

Gefter v Miller

2022 NY Slip Op 31153(U)

March 31, 2022

Supreme Court, Kings County

Docket Number: Index No. 513913/2016

Judge: Bernard J. Graham

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SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF KINGS

VALERIY GEFTER, as the Administrator of the Estate of
VERA GEFTER, Deceased,

Index No.: 513913/2016

Plaintiff(s),

DECISION/ORDER

-against-

HANAN MILLER, M.D. and SEPHARDIC NURSING
HOME,

Hon. Bernard J. Graham
Supreme Court Justice

Defendants.

**Recitation, as required by CPLR 2219(a), of the papers considered on the review of
this motion and cross-motion to: award summary judgment to the defendant Hanan
Miller, M.D., as well as a dismissal of all claims, pursuant to CPLR § 3212.**

Papers	Numbered
Notice of Motion and Affidavits Annexed.....	1-2
Order to Show cause and Affidavits Annexed.....	
Answering Affidavits & Cross-motion.....	3
Replying Affidavits.....	4
Exhibits.....	
Other: (memo).....	

Upon the foregoing cited papers, the Decision/Order on this motion is as follows:

Defendant, Hanan Miller, M.D. (“Dr. Miller”), has moved (seq. 2), pursuant to CPLR § 3212, for an Order awarding summary judgment and a dismissal of all causes of action as against said defendant upon the grounds that there was no negligence nor a departure from the standards of care on behalf of the defendant, and the plaintiff will be unable to establish a prima facie case against said defendant at trial.

Counsel for the plaintiff Valeriy Gefter, as the Administrator of the Estate of Vera Gefter, deceased (“plaintiff”), has opposed the relief sought by the defendant, Dr. Miller, asserting that there are triable issues of fact with respect to whether the defendant was negligent in the care and treatment that was rendered to Vera Gefter (“decedent”) while she was a patient at Sephardic Nursing Home (“King David”).

Background:

On or about August 8, 2016, an action was commenced on behalf of the plaintiff, by the filing of a summons and verified complaint with the Clerk's office of Kings County. In said complaint, the plaintiff seeks to recover damages based upon alleged medical malpractice and common law negligence.

Issue was joined as to the defendant Dr. Miller, by the service of a verified answer, dated September 26, 2016.

The plaintiff alleges that Dr. Miller was negligent in his care and treatment of the decedent while she was a patient at King David from February 20 until her death on March 1, 2015. The alleged departure was the failure to: take into account the decedent's medical history of leukemia, provide proper care; appreciate her vital signs, as well as a hematologic emergency, as there was a delay in transferring the decedent to a hospital where she could have undergone immediate and necessary treatment.

The plaintiff was deposed on August 29, 2019, and Dr. Miller submitted to an EBT on March 12, 2020. Donna Peragine, a nurse practitioner, who appeared on behalf of King David, was deposed on October 20, 2020.

A third-party party action was instituted by the co-defendant, King David against Park Avenue Health Care Management and Donna Peragine, N.P., which resulted in the caption of this matter being amended in accordance therewith. Thereafter, that action was alleged to have been settled and the third-party action discontinued.

A Note of Issue and Certificate of Readiness was filed on behalf of the plaintiff on or about August 16, 2021.

Facts:

The decedent, who was 78 years old, was admitted to King David from N.Y. Presbyterian Hospital on February 20, 2015, for short term rehabilitation. The decedent had a history of myeloproliferative neoplasm ("MPN") (a blood cancer). At N.Y. Presbyterian, the decedent was diagnosed with acute leukemia, as well as influenza. The decedent did undergo one round of chemotherapy and two additional rounds were

recommended, but the patient was too weak to proceed (see Dr. Miller EBT p. 24). Decedent's other significant medical history included hypertension, diabetes, and hypothyroidism.

Dr. Miller has been a physician at King David since 2003 and was assigned to the floor that the decedent was placed upon her admission (see Dr. Miller EBT p. 10, 16). The facility had nurse practitioners and registered nurses but there was no physician on duty at King David at night (see Dr. Miller EBT p. 35).

The first evaluation of the decedent by Dr. Miller took place on February 20, 2015. The notes of Dr. Miller indicate that the influenza had resolved and the decedent was scheduled to meet with an oncologist on February 25. Dr. Miller ordered the decedent to remain on nasal cannula due to her low oxygen-saturation level of 88%. Dr. Miller determined that while the oxygen saturation level was low, it did not require a more aggressive course of treatment. The decedent was further directed to remain on the medication that was prescribed by N.Y. Presbyterian, but that the prescribed amount of prednisone was to be reduced. Dr. Miller also prescribed Tramadol and oxycodone in an attempt to limit the patient's pain.

Dr. Miller ordered a CBC (to monitor decedent's lab values and her malignancy), as well as a physical therapy consultation and physical rehabilitation sessions. The decedent exhibited the signs and symptoms (weakness, lethargy, malaise) associated with myeloproliferative disorder. Due to the fact that the decedent's white blood cell count was elevated, it was the doctor's impression that the decedent was at a high risk for death from cancer (see Dr. Miller EBT p. 28-29)

Dr. Miller's next examination of the decedent was on February 22nd, at which time he found her lungs to be clear and her level of pain had improved. The CBC results indicated that the white blood cell count had been reduced from 32,000 to 29,800, but that the potassium level had been elevated to which a potassium supplement was prescribed. The following day at the request of decedent's son, Dr. Miller examined the decedent after she had vomited and was constipated (see Dr. Miller EBT p. 62), and

found her to be alert and her lungs were clear. Dr. Miller ordered another potassium supplement (Senna), and an enema, as well as a steroid inhaler for the decedent.

On February 25, the decedent was transported to her oncology appointment that was held outside of the nursing home, and she returned later that day to King David.

On February 26, Dr. Miller in addressing decedent's nausea, directed the patient to stop drinking juices which were allegedly brought to the facility by family members and prescribed Pepto Bismol, as well as a repeat CBC (see Dr. Miller EBT p. 65). Those CBC results were received at King David on February 27th at 3:42 P.M., after Dr. Miller, who was a Sabbath observer, had left the facility in mid-day that Friday. (Dr. Miller was not on-call again until Sunday March 1st).

On February 27th, the decedent appeared to be weak and pale, and the staff nurses noted that she had slept most of the day.

When Dr. Miller observed the decedent on March 1st, she had become diaphoretic, hypotensive, and experienced shortness of breath. Since the patient's oxygen level had decreased and she would not keep the nasal cannula in her nose, Dr. Miller ordered the decedent to be transferred to the emergency department. An ambulance was summoned, but prior to its arrival, the decedent became unresponsive, she vomited, and her pulse was lost. The decedent was suctioned, IV fluids as well as CPR were administered, but after twenty-five (25) minutes, the decedent passed away.

Parties' contentions:

Here, the Court is presented with the issue as to whether Dr. Miller departed from accepted medical practice in the care and treatment rendered to the plaintiff while she was patient at King David, and if so, whether that departure from accepted medical practice was the proximate cause of the injuries that allegedly occurred as well as her death.

In support of defendant Dr. Miller's Motion to Dismiss, counsel offers the affirmation of Dr. Martin Bolic ("Dr. Bolic"), Board certified in Internal Medicine, who

opined that the medical treatment rendered by Dr. Miller to the decedent was within the standard of good and accepted medical care.

Plaintiff, by her attorneys, opposes the relief sought in defendant's motion by offering the affirmation of a physician board-certified in internal medicine, who opines that Dr. Miller departed from the standard of care by failing to: follow up on results of a CBC he ordered; appreciate the substantial rise in the decedent's white blood cell count and timely transfer the decedent to the hospital for immediate treatment.

Discussion:

A defendant moving for summary judgment in a case sounding in medical malpractice "must make a prima facie showing either that there was no departure from accepted medical practice, or that any departure was not a proximate cause of the plaintiff's injuries." Guctas v Pessolano, 132 AD3d 632, 633 [2d Dept 2015], quoting Matos v Khan, 119 AD3d 909, 910 [2d Dept 2014]. This Court finds that the defendant Dr. Valsamis has presented evidence sufficient to meet this burden.

Once the movant has made a prima facie showing, the plaintiff must submit evidence in opposition to rebut the movant's prima facie showing. Alvarez v Prospect Hosp., 68 NY2d 320 [1986]; Poter v Adams, 104 AD3d 925 [2d Dept 2013]; Stukas v Streiter, 83 AD3d 18 [2d Dept 2011]. The plaintiff must "lay bare her proof and produce evidence, in admissible form, sufficient to raise a triable issue of fact as to the essential elements of a medical malpractice claim, to wit, (1) a deviation or departure from accepted medical practice, [and/or] (2) evidence that such a departure was a proximate cause of injury." Sheridan v Bieniewicz, 7 AD3d 508, 509 [2d Dept 2004]; Gargiulo v Geiss, 40 AD3d 811-812 [2d Dept 2007]. In order to prevail on a claim for medical malpractice, "expert testimony is necessary to prove a deviation from accepted standards of medical care and to establish proximate cause." Nicholas v Stammer, 49 AD3d 832-833 [2008]. In addressing the issue of proximate cause, the Court notes that "[i]n a medical malpractice action, where causation is often a difficult issue, a plaintiff need do no more than offer sufficient evidence from which a reasonable person might conclude

that it was more probable than not that the injury was caused by the defendant.” Johnson v Jamaica Hosp. Med. Ctr., 21 AD3d 881, 883 [2d Dept 2005]. “A plaintiff’s evidence of proximate cause may be found legally sufficient even if his or her expert is unable to quantify the extent to which the defendant’s act or omission decreased the plaintiff’s chance of a better outcome or increased the injury, as long as evidence is presented from which the jury may infer that the defendant’s conduct diminished the plaintiffs chance of a better outcome or increased [the] injury.” Semel v Guzman, 84 AD3d 1054, 1055-1056 [2d Dept 2011]. “The issue is whether a doctor’s negligence is more likely than not a proximate cause of [a plaintiff’s] injury is usually for the jury to decide.” Polanco v Reed, 105 AD3d 438, 439 [1st Dept 2013]. It has also been held that where “a failure to treat is alleged, the plaintiff simply must show that it was probable that some diminution in the chance of survival had occurred.” Borawski v Huang, 34 AD3d 409, 410 [2d Dept 2006]. “[T]he evidence presented by the plaintiff need not eliminate every other possible cause of the resulting injury.” Clarke v Limone, 40 AD3d 571, 571-572 [2d Dept 2007], *lv denied* 9 NY3d 809 [2017].

This Court finds that the defendant has established prima facie entitlement to summary judgment by the submission of the affirmation of Dr. Bolic, who opines that the treatment rendered by Dr. Miller to the decedent did not depart from the standard of care. Dr. Bolic opined that when Dr. Miller evaluated the decedent for the first time on February 20, 2015, he took proper note of her cancer diagnosis and that the patient was scheduled to meet with her oncologist, and appropriately addressed the situation by deferring to the oncologist and ordering a CBC to monitor her lab values. It was Dr. Miller’s impression that based upon the decedent’s medical records and high white blood cell count that she was at a high risk for death from cancer.

Dr. Miller addressed the decedent’s influenza by acknowledging that it had cleared and appropriately determined that no further treatment was required. Due to the patient’s low saturation level, Dr. Bolic opined that Dr. Miller correctly determined that administering oxygen to the patient should continue, as well as ordering the medications that the decedent was receiving at the hospital and prescribing additional medications to

address her pain. Dr. Miller appropriately requested that the decedent have a consult with a physical therapist so that rehabilitation could begin. On February 22, 2015, when the results of the CBC that Dr. Miller had ordered revealed a low potassium level, a potassium supplement was appropriately ordered. On February 23, when Dr. Miller addressed the decedent's condition after she had allegedly vomited and was constipated, the expert opined that prescribing both a laxative and an enema was appropriate. Additionally, the expert agreed with the approach of Dr. Miller, that despite the fact that the decedent's oxygen-saturation level was slightly low, implementing a more aggressive approach was not required. The expert maintains that the doctor properly addressed non-threatening gastrointestinal issues, including ordering Pepto Bismol, to address decedent's nausea, and appropriately directed patient to refrain from drinking juices that were brought into the facility by her family from the outside.

Dr. Bolic opined that at no point from February 20-February 27, was the decedent in acute distress which would have warranted a transfer to a hospital. During that period, the patient did not have a significant drop in her oxygen saturation level, experience shortness of breath or have an acute respirator incident. Dr. Bolic asserted that once Dr. Miller was informed of decedents status on March 1st, it was appropriate to order the decedent's immediate transfer to a hospital for emergent care. Dr. Bolic maintained there was nothing further that Dr. Miller should have done at the time and nothing he did or failed to do that resulted in decedent's death. It is further contended that during the time that the decedent was a patient at King David, when Dr. Miller was not present or on-call, there were other physicians who were either present or on-call to address medical issues.

In opposition, plaintiff has pointed to several possible deviations from the standard of care by Dr. Miller. Plaintiff argued that Dr. Miller, as the attending physician, became and remained responsible for the overall care of the decedent while she was a patient at King David and had a responsibility and obligation to continuously monitor the decedent's white blood cell count in light of her hematologic history. When the lab results were faxed to King David on February 27th at 2:19 P.M., and revealed a white blood cell count of 72,800, plaintiffs expert claimed such a result demonstrated a

significant increase and signaled a hematologic emergency that warranted an immediate transfer to the hospital, where she could receive cytoreduction treatment in the form of hydroxyurea and chemotherapy. Plaintiff's expert opined that the decedent's clinical deterioration due to leukostasis was evidenced by her appearing to be weak and sleepy on February 27-28.

Plaintiff's expert further opined that while Dr. Miller had left the facility on February 27th to observe the Sabbath, it was a departure from accepted standard of care to not follow up on the blood laboratory results he had ordered and instead had relied upon the nursing staff to understand the significance of these results. The doctor's reliance on nurses to know what leukostasis is and what WBC level warrants transfer to the hospital, was ill advised. The expert opined that the nursing chart is devoid of any orders in which Dr. Miller requested that lab results be reported to him, and he was duty bound to contact the facility to obtain the CBC results as part of his continuous monitoring.

It is well settled that where parties to a medical malpractice action offer conflicting expert opinions on the issue of malpractice and causation, issues of credibility require resolution by the factfinder (see Loaiza v Lam, 107 AD3d 951, 953 [2013]; Omane v Sambaziotis, 150 AD3d 1126, 1129 [2d Dept. 2017]; Dandrea v Hertz, 23 AD3d 332, 333 [2005]). Summary judgment is not appropriate in a medical malpractice action where the parties adduce conflicting medical opinions (see Elmes v Yelon, 140 AD3d 1009, 1011 [2d Dept. 2016], Feinberg v Feit, 23 AD3d 517, 519 [2d Dept. 2005]; Shields v Baktidy, 11 AD3d 671, 672 [2d Dept. 2014]).

This Court finds that there are issues of fact with respect to the care and treatment provided by Dr. Miller to the decedent. In reaching this determination, this Court considered that the experts offered differing opinions as to whether Dr. Miller had a duty to follow up on the blood test results and instruct the nursing staff regarding when to transfer the decedent to the hospital. The Court was also not provided with sufficient evidence to determine whether there was a protocol in place to address medical issues when Dr. Miller was unavailable and not on-call.

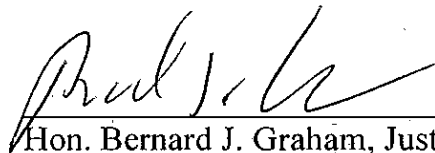
Conclusion:

While the defendant Dr. Miller has met his burden for establishing a prima facie case for summary judgment, the plaintiff, in opposition, has met her burden to offer admissible evidence raising a question of fact as to whether Dr. Miller departed from good and accepted medical practice in the treatment rendered to the decedent. The issue of credibility regarding conflicting expert testimony must be submitted to the trier of fact. Accordingly, the motion by Dr. Miller for summary judgment and a dismissal of plaintiff's complaint, pursuant to CPLR §3212, is denied.

This shall constitute the decision and order of this Court.

Dated: March 31, 2022
Brooklyn, NY

ENTER



Hon. Bernard J. Graham, Justice
Supreme Court, Kings County

HON. BERNARD J. GRAHAM