

Simmons v Rubano

2023 NY Slip Op 31298(U)

April 14, 2023

Supreme Court, Kings County

Docket Number: Index No. 510343/2020

Judge: Genine D. Edwards

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At an I.A.S. Trial Term, Part 80 of the Supreme Court of the State of New York, held in and for the County of Kings, at the Courthouse, located at 360 Adams Street, Borough of Brooklyn, City and State of New York, on the 14th day of April 2023

P R E S E N T :

Hon. Genine D. Edwards, Justice

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SHAQUIA SIMMONS, as Administrator of the Estate of JUDITH PRESCOTT, and SHAQUIA SIMMONS, Individually,

Index No.: 510343/2020

Plaintiffs,

-against-

ELIZABETH RUBANO, M.D. and MOUNT SINAI BROOKLYN,

Defendants.
-----x

The following e-filed papers read herein:

NYSCEF Doc No.:

Notice of Motion, Affirmations and Exhibits.....16-32

Affirmation in Opposition and Exhibits.....35-46

Reply.....47

Stipulations.....33, 34

In this action to recover damages for medical malpractice and wrongful death, defendants pursuant to CPLR § 3212, for summary judgment dismissing the complaint. Plaintiffs opposed the motion.

FACTS

Decedent Judith Prescott had a history of non-ST elevation myocardial infarction, coronary artery disease, cervical nerve root compression, asthma, chronic bronchitis, former tobacco use, hypertension, stroke, obesity, and subclinical hyperthyroidism. She presented to Mount Sinai Brooklyn's emergency department on August 11, 2019, at 12:33 AM, with difficulty breathing, shortness of breath for the past week, and left-sided neck pain radiating down her left arm, which worsened on inspiration. She used her inhaler at home, but it did not improve her shortness of breath, and her neck and arm pain became more severe throughout the day.

Dr. Rubano examined decedent and found mild respiratory distress, tachypnea, and tachycardia with 98% oxygen saturation after receiving oxygen through a non-rebreather mask. She ordered a "cardiac workup," including one troponin test, an electrocardiogram (EKG), and a chest x-ray. She also ordered pain control, and duonebs (an inhaler) for decedent's asthma. Decedent's EKG showed normal sinus rhythm with a possible left atrial enlargement. On the chest x-ray, decedent's cardiomedial silhouette was unremarkable, the trachea was normal in course and caliber, and there was no pleural effusion or pneumothorax. Bloodwork was essentially normal, with decedent's troponin assay result at 0.025 ng/mL.

Decedent was given morphine at 1:30 AM, Solu-Medrol at 1:35 AM, albuterol at 1:35 AM, Toradol at 2 AM, albuterol at 2:31 AM and valium at 4:12 AM. Her initial pain level was 5 out of 10; then, at 2:00 AM, 7 out of 10. At 4:05 AM, decedent was resting comfortably on a stretcher. She reported improved pain, had a normal respiratory rate, and was no longer in respiratory distress. However, she continued to indicate pain

radiating from her neck to her left arm. Finally, at 5:37 AM, she reported that the pain was 6 out of 10. Decedent was diagnosed with a pinched nerve in the neck, also known as “cervical radiculopathy,” and discharged at 7:02 AM on August 11, 2019, about six hours after her initial arrival.

On August 12, 2019, the New York City Fire Department Emergency Medical Service (“EMS”) found decedent lying in vomit on the floor of her apartment with an altered mental status. Decedent was verbal but not responding to questions. An initial EMS assessment revealed decedent’s lungs were clear, equal, and bilateral, the respiratory rate regular and labored, and the heart rate was slow and regular. Thereafter, decedent went into respiratory arrest, then cardiac arrest. EMS started CPR. Resuscitation was attempted with a non-rebreather mask and intubation. Decedent arrived at Brookdale Medical Center (“Brookdale”) at 12:42 AM on August 13, 2019. The endotracheal tube was checked upon arrival at the emergency department and found in decedent’s esophagus. Brookdale removed the tube, and decedent was reintubated using a glidoscope. Decedent died at Brookdale on August 13, 2019, at 1:09 AM. Decedent’s family declined an autopsy.

LAW

“A physician [who moves] for summary judgment dismissing a complaint alleging medical malpractice must establish, prima facie, either that there was no departure from accepted standards of medical care or that any departure was not a proximate cause of plaintiff’s injuries.” *Schwartzberg v. Huntington Hospital*, 163 A.D.3d 736, 81 N.Y.S.3d 118 (2d Dept. 2018) quoting *Mackauer v. Parikh*, 148 A.D.3d 873, 49 N.Y.S.3d 488 (2d Dept. 2017). See *McAlwee v. Westchester Health Associates, PLLC*, 163 A.D.3d 549, 80 N.Y.S.3d 401 (2d Dept. 2018). To sustain the burden, the

physician “must address and rebut any specific allegations of malpractice set forth in a plaintiff’s bill of particulars.” *Mackauer*, 148 A.D.3d 873.

“It is plaintiff’s burden to raise a triable issue of fact regarding the element or elements on which defendant has made a prima facie showing.” *Aliosha v. Ostad*, 153 A.D.3d 591, 61 N.Y.S.3d 55 (2d Dept. 2017). Accordingly, a plaintiff must submit the affidavit of “a[n expert] physician attesting to a departure from good and accepted practice, and stating the physician’s opinion that the alleged departure was a competent producing cause of plaintiff’s injuries.” *Shectman v. Wilson*, 68 A.D.3d 848, 890 N.Y.S.2d 117 (2d Dept. 2009). *See Burns v. Goyal*, 145 A.D.3d 952, 44 N.Y.S.3d 180 (2d Dept. 2016) (“Expert testimony is necessary to prove a deviation from accepted standards of medical care and to establish proximate cause.”). “In order not to be considered speculative or conclusory, expert opinions in opposition should address specific assertions made by the movant’s experts, [explaining] the reasoning and relying on specifically cited evidence in the record.” *Tsitrin v. New York Community Hosp.*, 154 A.D.3d 994, 62 N.Y.S.3d 506 (2d Dept. 2017).

ANALYSIS

Defendants established their prima facie entitlement to judgment as a matter of law dismissing the complaint by submitting, *inter alia*, the expert affirmations of Stanley J. Schneller, M.D., board certified in the fields of cardiovascular diseases and internal medicine, and Timothy Haydock, M.D., FACEP, board certified in emergency medicine, who opined within a reasonable degree of medical certainty that the care defendants rendered to decedent was in accordance with good and accepted practice and that neither the acute cardiac condition nor the pulmonary embolism, that plaintiffs allege, was the proximate cause of decedent’s death. Specifically, Dr. Schneller opined

that on August 12, 2019 into August 13, 2019, decedent suffered an acute respiratory event resulting from decedent's altered mental state and vomitus that interfered with decedent's airway. Then the improper placement of the endotracheal tube into decedent's esophagus by non-party EMS caused her death, not a cardiac condition or a pulmonary embolism.

Dr. Haydock opined that on August 11, 2019, decedent denied any chest pain on triage and again on review of symptoms. Upon Dr. Rubano's physical examination, decedent's heart rhythm, sounds, and intact distal pulses were all "regular." The cardiac workup revealed normal EKG, bloodwork, and troponin. As a result, Dr. Rubano was not required to order additional testing or a cardiology consultation due to decedent's improving condition, acceptable levels of troponin, and the findings on the EKG and chest x-rays. A second troponin test would only be required if decedent had worsening symptoms, which were absent here. In addition, while decedent's sinus tachycardia (rapid heart rate) continued throughout her hospital stay, it was not a departure for Dr. Rubano to assess that decedent's tachycardia was not of concern when considering the other signs and symptoms that were within normal limits as well as her history of asthma and response to the asthma medication. Finally, given the results of decedent's initial bloodwork, her history of asthma, and the improvement in her oxygen saturation, there was no basis for Dr. Rubano to suspect and test for a pulmonary embolism, call for a pulmonology consult or order further bloodwork, including culture and D-Dimer, EKG, echocardiogram, and radiology testing, such as a CT scan. Dr. Schneller added that neither the vomiting that interfered with decedent's airway nor decedent's altered mental status was consistent with a pulmonary embolism.

In opposition, plaintiffs' evidence was insufficient, including the expert affidavit of a physician board certified in emergency medicine, and the affirmation of a physician board certified in pulmonary medicine, critical care medicine, and neuro-critical care, to raise a triable issue of fact. The experts' opinions were conclusory and speculative and failed to address specific assertions made by defendants' experts. For example, plaintiffs' experts did not address the conclusion of defendants' experts that decedent's death was caused by a respiratory event secondary to aspiration pneumonia as complicated by the placement of the endotracheal tube in decedent's esophagus. Nor did they address defendants' experts' claim that there was no indication of cardiac damage either from pulmonary embolism or otherwise until after intubation that pumped air into decedent's stomach instead of her lungs. Plaintiffs' experts also failed to address defendants' experts' claims that decedent significantly improved in the emergency room after receiving asthma medication. Lastly, plaintiffs' experts' opinions about the need for further testing and ruling out a pulmonary embolism were unsupported by the medical evidence. *Elstein v. Hammer*, 192 A.D.3d 1075, 145 N.Y.S.3d 572 (2d Dept. 2021).

Accordingly, it is

ORDERED that the motion is granted. The complaint is dismissed.

This constitutes the Decision/Order of the Court.

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HON. GENINE D. EDWARDS