Lowry v McPherson
2022 NY Slip Op 34355(U)
July 7, 2022
Supreme Court, Kings County
Docket Number: Index No. 510998/2018
Judge: Ellen M. Spodek
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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 7th day of July 2022

PRESENT:

HON. ELLEN M. SPODEK, Justice

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JEANETTE LOWRY and WILHEMINIA LOWRY, as Co-Administrators of the Estate of LATOYA LOWRY, Deceased,

Plaintiffs,

-against-

PHILIP McPHERSON, M.D., ANNE CHAMANI, P.A.-C, CARMEN ANDERSON, R.N., and KINGSBROOK JEWISH MEDICAL CENTER,

Defendants

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DECISION AND ORDER

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Defendants PHILIP McPHERSON, M.D., ANNE CHAMANI, P.A.-C, CARMEN ANDERSON, R.N., and KINGSBROOK JEWISH MEDICAL CENTER ("Kingsbrook") move pursuant to CPLR 3212 for an order granting summary judgment and dismissing the complaint against them. Plaintiffs Jeanette Lowry and Wilheminia Lowry oppose the motion.

On September 21, 2016, at 3:38 a.m., Latoya Lowry (hereinafter "Decedent" or "Ms. Lowry") presented to the Emergency Department at Kingsbrook Jewish Medical Center (hereinafter "KJMC"). At about 3:41 a.m., she was triaged by Betty Napon, R.N., who obtained a

history and performed a physical examination. Ms. Lowry complained of a fever, body aches, and chills. She also reported a mild cough which had lasted seven days, and advised that she was treated for pneumonia at Jamaica Hospital one week prior. She denied taking any medications and reported a history of hypertension. Ms. Lowry did not report any other preexisting conditions or medical history. Nurse Napon found that Ms. Lowry was alert and oriented x3, and her examination revealed no significant abnormalities.

At 3:43 a.m., Nurse Fetter obtained Ms. Lowry's vital signs, and documented that her blood pressure was 110/80, her pulse was 103 bpm, her respiration rate was 20 breaths per minute, and her oxygen saturation was 98%. She was afebrile, with a temperature of 98.4 degrees, and she was in no obvious discomfort. Nurse Fetter conducted a physical examination and found no abnormalities. Ms. Lowry had no swelling or edema in any of her extremities. She reported an aching pain which she rated as 6/10. Ms. Lowry was alert and oriented x4, had normal affect, and responded appropriately to questions.

At about 5:08 a.m., Ms. Lowry was seen by Elizabeth Resnick, P.A. She reported she had body aches and a cough with shortness of breath lasting 4 days, and again advised that she was previously seen at Jamaica Hospital, where she received antibiotics for pneumonia. She also reported being seen at Brookdale. PA Resnick found that Ms. Lowry did not provide many details about the treatment she received at Jamaica Hospital and Brookdale. However, she determined that Ms. Lowry was alert and oriented x3 with normal affect. Ms. Lowry stated she experienced shortness of breath after smoking a cigarette, and reported she had similar episodes in the past. She denied chest pain, and a physical examination again revealed no abnormalities and no swelling in Ms. Lowry's extremities. Ms. Lowry reported that there was nothing that made her symptoms better or worse. ED Attending Philip McPherson, M.D. also examined the patient and agreed with

PA Resnick's findings. They suspected the patient might have an upper respiratory infection or viral syndrome, and ordered a chest x-ray to rule out pneumonia.

At 5:17 a.m., a chest x-ray was performed and interpreted by radiologist Albert Chang, M.D. Dr. Chang reported that the x-ray revealed an unremarkable cardiomediastinal silhouette, mild left basilar subsegmental atelectasis, and no evidence of acute pulmonary disease. At 5:26 a.m., Nurse Fetter documented that Ms. Lowry's blood pressure was 115/82, her pulse was 100 bpm, her respiratory rate was 20 bpm, and her oxygen saturation was 98%. Ms. Lowry complained of aching pain which she rated as a 6/10, for which she was given Tylenol. At about 5:56 a.m., Dr. McPherson interviewed and examined Ms. Lowry. He reviewed her chart, including test results and the x-ray report, and discussed the treatment plan with PA Resnick, and determined that Ms. Lowry most likely had a viral syndrome. At 6:26 a.m., Nurse Fetter obtained Ms. Lowry's vital signs, and documented that her blood pressure was 112/78, her pulse had decreased to 89 bpm, her respiratory rate had decreased to 18 breaths per minute, and her oxygen saturation had improved to 99%. Ms. Lowry reported that her pain had improved to 2/10.

At about 7:00 a.m., PA Resnick documented that Ms. Lowry had rested comfortably all night and was in no acute distress, she and Dr. McPherson determined that the patient was cleared for discharge. She was given a prescription for 325 mg. Tylenol, which she was advised to take every 4-6 hours as needed for pain or fever. PA Resnick encouraged Ms. Lowry to follow up with her primary care provider or the medical clinic and told her to return to the ED if her symptoms worsened. Ms. Lowry verbalized understanding and the ability to comply, and she left the ED in stable condition at 7:16 a.m. Defendants Anne Chamani, P.A. and Carmen Anderson, R.N. did not see *Ms. Lowry at any time during this ED visit and had no involvement in Ms. Lowry's care until* September 22, 2016.

On September 22, 2016, at 8:44 p.m., Ms. Lowry returned to the KJMC ED. Keturah Ponce, R.N. obtained a history and performed a physical examination at 8:46 p.m. Ms. Lowry reported she was seen in the KJMC ED the day before, she reported a history of pneumonia and hypertension, and she did not report any home medications or other medical history. She complained of abdominal pain, which she rated as 7/10, and she denied all other symptoms. Nurse Ponce conducted a physical examination which revealed no abnormal findings, and she found that Ms. Lowry was alert and oriented x 3. She also took Ms. Lowry's vitals, which she documented as follows: blood pressure of 133/102; pulse of 110 bpm; respiration rate of 18 bpm; and oxygen saturation 98%. Ms. Lowry was assigned an acuity level of three, on a scale of one to five, with one being most urgent. Shortly before 9:30 p.m., PA Chamani reviewed Ms. Lowry's records from the September 21, 2016 ED visit and noted that the chest x-ray from that visit was negative. She then obtained a history from Ms. Lowry and conducted a physical examination. Ms. Lowry complained of a sore throat, cough, and shortness of breath, and she denied chest pain. PA Chamani suspected that the patient had a viral syndrome. PA Chamani's physical examination revealed no significant abnormalities. Ms. Lowry was in no acute distress, no obvious discomfort, and she did not have swelling in her extremities. Ms. Lowry was alert and oriented x 3 with normal affect, and she responded appropriately to questions. PA Chamani consulted with Dr. McPherson, informed him of the patient's history and the findings from her examination, and discussed a plan of treatment.

At about 9:30 p.m., Dr. McPherson spoke to Ms. Lowry and obtained a history. He thought Ms. Lowry might have a pulmonary embolism ("PE"), and a Complete Blood Count ("CBC") was ordered to evaluate kidney function in preparation for obtaining a CT scan to rule out a PE. At 9:43 p.m., orders were placed for a Troponin I test, EKG, CBC differential, comprehensive

metabolic panel (CMP), lipase serum, urine toxicology screen, and urinalysis. At 9:44 p.m., Sherry Ann Reid, R.N. inserted a 22-gauge saline-lock in the right hand and blood was drawn for the CBC differential, comprehensive metabolic panel, lipase serum and Troponin I. At 9:44 p.m., PA Chamani ordered Ipratropium-Albuterol to alleviate Ms. Lowry's cough and shortness of breath. PA Chamani also ordered 30 mg of IV Ketorolac Tromethamine for pain.

At 9:45 p.m., PA Chamani ordered 1,000 ml of NaCl 0.9% ("normal saline") to be administered by IV at a rate of 1,000 mL per hour. At about 10:31 p.m., Nurse Anderson hung 1,000 ml of normal saline in accordance with PA Chamani's order. She primed the bag with tubing, verified that Ms. Lowry was the correct patient, verified that the bag was filled to 1,000 ml, and confirmed that the dosage and rate were correct pursuant to the order. Nurse Anderson then hung the fluid, attached the tubing to the hep lock, and turned the roller clamp to begin the infusion at a rate of 1,000 ml per hour. At about 10:34 p.m., Nurse Anderson gave Ms. Lowry ipratropium albuterol via a nebulizer treatment to alleviate her cough and shortness of breath, and she administered IV Ketorolac tromethamine for pain. By that time, Ms. Lowry was on a cardiac monitor which displayed her vitals.

At about 11:16 p.m., Nurse Anderson documented Ms. Lowry's vital signs as follows: blood pressure of 159/109; pulse of 119 bpm; respiration rate of 18 bpm; and oxygen saturation of 95%. PA Chamani and Dr. McPherson suspected the patient might have a PE. Orders were placed for a D Dimer test and a CTA of the Chest PE/DVT without contrast, and Ms. Lowry was started on 3 liters of oxygen by nasal cannula.

At 11:26 p.m., PA Chamani signed over the care of the patient to Dr. McPherson. Her shift ended at 11:30 p.m., and PA Chamani had no further involvement in Ms. Lowry's care. At 12:16 a.m., Ms. Lowry was transported via stretcher to radiology to undergo the CT scan. She returned

at 1:33 a.m. in stable condition and the IV bag still contained fluid, as the 1,000 ml of normal saline had not fully infused. At that time, Nurse Anderson placed Ms. Lowry on the cardiac monitor again.

At 1:34 a.m., Dr. Ravi Giyanani called Dr. McPherson and advised that the CT scan was suggestive of pulmonary edema as a result of congestive heart failure. Immediately thereafter, a nurse notified Dr. McPherson that Ms. Lowry was having trouble breathing, and Dr. McPherson went immediately to the patient's bedside. Ms. Lowry went into arrest, a code was called at 1:55 a.m., and Dr. McPherson placed an endotracheal tube. Despite aggressive efforts to resuscitate Ms. Lowry, her heart could not be restarted, and she was pronounced dead at 2:35 a.m. According to the autopsy report, Ms. Lowry died as a result of cardiovascular disease with pericardial effusion and pulmonary edema.

Defendants now move for summary judgment dismissing the complaint on the grounds that their actions and/or inactions did not cause or contribute to the decedent's death, and that they followed the appropriate medical procedures to manage the decedent's medical conditions.

Defendants submit an expert affirmation from Dr. Saul Melman, a Board-certified Emergency Medicine Physician. Dr. Melman states that Defendants administered appropriate medical intervention and procedures during both of Ms. Lowry's ER visits. Dr. Melman opines that Ms. Lowry's symptoms of abdominal pain, sore throat, cough, and shortness of breath, which was not worsened by exertion or lying down were consistent with a virus, rather than a cardiac issue. Dr. Melman strongly emphasized that Ms. Lowry did not complain of fatigue or show swelling in her lower extremities, which is a common symptom of cardiomyopathy. Furthermore, Dr. Melman opines that Ms. Lowry showed none of the common symptoms of severe cardiomyopathy, such as shortness of breath, restlessness, anxiety, or distress. Dr. Melman further

opines that Ms. Lowry never reported any prior cardiac history, and due to her complaints, symptoms, young age, vital signs, and repeated physical assessments, the attending physicians had no reason to believe that Ms. Lowry would be unable to tolerate a standard IV infusion of saline.

Dr. Melman opines that Defendants took appropriate steps to manage Ms. Lowry's condition, and there was no possible life-saving intervention for her rapid and unforeseeable decompensation. Dr. Melman further opines that Ms. Lowry died as a result of her non-disclosed previous cardiomyopathy and not as a result of any act or omission by the Defendants.

Plaintiffs, in opposition, submit an expert affirmation from a doctor who is a physician Board Certified by the American Board of Surgery and the American Board of Vascular Surgery, as well as a co-director of the Surgical ICU at a major academic medical center. The expert opines that Defendants deviated from the standard of care on September 21, 2016, by failing to differentiate their diagnosis of pneumonia after observation of persistent cough, failing to use EKG despite noting the need for one, failing to ascertain medications for hypertension, and discharging the patient with a prescription for Tylenol only, and no further care or follow ups. The expert further opines that the Defendants deviated from the standard of care on September 22, 2016 by failing to obtain the medical records, or at a minimum the discharge summary, from Jamaica Hospital; failing to contact the Emergency Department doctors who saw and treated Ms. Lowry two weeks prior to her admission at KJMC; failing to recognize the significance of the fact that despite hospitalization and antibiotics, Ms. Lowry's symptoms of shortness of breath and persistent cough had persisted; failing to recognize the significance of the fact that despite 3 liters of oxygen via nasal cannula, Ms. Lowry's oxygen saturation became less which was an indication that she had congestive heart failure; failing to recognize the significance of a finding of moderate cardiomegaly as an indication that Ms. Lowry had congestive heart failure; failing to recognize

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that evidence of interstitial edema was suspicious for pulmonary edema and congestive heart failure; failing to consider a cardiac etiology as the source of plaintiff's decedent's complaints; improperly ordering and causing a liter of saline to be infused over one hour only 15 minutes after vital signs suggested congestive heart failure; improperly ordering and infusing 1 liter of saline, where there was no evidence of dehydration or need for the same; failing to hold fluids, and failing to give Lasix.

Discussion

Defendants move for summary judgment, denying Plaintiff's allegations that Defendants failed to diagnose and treat Decedent's cardiomyopathy and congestive heart failure, negligently administered intravenous fluids resulting in Ms. Lowry's developing florid pulmonary edema and death, lack of informed consent with respect to "treatment rendered," and allegations that the KJMC staff were negligently hired and trained on a theory of res ipsa loquitur. Plaintiffs also allege that Defendants failed to obtain informed consent from Ms. Lowry and properly inform her of the "nature and extent of her illness and condition".

Summary judgment is a drastic remedy that deprives a litigant of his or her day in court and should, thus, only be employed when there is no doubt as to the absence of triable issues of material fact (Kolivas v. Kirchoff, 14 AD3d 493 [2005]; see also Andre v. Pomeroy, 35 NY2d 361, 364 [1974]). However, a motion for summary judgment will be granted if, upon all the papers and proof submitted, the cause of action or defense is established sufficiently to warrant directing judgment in favor of any party as a matter of law (CPLR 3212 [b]; Gilbert Frank Corp. v. Federal Ins. Co., 70 NY2d 966, 967 [1988]; Zuckerman v. City of New York, 49 NY2d 557, 562 [1980]), and the party opposing the motion for summary judgment fails to produce evidentiary proof in

admissible form sufficient to establish the existence of material issues of fact (Alvarez v. Prospect Hosp., 68 NY2d 320, 324 [1986], citing Zuckerman, 49 NY2d at 562).

"The proponent of a motion for summary judgment must make a prima facie showing of entitlement to judgment, as a matter of law, tendering sufficient evidence to demonstrate the absence of any material issues of fact" (Manicone v. City of New York, 75 AD3d 535, 537 [2010], quoting Alvarez, 68 NY2d at 324; see also Zuckerman, 49 NY2d at 562; Winegrad v. New York Univ. Med. Ctr., 64 NY2d 851, 853 [1985]). If it is determined that the movant has made a prima facie showing of entitlement to summary judgment, "the burden shifts to the opposing party to produce evidentiary proof in admissible form sufficient to establish the existence of material issues of fact which require a trial of the action" (Garnham & Han Real Estate Brokers v. Oppenheimer, 148 AD2d 493 [1989]).

The court must evaluate whether the issues of fact alleged by the opposing party are genuine or unsubstantiated (Gervasio v. Di Napoli, 134 AD2d 235, 236 [1987]; Assing v. United Rubber Supply Co., 126 AD2d 590 [1987]; Columbus Trust Co. v. Campolo, 110 AD2d 616 [1985], affd 66 NY2d 701 [1985]). Mere conclusory statements, expressions of hope, or unsubstantiated allegations are insufficient to defeat a motion for summary judgment (Gilbert Frank Corp., 70 NY2d at 967; Spodek v. Park Prop. Dev. Assoc., 263 AD2d 478 [1999]). "[A]verments merely stating conclusions, of fact or of law, are insufficient to defeat summary judgment" (Banco Popular N. Am. V. Victory Taxi Mgt., 1 NY3d 381, 383-384 [2004], quoting Mallad Constr. Corp. v. County Fed. Sav. & Loan Assn., 32 NY2d 285, 290 [1973]). If there is no genuine issue of fact, the case should be summarily determined (Andre, 35 NY2d at 364).

"In order to establish the liability of a professional health care provider for medical malpractice, a plaintiff must prove that the provider 'departed from accepted community standards

of practice, and that such departure was a proximate cause of the plaintiff's injuries'" (Schmitt v. Medford Kidney Ctr., 121 AD3d 1088, 1088 [2014], quoting DiGeronimo v. Fuchs, 101 AD3d 933, 936 [2012] quoting Stukas v. Streiter, 83 AD3d 18, 23 [2011] [internal quotation marks omitted]).

A defendant moving for summary judgment dismissing a medical malpractice action 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 patient's injuries (see Williams v. Bayley Seton Hosp., 112 AD3d 917, 918 [2013]; Makinen v. Torelli, 106 AD3d 782, 783-784 [2013]). "Once the health care provider has made such a showing, the burden shifts to the plaintiff to demonstrate the existence of a triable issue of fact, but only as to the elements on which the defendant met the prima facie burden" (Schmitt, 121 AD3d at 1088; see Stukas, 83 AD3d at 30).

After considering oral arguments and the relevant documents, the Court finds that the defendants have sustained their burden of showing that they did not depart from good and accepted medical standards of care. The burden then shifted to plaintiffs to provide evidence to the Court that the defendants did in fact deviate from the accepted standards of medical care, raising a triable issue of fact. The Court finds that plaintiffs have not sustained their burden. Plaintiffs failed to lay a proper foundation for the Court to consider their expert's affirmation. "Physicians offering opinions in medical, dental, podiatric, chiropractic, or other specialty malpractice actions must establish their credentials in order for their expert opinions to be considered by the court." Bongiovanni v. Cavagnuolo, 138 AD 3d 12, 18 (2d Dept. 2016). "Thus, when a physician offers an expert opinion outside of his or her specialization, a foundation must be laid tending to support the reliability of the opinion tendered." Id.

A foundation for expert opinion regarding deviation from standard care outside of an expert's area of specialization may be established by an affidavit from the expert demonstrating that the expert is familiar with the relevant literature or otherwise sets forth how he was, or became, familiar with the applicable standards of care in this specialized area of practice. Behar v. Coren, 21 A.D.3d 1045, 1046 (2d Dept. 2005). Here, Plaintiffs fail to provide a foundation showing that their expert has the necessary medical expertise to opine on the specific circumstances of this case. The CV, which the Court reviewed, does not indicate that he/she treats patients in the emergency department outside of the Surgical ICU. The affirmation merely states that he is a "a co-director of the Surgical ICU at a major academic medical center" who has "participated in the evaluation of hundreds of patients in the Emergency Department setting" and that he has "completed a residency in general surgery, as well as fellowships in critical care surgery and vascular surgery at a major metropolitan hospital center in New York".

These statements are insufficient to lay a proper foundation for the expert to opine on the circumstances of this case which involve emergency room treatment of a non-surgical pulmonary and cardiac emergency, and therefore the affirmation is not considered a reliable expert opinion. Without an expert's opinion, plaintiffs have failed to sustain their burden to show that there is a question of fact that the defendants departed from good and accepted medical practice in the treatment of the decedent. As plaintiffs have failed to sustain their burden, defendants' motion for summary judgment must be granted. The complaint against the defendants is dismissed.

This constitutes the decision and order of the Court.

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