgment bears the burden of making a *prima facie* showing that there was no departure from good and accepted medical practice, or any departure was not a proximate cause of the patient's injuries (*Id.* at 24). A defendant medical provider may establish *prima facie* entitlement to summary judgment by submitting his or her own affidavit, or the affirmation of an expert, the deposition of the parties, and medical records. (*Makin v. Torelli*, 106 AD3d 782, 784 [2d Dept. 2013])

Pursuant to CPLR 4519, “[u]pon the trial of an action ... a party or a person interested in the event... shall not be examined as a witness in his own behalf or interest... against the executor, administrator or survivor of a deceased person or the committee of a mentally ill person... concerning a personal transaction or communication between the witness and the deceased person or mentally ill person, except where the executor, administrator, survivor, committee or person so deriving title or interest is examined in his own behalf, of the testimony of the mentally ill person or deceased person is given in evidence, concerning the same transaction or communication.” Here, Dr. Sharma and Dr. Sheth were defendants at the time they gave deposition testimony, making them interested parties under the statute. (*Grechko v. Maimonides Medical Center*, 188 AD3d 832 [2d Dept 2020]) However, with respect to Ms. Mack, “the mere employer-employee relationship existing between a party and witness, either at the time of the incident in suit or at the time of trial, does not make the employee an interested witness...” (*Coleman v. New York City Tr. Auth.*, 37 NY2d 137, 142 [1975]) And, it need not be ignored that the details set forth in the defendant doctors' affidavits correspond to their deposition testimony, Ms. Mack's testimony, and the office records.

Defendants have made a *prima facie* showing of entitlement to summary judgment. Dr. Sharma and Dr. Sheth opine, to a reasonable degree of medical certainty, that defendants did not depart from good and accepted standards of medical practice in evaluating and treating Ms. Weber.

Dr. Sharma avers that the decedent presented with atypical chest pain. Suspecting a cardiac issue, an immediate referral to a cardiologist was made. Dr. Sheth was unable to perform an

echocardiogram or troponin testing in the Crystal Run office because of the time of day. He advised the decedent of this and recommended immediate transfer to the emergency room by ambulance or car. The decedent refused. The decedent was given a dose of nitroglycerine which provided no relief. Dr. Sheth asked Debra Mack, head cardiac nurse, to convince the decedent to go to the emergency room. The decedent was discharged against medical advice; she did not sign an AMA. Dr. Sheth's note indicated, "Pt declines transfer to ER for Trops." Ms. Mack's notes indicates "Pt was advised by Dr. Sheth to go to ER for CP SX... Md. advised again to go to ER, pt refusing."

The defendants having met their initial burden, the burden shifts to plaintiff to demonstrate the existence of a triable issue of fact as to those issues on which defendants have met their *prima facie* showing. (*Garrett v. University Assocs. in Obstetrics & Gynecology, PC*, 95 AD3d 823 [2d Dept. 2012])

In opposition, plaintiff's expert offers a general opinion that the defendants failed to adequately and appropriately evaluate, assess and treat the plaintiff, and that failure represented a deviation and departure from good and accepted practice of medicine. Dr. X essentially concludes that defendants' failure to transfer the decedent to a hospital was the proximate cause of her death. The expert concludes, as did the defendants, that the decedent's symptoms were "consistent with coronary artery disease." He concludes, as did the defendants, that immediate transfer to a hospital was necessary.

Dr. X offers no specific opinions as to how Dr. Sharma's actions or omissions represented a departure. Similarly, no specific opinions as to Crystal Run's negligence is proffered. Most of the expert's opinions are directed at Dr. Sheth.

"Dr. Sheth failed to adequately and appropriately evaluate and assess the Plaintiff on 1/18/18, failed to administer nitroglycerin, failed to facilitate Ms. Weber's transfer to the hospital." No

evidence is proffered to support the conclusion. “ Dr. Sheth did not give Ms. Weber an Aspirin, ...” Medical records indicate aspirin was “started” the date of the treatment. “There is absolutely no mention of any counseling done to Ms. Weber by Dr. Sheth regarding the probable life-threatening condition in which she found herself, and that she risked death if she went home.” The expert draws an unclaimed conclusion.

“A physician’s affidavit in opposition to a summary judgment motion must attest to the departure from accepted practice and must contain an opinion that the challenged acts or omissions were a competent producing cause of the injury.” (*Swezey v. Montague Rehab & Pain Management, P.C.*, 59 Ad3d 431 [2d Dept. 2009]). The expert must differentiate between the acts and omissions of the various defendants. (*Ahmed v. Pannone*, 116 AD3d 802, 806 [2d Dept 2014])

Plaintiff’s expert fails to sufficiently differentiate between the acts and omissions of the various defendants. Many of the opinions are conclusory, speculative, based on hindsight reasoning, and in contradiction to the medical records. (*Ortiz v. Wyckoff Hgts. Med. Ctr.*, 149 AD3d 1093 [2d Dept. 2017]) Many of the opinions are based on claims not previously made.

On the basis of the foregoing, it is

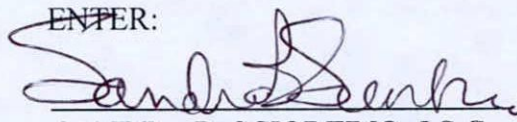
ORDERED that the application for summary judgment against defendants Sharma, Sheth, and Crystal Run is granted and the complaint is dismissed.

All matters not decided herein are denied.

This decision shall constitute the order of the Court.

Dated: March 8, 2021  
Goshen, New York

ENTER:

  
SANDRA B. SCIORTINO, J.S.C.

To: *Counsel of Record via NYSCEF*