

<b>Brenner v Blackstock</b>
2022 NY Slip Op 31291(U)
April 12, 2022
Supreme Court, Kings County
Docket Number: Index No. 518666/2016
Judge: Bernard J. Graham
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SUPREME COURT OF THE STATE OF NEW YORK  
COUNTY OF KINGS

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ROBIN BRENNER,

Index No.: 518666/2016

Plaintiff(s),

**DECISION/ORDER**

-against-

UCHE BLACKSTOCK, M.D. JOSEPH RAHIMIAN, M.D.,  
NYU LANGONE MEDICAL CENTER, NYU HOSPITAL  
CENTER and VILLAGE PARK MEDICAL CENTER, P.C.,

Hon. Bernard J. Graham  
Supreme Court Justice

Defendants.  
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**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 defendants Uche Blackstock, M.D., NYU Langone Medical Center and NYU Hospital Center as well as a dismissal of the causes of action as against said defendants, pursuant to CPLR § 3212.**

<b>Papers</b>	<b>Numbered</b>
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:**

Defendants, Uche Blackstock, M.D. (“Dr. Blackstock”) and NYU Hospitals Center s/h/a NYU Langone Medical Center and NYU Hospital Center (“NYU”), have moved (seq. 1), pursuant to CPLR § 3212, for an Order awarding summary judgment to said defendants and a dismissal of all causes of action as against said parties upon the grounds that there was no negligence on behalf of the defendants and plaintiff will be unable to establish a prima facie case against the defendants at trial.

Counsel for the plaintiff Robin Brenner (“plaintiff”), has opposed the relief sought by the defendants, asserting that there are triable issues of fact with respect to whether the defendants were negligent in their failure to recognize the signs and symptoms of arterial

insufficiency and occlusion and providing adequate care and treatment to the plaintiff from February 15, through March 9, 2016.

Background:

On or about October 21, 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 defendants NYU and Dr. Blackstock by the service of their verified answers, dated November 16, 2016.

In plaintiff's response to defendants' Demand for a Bill of Particulars, it is alleged that the defendants were negligent between February 15-March 9, 2016 in misdiagnosing the plaintiff with dehydration; failing to take and appreciate a full medical history and order diagnostic testing, perform Doppler's, aortogram, CT, MRA, and other vascular testing as well as a differential diagnosis; heed to the plaintiff's signs and symptoms which included significant pain in her legs, numbness and inability to walk; understand that the etiology of plaintiff's symptoms were vascular related; recognize the significance of difficulty in detecting pulses in the lower extremities; appreciate that plaintiff was pro-thrombotic based on her medical history; consult and/or refer plaintiff to other health professionals, etc. As a result of the alleged malpractice, the plaintiff claimed to have: a total arterial occlusion and the loss of a chance of a better medical outcome; a blood clot; the need for further surgery which included an aortic bifemoral bypass on March 1, 2016; aortoiliac endarterectomy; significant pain in her lower extremities; numbness, tingling and weakness in her left lower leg and feet which resulted in difficulty walking/ambulating and affecting her ability to perform daily tasks.

The plaintiff was deposed on April 1, 2019, Dr. Blackstock submitted to an EBT on June 3, 2019, and Dr. Joseph Rahimian's deposition was held on October 18, 2019.

On March 10, 2020, all parties agreed to the discontinuance of the action as against defendants Dr. Joseph Rahimian and Village Park Medical P.C.

A Note of Issue and Certificate of Readiness was filed on behalf of the plaintiff on or about April 2, 2021.

Facts:

The plaintiff, who was 56 years old, presented to the Emergency Department at NYU on February 15, 2016 due to complaints of shortness of breath and a cough for a week.<sup>1</sup> The plaintiff, who was a smoker, had allegedly stopped one week prior when her symptoms began. Before presenting to the hospital, the plaintiff was evaluated at CityMD, where a chest x-ray revealed pneumonia and a recommendation was made to be evaluated at the emergency room.

At the hospital, the plaintiff was noted to have nephrotic syndrome with amyloidosis of the kidney, hypertension, hyperlipidemia and non-Hodgkin's lymphoma for which she just completed six months of chemotherapy. The plaintiff was evaluated by Latrice Triplett, M.D., a resident, who noted that the patient had bilateral pedal edema. A chest x-ray revealed pneumonia and coronavirus. The plaintiff was administered antibiotics and placed on Lovenox. The oncology department recommended that plaintiff be admitted to the hospital due to her immunocompromised state. Upon admission, the plaintiff was evaluated between February 16-18, 2016 by Dr. Goldenberg, her oncologist, as well Dr. Rahimian, an infectious disease physician. Dr. Rahimian recommended the continued use of vancomycin and cefepime which were then discontinued when the plaintiff was reevaluated and resulted in a change in the antibiotic that was being administered. Dr. Rahimian's notes indicated that the plaintiff had a history of a weak

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<sup>1</sup> The plaintiff had prior treatment at NYU. In July 2014, the plaintiff underwent a hysterectomy. In August 2014, the plaintiff presented to NYU with complaints of shortness of breath and rib pain. A chest CT disclosed a ground glass nodule at the base of the right upper lobe and lab work revealed a low PT and INR. The plaintiff was released and advised to follow-up with her primary care physician. In July 2015, the plaintiff was seen as an outpatient for a renal biopsy due to nephrotic syndrome.

history of a weak pulse and it was recommended that there be further monitoring of her respiratory status, shortness of breath and white blood cell count. On February 18, 2016, when the plaintiff was determined to be in stable condition, she was discharged with instructions to continue with the prescribed medications.

The plaintiff then presented to the Emergency Department of NYU on February 20, 2016, with complaints of a pins and needles sensation in her bilateral lower extremities, left leg numbness and cramping of her left foot. She was evaluated by Peter Ma, P.A. who ordered labs and a duplex study. Dr. Blackstock also examined the plaintiff and recommended lab work to evaluate her electrolytes and a lower extremity Doppler to rule out DVT. A Venous Duplex Doppler performed of the lower extremities was negative for Deep Vein Thrombosis (DVT). Lab results revealed an elevated glucose level and red blood cell count, as well as hemoglobin and hematocrit. The plaintiff, who was also evaluated by Dr. Blumberg, a vascular surgery fellow, as well as Dr. Lugo, an attending physician, was diagnosed with dehydration and IV electrolytes. The plaintiff was discharged from the hospital on February 21, 2016.

The following day, the plaintiff presented to Dr. Rahimian, as an outpatient, to address the pneumonia, in which a physical exam revealed normal results (normal ambulation and no edema).

On March 1, 2016, the plaintiff had an office visit with Dr. Rabbin, a dermatologist, to address the presence of a rash on her feet, an area in which she experienced both burning and tingling. Later that day, the plaintiff after getting up from a lying position, noticed whitening of the skin on her right heel and toes, as well as numbness in her feet. That afternoon, the plaintiff returned to the Emergency Department of NYU with complaints of a cold left foot and was evaluated by Dr. Cohen, a vascular surgery resident. The plaintiff underwent a CT angiogram of the abdomen and pelvis, the results of which showed a "thrombus in the infrarenal abdominal aorta extending distally to the iliac bifurcation and minimally into the bilateral common iliac arteries" with a 70-80% stenosis of these vessels. The plaintiff was placed on Heparin and evaluated by vascular surgeon Dr. Rockman after which treatment options were allegedly discussed

and considered. On March 3, 2016, Dr. Rockman performed an aortic thromboendarterectomy and aorto-iliac bypass. The plaintiff allegedly recovered well from the procedure without complications and remained at the hospital for several days for surgical recovery and monitoring. On March 9, 2016, the plaintiff was discharged with instructions to take Bumex and potassium chloride and to follow-up with her primary care physician, as well as her specialists (nephrologists, oncologist, cardiologist and surgeon).

Following her discharge, the plaintiff presented to Dr. Rockman in March, April, May, July and October, 2016. During that period of time, Dr. Rockman considered treatment options as the plaintiff allegedly experienced her left foot being cooler and the right foot appearing pink. The calcification that was present was characterized as being consistent with chronic atherosclerotic disease. The pain and weakness that the plaintiff was experiencing, as well as her difficulties in standing and walking, allegedly continued thereafter.

Parties' Contentions:

Here, the Court is presented with the issue as to whether defendant Dr. Blackstock departed from accepted medical practice in the care and treatment rendered to the plaintiff, and if so, whether that departure from accepted medical practice was the proximate cause of the injuries that allegedly occurred.

In support of defendant Dr. Blackstock's motion to dismiss, counsel offers the affirmations of Thomas Kwiatkowski, M.D. ("Dr. Kwiatkowski") and William Suggs, M.D. ("Dr. Suggs"), who opine that the plaintiff's arterial occlusion in the aorta was timely diagnosed on March 1, 2016, when signs of arterial occlusion first presented. Dr. Kwiatkowski and Dr. Suggs assert that the medical treatment rendered during plaintiff's admission to NYU from February 15 to February 18, 2016 was in accordance with the standard of care, and there was no evidence to suggest an arterial occlusion during said admission. Dr. Kwiatkowski and Dr. Suggs further assert that there was no evidence of an

arterial occlusion on plaintiff's presentation to the NYU emergency department on February 20, 2016, and it was proper to discharge plaintiff after her symptoms resolved and she was able to ambulate because plaintiff was not exhibiting any emergency condition that warranted admitting her. Counsel notes that Dr. Blackstock only treated plaintiff during her February 20, 2016 presentation to the emergency department, and asserts that any and all claims against Dr. Blackstock related to dates before or after February 20, 2016 must be dismissed.

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. Blackstock departed from the standard of care by failing to conduct the proper tests to diagnose arterial occlusion. Plaintiff's expert alleges that these failures on behalf of Dr. Blackstock prevented the timely diagnosis of the plaintiff's arterial occlusion, and as a result plaintiff sustained arterial obstruction, which necessitated further surgery including an aortic bifemoral bypass and an open aortoiliac endarterectomy. Plaintiff claims her injuries include permanent damage to her lower extremities (left lower leg), difficulty walking/ambulating, inability to perform daily tasks, and the need for continued and further treatments.

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 affirmations of Dr. Kwiatkowski and Dr. Suggs, who opine that Dr. Blackstock and NYU treated plaintiff in accordance with the standard of care and timely diagnosed plaintiff’s arterial occlusion on March 1, 2016. Dr.

Kwiatowski and Dr. Suggs argue that prior to March 1, 2016, plaintiff was not exhibiting symptoms of arterial occlusion, and thus, there was no cause for Dr. Blackstock or the NYU staff to suspect arterial occlusion before that date.

In opposition, plaintiff has pointed to several possible deviations from the standard of care by Dr. Blackstock and NYU. Plaintiff's expert opines that Dr. Blackstock and NYU failed to perform the appropriate diagnostic tests, including a lipid panel, an arterial doppler, a Magnetic Resonance Angiogram (MRA) and arteriogram, all of which were indicated due to plaintiff's signs, symptoms, medical history,<sup>2</sup> and negative venous doppler. Plaintiff's expert explains that arterial obstruction is a condition that develops over time and presents with various symptoms, including weakness, tingling or pain in the extremities; cold extremities; extremity discoloration; and reduced or absent pulses in the extremities. In addition, plaintiff's expert asserts that plaintiff's "extremely high" cholesterol levels<sup>3</sup> alone should have prompted a lipid profile to be conducted, as such levels are indicative of a higher risk of cardiovascular issues. Plaintiff's expert also argues that the staff at NYU should have taken plaintiff's pneumonia into consideration, as pneumonia can increase the stress on the heart, which could lead to cardiovascular complications.

Plaintiff's expert states that performing a venous doppler was an appropriate response to plaintiff's complaint of leg pain on February 20<sup>th</sup>, but also argues that a venous doppler is insufficient when a patient shows warning signs of atherosclerotic disease, such as history of high blood pressure and high cholesterol, dizziness, leg pain, and numbness. Plaintiff's expert asserts that Dr. Blackstock and the NYU staff should have ordered an arterial doppler, MRA, and aortogram to rule out arterial obstruction. According to plaintiff's expert, the diagnosis of dehydration and subsequent discharge on February 20<sup>th</sup> was a departure from the standard of care. Plaintiff's expert opines that the

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<sup>2</sup> Plaintiff's expert points to plaintiff's history of high blood pressure, high cholesterol, status of a recent former smoker, and dizziness as indicators that her cardiovascular system should have received a proper workup, as these are all known risk factors for cardiovascular issues such as an arterial blockage.

<sup>3</sup> Plaintiff's expert notes that plaintiff's total cholesterol was 252 in 2015 and, when she was tested on March 2, 2016, her total cholesterol level was 379 and her HDL was 260.

delay in correctly diagnosing plaintiff caused the artery at issue to progress from obstructed to totally occluded. Plaintiff's expert states that acute arterial occlusion is considered a vascular emergency, and the resulting lack of blood flow to the affected limbs can cause permanent damage due to muscle tissue necrosis, causing permanent mobility limitations.

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. Blackstock and NYU to the plaintiff. In reaching this determination, the Court considered that the experts offered differing opinions as to whether Dr. Blackstock and the NYU staff administered the appropriate tests to plaintiff on February 20, 2016, and whether Dr. Blackstock should have diagnosed plaintiff with arterial occlusion at that time.

Conclusion:

While the defendants Dr. Blackstock and NYU have met her 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. Blackstock and NYU departed from good and accepted medical practice in the treatment rendered to plaintiff. The issue of credibility regarding conflicting expert testimony must be submitted to the trier of fact.

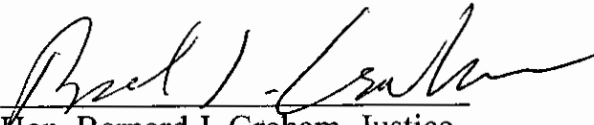
As no opposition has been offered with respect to plaintiff's cause of action for lack of informed consent, such cause of action is dismissed.

Accordingly, the motion by Dr. Blackstock and NYU for summary judgment and a dismissal of plaintiff's complaint, pursuant to CPLR §3212, is granted only to the extent of dismissing plaintiff's cause of action for lack of informed consent. In all other respects, the motion is denied.

This shall constitute the decision and order of this Court.

Dated: April 18, 2022  
Brooklyn, NY

ENTER

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

**HON. BERNARD J. GRAHAM**