At Part MMESP-6 of the Supreme Court of the State of New York, held in and for the County of Kings, at the Courthouse, at 360 Adams Street, Brooklyn, New York, on the 4th day of December 2023

PRESENT:

HON. GENINE D. EDWARDS
Justice.

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CELESTE VALENTINE, as Administrator of the Estate of NEREIDA NAPOLEONI, Deceased,

Plaintiff,

-against-

DAVID LOBEL, M.D., ZALMAN STAROSTA, M.D. and MAIMONIDES MEDICAL CENTER,

Defendants.

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Decision and Order

Index No.: 512065/2018

Motion Seqs. 2 & 3

The following e-filed papers read herein: NYSEF Nos.:

Notices of Motion, Affirmations, and Exhibits.....35-39, 59-63
Opposing Affirmations and Exhibits.....76-80
Affirmations in Reply[1].....82, 84

In this action to recover damages for medical malpractice and wrongful death, defendants David Lobel, M.D. ("Dr. Lobel") and Maimonides Medical Center ("Maimonides") moved for summary judgment and Zalman Starosta, M.D ("Dr. Starosta") moved for the same relief, both motions seeking to dismiss the complaint pursuant to CPLR 3212. Plaintiff opposed the motions.

[1] This Court does not consider exhibits annexed to Reply Affirmations. *Pena v. Geisinger Community Medical Center*, 209 A.D.3d 663, 174 N.Y.S.3d 873 (2d Dept. 2022).

FACTS

Celeste Napoleoni ("Decedent"), a 53-year-old woman with a past medical history of hypertension, diabetes, and high cholesterol, presented to the emergency room ("ER") at Maimonides at 6:27 a.m., on June 6, 2016, complaining of severe shoulder pain. The attending physician for this presentation was Dr. Lobel. Previously, in March of 2015, decedent appeared at Maimonides, with complaints of left shoulder pain, shooting up to her neck and shoulder area and across her back. At that visit, blood work showed her Troponin level was 0.02, with a normal reference range of 0.0-0.02. Her chest x-ray and EKG were normal. The decedent was also seen by a cardiologist, Dr. Elliot Borgen. It was noted that her diabetes and hypertension were not controlled. Decedent's pain was assessed as musculoskeletal in nature. Since her troponin level was negative and she was taking medication for hypertension, she was advised to follow-up with her private medical doctor. It was determined that a further cardiac workup was unnecessary at that time. Decedent was instructed to follow up with Dr. Borgen.

At the June 6, 2016 visit, a physical examination was performed. The decedent had a regular sinus rhythm with no murmur, no rales appreciated, normal respiration, and a normal examination of her head, eyes, ears, nose, mouth, and throat. The range of motion in her extremities were normal. Decedent was tender to palpation on her anterior shoulder musculature, and the differential diagnosis was muscle spasm. Decedent was given Toradol and Robaxin and advised to follow up in the pain clinic. Dr. Lobel noted that decedent was stable for discharge from the emergency department. He indicated that decedent felt better after taking Robaxin, and she wanted to go home. Her glucose and blood pressure were slightly improved. Decedent had an appointment with her physician in the afternoon.

Later that day, decedent presented to Dr. Starosta, an endocrinologist who treated decedent for diabetes and acted as her primary care physician. Dr. Starosta testified that the decedent did not complain of arm pain. He noted that she went to Maimonides for severe pain earlier that day. He performed several tests including an abdominal sonogram, a transabdominal sonogram, and an echocardiogram. The echocardiogram demonstrated mild pulmonary insufficiency, an enlarged left ventricle, and mitral regurgitation.

Dr. Starosta did not perform an electrocardiogram ("EKG") nor was a cardiac condition ruled out. Decedent did not complain of any cardiac issues to Dr. Starosta, but her complaints included pain in multiple sites, both shoulders, upper and lower torso, hip joints. Dr. Starosta concluded that decedent's glucose was out of control, and he wanted to rule out diabetic gastroparesis. He noted that the decedent was treating with cardiologist Dr. Borgen. He gave her a referral to a pain management physician. The decedent was scheduled for dental surgery on June 10, 2016, and was required to see Dr. Starosta on June 9th for medical clearance.

On June 9th, Dr. Starosta drew blood and indicated he would send the results to the oral surgeon the next day. To clear the decedent for dental surgery, Dr. Starosta also performed a sonogram of her venous lower extremities as well as an EKG. The EKG showed ST depressions and abnormal T waves, but he gave her clearance for the dental surgery.

On June 10th, rather than undergoing oral surgery, the decedent went to Coney Island Hospital's ER, complaining of left shoulder pain. She refused a cardiac work-up, advising the medical staff that she had her own cardiologist. She left the ER against medical advice. The decedent presented to Maimonides ER the same day, complaining of shortness of breath and severe left shoulder pain. A chest x-ray revealed evidence of congestive heart failure with a fluid overload. An x-ray of her shoulder showed no fracture or dislocation and normal degenerative

changes. An EKG revealed a possible STEMI (ST elevation myocardial infarction), thus a cardiology fellow was contacted immediately. A bedside ultrasound was consistent for congestive heart failure and possible septal and anterior wall motion abnormality. A progress note from the ER indicated that on the night of June 9th, decedent developed pleuritic chest pain and slowly worsening exertional dyspnea, prompting her to present to the ER. She became acutely, severely dyspneic while being transported for an x-ray in the ER and was in severe respiratory distress and tachycardic. The decedent did not tolerate BIPAP and was given Ativan and nitroglycerin intravenously, which resulted in rapid improvement. Decedent was admitted to the cardiology floor for a non-STEMI myocardial infarction with a new onset of congestive heart failure and respiratory failure.

At 10:53 p.m. on June 10th, a cardiac catheterization was performed. A note by cardiology fellow Dr. Shivani Verma indicated that the proximal left anterior descending artery (LAD) was 70% heavily calcified, the medial LAD was 99% heavily calcified, the distal LAD was 60% occluded, the ostial D1 was 50% occluded, but was no longer apparent post-intervention, and there was a total occlusion of the proximal right coronary artery. The LAD was stented.

Prior to decedent's release on June 16, 2016, a nephrology consult indicated that her renal disease was likely secondary to IV contrast and diuretics. It was noted that decedent's creatinine level was resolving to baseline. She was instructed to follow up in the renal clinic. Her discharge instructions included directions to follow up with a cardiologist, nephrologist, and endocrinologist. She was discharged home with a Life Vest and directions to follow up with her cardiologist in two weeks.

On June 20, 2016, decedent returned to Dr. Starosta. He noted her Maimonides visit on June 10th due to severe pain in her shoulders and diagnosed acute coronary syndrome. He further noted that the decedent was discharged on June 16th with instructions to see her cardiologist in two weeks. Dr Starosta indicated that the final diagnosis at discharge was anterior wall myocardial infarction and acute systolic heart failure. Dr. Starosta directed decedent to continue the medications she was prescribed at discharge from Maimonides, and she was to return in three weeks.

On the night of June 20th, the decedent was transported via EMS to Coney Island Hospital. The 911 call was received at 10:30 p.m., EMS responded at 10:55 p.m., and arrived at Coney Island Hospital at 11:01 p.m. The chief complaint was difficulty breathing. Upon arrival, the decedent was found pulseless. Cardiopulmonary resuscitation began at the scene and continued en route, with ambu-bagging and chest compressions. The decedent was pronounced dead upon arrival at Coney Island Hospital at 11:30 p.m.

LAW

The elements of a medical malpractice action are a deviation or departure from accepted practice and evidence that such departure was a proximate cause of injury or damage. *McHale v. Sweet*, 217 A.D.3d 666, 190 N.Y.S.3d 438 (2d Dept. 2023). A defendant's negligence is the proximate cause when it is a substantial factor in the events that produced the injury. *Templeton v. Papathomas*, 208 A.D.3d 1268, 175 N.Y.S.3d 544 (2d Dept. 2022). "When moving for summary judgment, a defendant… must establish the absence of any departure from good and accepted medical practice or that… plaintiff was not injured thereby." *Barnaman v. Bishop Hucles Episcopal Nursing Home*, 213 A.D.3d 896, 184 N.Y.S.3d 800 (2d Dept. 2023). To sustain the burden, a defendant "must address and rebut any specific allegations of malpractice

set forth in plaintiff's bill of particulars." *D.S. v. Poliseno,* 189 A.D.3d 1102, 133 N.Y.S.3d 831 (2d Dept. 2020).

In opposition, the plaintiff must "raise a triable issue of fact regarding the element or elements on which defendant has made its prima facie showing." *G.M.C. v. O'Sullivan,* 197 A.D.3d 1230, 153 N.Y.S.3d 565 (2d Dept. 2021). To do so, plaintiff must submit the affidavit of a 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. *Larcy v. Kamler,* 185 A.D.3d 564, 127 N.Y.S.3d 122 (2d Dept. 2020); *Shectman v. Wilson,* 68 A.D.3d 848, 890 N.Y.S.2d 117 (2d Dept. 2009).

ANALYSIS

Defendants argued that when decedent presented in the ER due to severe left shoulder pain, there were no signs of any imminent cardiac event. She specifically told them that she did not have shortness of breath. On the Patient Information Sheet, there was a notation that there was a dyspnea, but both Dr. Lobel and Dr. Yetter testified that this was a billing code and not a complaint made to either of them. Moreover, this condition was not noted by the senior resident who also took a history from the decedent.

Defendants agreed that decedent had risk factors that put her at an increased risk to suffer a myocardial infarction including hypertension, hyperlipidemia, diabetes, and she was overweight. In addition, the decedent had a family history of heart disease. Dr. Lobel testified that he was aware of these risk factors at the time he assessed the decedent on June 6, 2016. He reviewed decedent's records regarding her presentation to the ER more than a year earlier, on March 23, 2015. At that time, decedent complained of shoulder pain and shortness of breath and

the EKG as well as her Troponin levels indicated that decedent was not having a myocardial infarction. Dr. Lobel further testified that he was aware during the June 6th ER presentation that decedent also had a cardiology consultation during her prior ER presentation on March 23, 2015, that she was currently following with a cardiologist and that her last cardiology consult was on March 17, 2016. Maimonides and Dr. Lobel asserted that it was reasonable to rely on decedent's cardiologist to perform all indicated cardiac evaluations, that the symptoms she presented with were consistent with musculoskeletal issues, and that there were no deviations from accepted practice during the June 6th ER visit. They contended that decedent reported that she was going to see her doctor later that day. Considering that decedent was presenting to her doctor who knew her history and condition, and with the understanding that she was already under the care of a cardiologist, it was perfectly reasonable and appropriate for Dr. Lobel and the providers at Maimonides to discharge decedent from the ER on June 6th without a cardiac workup.

Defendants' internal medicine expert, Dr. Stanley Schneller ("Dr. Schneller"), disputed plaintiff's assertions that decedent was having a stuttering myocardial infarction when she presented to Maimonides on June 6th. Dr. Schneller opined that the evidence in this case indicated that the myocardial infarction started on June 9, 2016. Given the history of a sudden change in her pain on June 9th. and the elevated troponin level in the ER on June 10th, Dr. Schneller opined that decedent suffered a myocardial infarction on June 9, 2016.

Although Dr. Schneller failed to consider the sudden pain that brought decedent to the ER on June 6th, defendants' experts posited that the fact that decedent had a myocardial infarction on June 9th, three days after the ER visit, does not mean that she had symptoms on June 6th since myocardial infarctions can arise suddenly. Defendants further point out that the complaint does not claim departures in the treatment provided on June 10, 2016 or thereafter.

Dr. Starosta's endocrinologist, Irwin L. Klein, M.D. ("Dr. Klein"), averred that decedent was seeing Dr. Starosta for management of her uncontrolled diabetes in 2015. Her past medical history included hypertension, diabetes mellitus, anemia, kidney failure, obesity, and degenerative osteoarthritis of multiple joints. However, she resisted insulin injections. On June 6th, decedent presented to the ER with a chief complaint of left shoulder pain that worsened in the last month. She was given five units of insulin, prescribed Motrin and Robaxin, and was diagnosed with muscle spasms and hyperglycemia. She was discharged home. There were two indications in the ER chart that she had dyspnea, however this was not addressed at Maimonides. No EKG was conducted and there was no cardiac workup. Decedent left the ER and presented to Dr. Starosta's office that same day. Her only documented complaints were of abdominal discomfort and bloating. She advised Dr. Starosta that she went to the ER that day because she was out of her medications. Dr. Starosta performed a transabdominal sonogram, which was grossly normal. He also performed an echocardiogram which indicated left ventricular hypertrophy and mitral regurgitation, and a normal ejection fraction. His assessment was diabetes mellitus loosely controlled, generalized osteoarthritis and fibromyalgia. Dr. Starosta's plan was to rule out acute diabetic gastroparesis, thus he prescribed medication. According to Dr. Klein, Dr. Starosta's exam was appropriate based upon the complaints presented.

Dr. Starosta saw the decedent three days later, on June 9th, for clearance for oral surgery scheduled for June 10th. A sonogram of her venous lower extremities and an EKG were grossly normal. Decedent was cleared for dental surgery, and Dr. Klein opined that there were no departures on June 9th.

On June10th, decedent presented to the Maimonides ER complaining of shortness of breath and severe left shoulder pain. She was noted to have had a myocardial infarction and was

stented in the cardiac catheter lab. Dr. Klein opined that Dr. Starosta did not treat the decedent in the hospital therefore there were no departures on Dr. Starosta's behalf on June 10th.

Decedent was next seen by Dr. Starosta on June 20, 2016. Dr. Starosta noted that decedent had undergone an emergency angiogram on June10th for an acute myocardial infarction and that she was discharged on June 16th, with instructions to see Dr. Borgen within two weeks. He reviewed decedent's medications. She complained of fatigue and shortness of breath upon walking but denied chest pain or palpitations. Upon physical exam, decedent's blood pressure was 110/70 with a pulse of 88 bpm. No jugular vein distention was noted. Scattered rhonchi were heard at the bases of both lungs. Edema was noted in both lower extremities. Dr. Starosta's assessment indicated that decedent was status post-acute anterior wall myocardial infarction, acute systolic heart failure with an ejection fraction of less than 40%, status post PCI, (percutaneous coronary intervention, a non- surgical procedure that uses a catheter to place a stent to open blood vessels narrowed by plaque). He also noted that she had poorly controlled diabetes, chronic renal failure, anemia of chronic disease, obesity, and hypercholesterolemia. He did not note that decedent was in acute congestive heart failure at the time nor that she was having symptoms of ongoing coronary ischemia. He also did not note whether decedent had a LifeVest in place. Dr. Starosta continued the medications that decedent was prescribed at discharge, except he increased the Lasix from 20mg q.d. to 20mg b.i.d. Decedent was advised to schedule an appointment and follow up with her cardiologist.

Decedent died on the evening of June 20, 2016, after her visit with Dr. Starosta. No autopsy was performed, and no cause of death was listed on the death certificate. Dr. Starosta's internal medicine and cardiovascular disease expert, David A. Hess, M.D., opined that decedent did not have a significant change in her condition that would have required a repeat

hospitalization on June 20th. Her sugar and blood pressure were good; her pedal edema was a 1 or 2 plus, which was inconsistent with worsening heart failure. Although Dr. Starosta noted scattered rhonchi, this would not have been indicative of heart failure to support hospitalizing the decedent. There was no evidence of acute coronary ischemia since the decedent was not complaining of chest pain. There was no evidence of acute cardiac arrhythmias as the decedent was not complaining of palpitations, rapid or irregular heartbeats. She denied dizziness, lightheadedness, or syncope. Nor is there any proof that she had an acute pulmonary embolism, which is manifested by severe shortness of breath and sudden death. There is no evidence to confirm that this occurred, thus such claim is speculative. As there was no autopsy performed, the cause of death is unknown.

In opposition, plaintiff's expert in internal medicine and cardiovascular disease, Bruce Charash, M.D. ("Dr. Charash"), opined that Maimonides Medical Center, through its staff as well as Dr. Lobel deviated from accepted medical practice in their care and treatment of the decedent on June 6th and Dr. Starosta departed from accepted medical practice in his care and treatment of the decedent on June 6th, June 9th, and June 20th. Neither Maimonides nor Dr. Lobel obtained a complete and accurate history of the decedent. Additionally, Maimonides and Dr. Lobel failed to understand the significance of decedent's family history, and more specifically that her family history placed her at an increased risk for heart disease and suffering a heart attack. Since Dr. Lobel and Dr. Yetter reviewed decedent's records from her March 23, 2015 ER presentation they should have known of decedent's significant family history. Myocardial infarction, more commonly known as a heart attack, is the primary cause of death in diabetic patients. Over time, high blood pressure can damage blood vessels and the nerves that control the heart. It was a departure from accepted medical practice for Maimonides to fail to

perform an EKG when decedent was evaluated on June 6th. Her medical history of diabetes (as well as the other risk factors), her complaint of shoulder pain. and her very appearance in the ER should have prompted the performance of an EKG. Similarly, Dr. Lobel deviated from accepted medical practices when he did not order an EKG when he took over the care of decedent and was not provided with an EKG report. Further, decedent presented with acutely worsened left shoulder pain in the absence of trauma, hence there was no external basis for her shoulder pain. Shoulder pain can be an indicator of a heart attack. Dr. Charash opined that if an EKG had been performed at Maimonides on June 6th, it would have revealed ST depression and T wave abnormalities that would have then resulted in a complete cardiac workup and evaluation.

Dr. Charash opined that Dr. Starosta knew that decedent had an increased risk of coronary disease and heart attack. Although Dr. Starosta knew she was being treated by a cardiologist, he had no idea as to what diagnoses, if any, were made. While decedent began her treatment with Dr. Starosta as an endocrinologist, it was clear from the testing he performed that he was acting as her primary care physician. According to Dr. Starosta's chart, on June 6th, decedent informed him that she presented at the ER for pain in all her muscles and that she was diagnosed with muscle spasms and advised to seek a pain management physician. He found pain in both of her shoulders and noted abdominal discomfort and bloating. These findings should have been most concerning to Dr. Starosta since shoulder pain, abdominal discomfort, and bloating are indicators of heart attacks in women. Although Dr. Starosta denied having any cardiac concerns for the decedent on June 6th, he performed an echocardiogram and cardiac doppler study. He testified they were performed as a matter of course due to her diabetes and hypertension although he had been treating her for over a year and never performed these tests. He also performed an abdominal sonogram. Dr. Starosta was clearly concerned about her

symptoms since he performed these tests, and when the abdominal sonogram results were abnormal, Dr. Starosta deviated from accepted medical practice by failing to refer decedent back to the hospital for a cardiac workup.

Dr. Starosta performed an EKG on June 9th, as part of his dental clearance. Dr. Charash opined that the EKG showed abnormalities and Dr. Starosta failed to act within the standard of care. The findings suggested the presence of ischemic heart disease. Ischemia in the heart is caused by the presence of plaque which blocks or restricts blood flow, and thus oxygen, to the heart. Given decedent's complaints of shoulder pain for three days, her complaint of shortness of breath, her medical and family history, and the EKG findings, Dr. Starosta should have referred decedent to the hospital for immediate cardiac evaluation. Dr. Starosta departed from accepted medical practice in failing to send her to the hospital on June 9th. Dr. Charash further indicated that decedent was exhibiting signs and symptoms of a stuttering or impending heart attack on June 6th and June 9th, when she presented to Dr. Starosta, given her complaints of shoulder pain, shortness of breath as well as her elevated glucose levels. Dr. Charash contends that if a stuttering or impending heart attack is properly and timely diagnosed and treated, the patient can receive cardiac intervention before sustaining permanent heart damage.

Regarding the June 20th visit, Dr. Charash opined that Dr. Starosta found out that decedent had a recent heart attack and was given a LifeVest. Dr. Starosta knew or should have known that his patient also had drug-eluting stents. This information was in the Maimonides records, which Dr. Starosta testified to having reviewed, but he failed to understand the significance of the entries of DES (drug-eluting stent), having stated that decedent had stents placed years before - even though he never noted stents in the fourteen months that he treated her. Drug-eluting stents have a known complication of clotting, especially when the person has

diabetes. Dr. Charash posited that on June 20th, considering the decedent's presentation, accepted medical practice mandated that Dr. Starosta call for an ambulance to have her emergently transported to the hospital. Instead, he sent her home. This was a departure from accepted medical practice.

In this action, because no cardiac workup was performed on June 6th, there is no direct evidence to establish whether decedent was having a stuttering myocardial infarction or what an EKG would have shown on that date. However, in 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 defendant's deviation was a substantial factor in causing the injury. *Bilyavskiy v. Parikh*, 197 A.D.3d 605, 152 N.Y.S.3d 721 (2d Dept. 2021). "A plaintiff's evidence of proximate cause may be found legally sufficient … as long as evidence is presented from which the jury may infer that the defendant's conduct diminished the plaintiff's chance of a better outcome or increased [the] injury," *Grullon v. Thoracic Surgical, P.C.*, 208 A.D.3d 1163, 174 N.Y.S.3d 747 (2d Dept. 2022).

Here, the defendants established their prima facie entitlement to judgment as a matter of law through submission of, inter alia, affirmations of three physicians, who collectively opined that based on their review of the medical records, the care and treatment received by the decedent was in accordance with good and accepted standards of care. Notwithstanding the defendants' contentions, in opposition, the plaintiff raised triable issues of fact regarding, among other issues, the failure to perform additional diagnostic testing, the failure to perform a cardiac workup and the failure to immediately refer decedent to a cardiac disease specialist. *Sunshine v. Berger*, 214 A.D.3d 1020, 1023, 186 N.Y.S.3d 326, 329 (2d Dept. 2023). "Summary judgment is

not appropriate in a medical malpractice action where the parties adduce conflicting medical expert opinions." *Cerrone* v. *North Shore-Long Is. Jewish Health Sys., Inc.*, 197 A.D.3d 449, 152 N.Y.S.3d 147 (2d Dept. 2021).

The Court considered the parties' remaining contentions and found them unavailing. All relief not expressly granted is denied.

Accordingly, it is

ORDERED that the defendants' motions for summary judgment are in all respects denied, and it is further

ORDERED that plaintiff's counsel is directed to electronically serve a copy of this decision/order with notice of entry on the defendants' respective counsel and to electronically file an affidavit of service with the Kings County Clerk, and it is further

ORDERED that the parties shall appear for an Alternative Dispute Resolution conference on December 21, 2023, at 12:30PM.

The foregoing constitutes the decision and order of this Court.

ENTER

J.S.C.

HON. GENINE D. EDWARDS