

**Evans v New York Presbyt.-Brooklyn Methodist Hosp.**

2024 NY Slip Op 31716(U)

May 13, 2024

Supreme Court, Kings County

Docket Number: Index No. 504748/18

Judge: Genine D. Edwards

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At an IAS Term, Part 80 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 13<sup>th</sup> day of May 2024.

PRESENT:

HON. GENINE D. EDWARDS,

Justice.

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EBONY EVANS, as Administratrix of the Goods,  
Chattels and Credits of BARBARA VANN, deceased,

Plaintiff,

-against-

NEW YORK PRESBYTERIAN-BROOKLYN  
METHODIST HOSPITAL, HARRY ZINN, M.D.,  
and SAMIR FAHMY, M.D.,

Defendants.  
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DECISION AND ORDER

Index No. 504748/18

Mot. Seq. Nos. 4-6

The following e-filed papers read herein:

NYSCEF Doc Nos.:

Notice of Motion, Affirmations, and Exhibits.....93-103; 104-118, 148; 119-147  
Affirmations (Affidavits) in Opposition, and Exhibits..... 150-154; 155-164; 165-169  
Reply Affirmations and Exhibits.....170; 171-172

In this action to recover damages for medical malpractice and wrongful death, defendants New York Presbyterian-Brooklyn Methodist Hospital (Methodist), Harry Zinn, M.D. (Dr. Zinn), and Samir Fahmy, M.D. (Dr. Fahmy),<sup>1</sup> separately moved for summary judgment dismissing all claims of Ebony Evans, as Administratrix of the goods, chattels, and credits of her late mother, Barbara Vann (plaintiff). Plaintiff opposed each motion.

<sup>1</sup> During the relevant time, Drs. Zinn and Fahmy were employees of nonparty SUNY Downstate Medical Center/University Hospital of Brooklyn (SUNY).

## Chronology of Events<sup>2</sup>

### **December 16, 2016<sup>3</sup> (First Emergency Visit to Methodist)**

Plaintiff's decedent, Barbara Vann (the patient), age 62, presented to the emergency department (ED) at Methodist on December 16<sup>th</sup> with complaints of left-sided back/flank pain and abdominal pain which she had been experiencing for approximately 24 hours prior. Her presenting medical history was significant for sickle cell disease, obesity (she was 5'2" in height and weighed 230 pounds), blindness in her right eye, osteoporosis, vitamin D deficiency, and cervical radiculitis. Methodist's SOF, ¶ 1; plaintiff's SOF, ¶ 14.<sup>4</sup>

During the patient's December 16<sup>th</sup> visit to Methodist's ED, the patient's oxygen saturation was 99% on room air, and her respiratory rate at rest was within the normal range of 20 breaths per minute.<sup>5</sup> Her cardiovascular rate and rhythm, on physical examination, were

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<sup>2</sup> This section is a composite of: (1) Methodist's Statement of Undisputed Material Facts Pursuant to Uniform Court Rules 202.8-g, dated April 24, 2023 (Methodist's SOF); (2) Dr. Zinn's Statement of Material Facts, dated April 21, 2023 (Dr. Zinn's SOF); (3) Dr. Fahmy's Statement of Material Facts, dated April 25, 2023 (Dr. Fahmy's SOF); and (4) plaintiff's Statement of Material Facts Pursuant to Rule 202.8, dated June 30, 2023 (plaintiff's SOF), as modified or supplemented by the entries in the patient's medical records. When quoting from the patient's medical records, the Court spelled out all abbreviations and corrected typographical errors. All references to SUNY's records are to the uncertified version e-filed by Methodist under NYSCEF Doc No. 146, which, by page count and content, appears more complete than the certified, but shorter, version e-filed under NYSCEF Doc Nos. 101 and 114 by Dr. Zinn and Dr. Fahmy, respectively.

<sup>3</sup> Unless otherwise stated, all references to the month of December are to December 2016 and all references to the month of January are to January 2017.

<sup>4</sup> Methodist's objection that plaintiff's SOF failed to provide citations to support each of her factual statements as required under 22 NYCRR 202.8-g (4) was overruled by the Court as non-substantive. *See Taveras v. Incorporated Vil. of Freeport*, 225 A.D.3d 822, 207 N.Y.S.3d 620 (2d Dep., 2024).

<sup>5</sup> Plaintiff's statements (in ¶¶ 15, 21-22, and 26-27 her SOF) that the patient's respiratory rate of 20 breaths per minute was tachypneic (or excessive) were not supported by any expert opinion. According to Methodist's expert, emergency medicine specialist Jeffrey Glassberg, M.D. (in ¶ 18 of his affirmation), the patient's "breathing was normal as her respiratory rate was between 16-20 bpm [breaths per minute]."

regular with a normal peripheral perfusion and without edema. Her lungs were clear, and her respirations were non-labored. Methodist's SOF, ¶ 2.<sup>6</sup>

The patient received Toradol and Morphine for pain relief. A CT scan of her abdomen and pelvis (with IV contrast) was performed to rule out diverticulitis and nephrolithiasis.

Methodist's records at 003669. The CT scan results were generally unremarkable, with the exception of "mild atelectatic changes" at "[t]he lung bases."<sup>7</sup> Methodist's records at 003670.<sup>8</sup>

There was no evidence of diverticulitis, nephrolithiasis, urolithiasis, colitis, hydronephrosis, or pyelonephritis. There was no free fluid, free air, or abscesses. Although a gallstone was uncovered on the CT scan, the study showed no evidence of acute gallbladder disease.

Methodist's SOF, ¶ 3; plaintiff's SOF, ¶ 16.

The ED team in charge of the patient's care on December 16<sup>th</sup> concurred that the patient was suffering from back pain, lumbar strain and/or a kidney stone. During her stay in the ED, the patient was able to eat and drink. She was discharged home the same day with instructions to follow up with her primary care physician, to take Ibuprofen for pain, and to come back if her symptoms worsened. Methodist's SOF, ¶ 4.<sup>9</sup>

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<sup>6</sup> Plaintiff's unsupported statement (in ¶ 15 of her SOF) that "Dr. Todd Mundy [one of Methodist's ED physicians] testified that [the patient] reported and informed him of symptoms of fever" was doubly incorrect. Dr. Mundy did not examine the patient during her December 16<sup>th</sup> visit, and the patient did not complain of fever to anyone at the ED during her December 16<sup>th</sup> visit.

<sup>7</sup> "Atelectasis" means a "[d]ecrease or loss of air in all or part of the lung, with resulting loss of lung volume itself." Stedman's Medical Dictionary, entry 82320 "atelectasis" (online edition).

<sup>8</sup> Methodist's reference (in ¶ 3 of its SOF) to a general statement (at page 003664 of its records) that "[t]he CT . . . was unremarkable," was contradicted by the CT scan's specific finding of the "mild atelectatic changes" at "[t]he lung bases" (as was noted at page 003670 of Methodist's records).

<sup>9</sup> Whether the patient's discharge diagnosis should have been "back pain" (as plaintiff contended in ¶ 17 of her SOF), instead of "abdominal pain" (as was indicated in Methodist's records at page 003657), was immaterial.

**December 18<sup>th</sup> (Second Emergency Visit to Methodist)**

Two days later, on December 18<sup>th</sup>, the patient returned to Methodist's ED, with the complaint of persistent left-sided back/flank pain. The pain intensity, though fluctuating, increased by then to 9 out of a maximum of 10. She received Toradol for pain. Her physical examination was negative for chest pain, shortness of breath, cough, fever, nausea, or vomiting. Her oxygen saturation on room air was within the normal range of between 96% and 99%, with her respiratory rate (likewise within the normal range) at between 16 and 19 breaths per minute. Methodist's SOF, ¶ 5; plaintiff's SOF, ¶ 18.

The patient's cardiovascular rate and rhythm were normal on physical examination. Her lungs, on auscultation, were clear with equal breath sounds in each lung. Bloodwork was ordered. According to the ED physician's note (Ryan Natale, M.D.), the patient reported "history of well controlled sickle cell [disease] . . . and was just treated for crisis [in Methodist's ED] 2 days ago with similar sickle cell symptoms. Patient [told] [Dr. Natale] she really [did] not want to be admitted but would like more analgesia." Methodist's records at 003581. The patient received Percocet and Ibuprofen for pain (which was in addition to the already administered Toradol). The ED team's clinical impression was that the patient was experiencing a sickle cell crisis.<sup>10</sup> Methodist's SOF, ¶ 6; plaintiff's SOF, ¶ 19.

During the patient's December 18<sup>th</sup> stay in the ED, the team noted that her "pain greatly improved" and that she "want[ed] to go home." Methodist's records at 003584. Her bloodwork was reviewed and noted as unchanged. *Id.* With her condition being stable, she was cleared for

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<sup>10</sup> Sickle cell crisis is one or more "'crisis' episodes of severe pain due to microvascular occlusions, bone infarcts, leg ulcers, and atrophy of the spleen associated with increased susceptibility to bacterial infections, especially streptococcal pneumonia." Stedman's Medical Dictionary, entry 36830 "sickle cell anemia."

release. At discharge she was given a prescription for a three-day supply of Percocet and was instructed to follow up with hematology/oncology clinic, as well as with her primary care physician. Methodist's SOF, ¶ 7; plaintiff's SOF, ¶ 20.

### **December 21<sup>st</sup> (Third Emergency Visit to Methodist)**

Three days later on December 21, the patient returned to Methodist's ED with complaints of the persistent left-sided flank/back pain of 10/10. The pain was resistant to the previously prescribed at-home Percocet. She complained of the new onset of nausea. Methodist's records at 003417. The ED attending on duty, nonparty Todd Mundy, M.D. (Dr. Mundy),<sup>11</sup> diagnosed the patient as suffering from "[a]cute left-sided low back pain." The patient denied chest pain, shortness of breath, fever, chills, or dizziness. Methodist's SOF, ¶ 8; plaintiff's SOF, ¶ 21.

During the patient's December 21<sup>st</sup> visit, her oxygen saturation remained within the normal range of between 96% and 100% as well as her respiratory rate with a normal range of 18-20 breaths per minute.<sup>12</sup> Her cardiovascular rate and rhythm were normal. Her lungs were clear to auscultation, and her respirations were non-labored. The patient's presenting medical history reflected that the patient returned to Methodist's ED for the third time, each time complaining of "pain to [her] left side[,] [that was] suspected of being [a] sickle cell crisis."

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<sup>11</sup> The parties' differing characterizations of the status of Dr. Mundy as either a "non-party" (Methodist's version) or as "an employee/agent" (plaintiff's version) were immaterial in the patient's case because "a hospital may be held vicariously liable for the acts of independent physicians if the patient [as was the instance here] enter[ed] the hospital through the emergency room and [sought] treatment from the hospital, not from a particular physician." *Goffredo v. St. Luke's Cornwall Hosp.*, 194 A.D.3d 699, 143 N.Y.S.3d 597 (2d Dept. 2021).

<sup>12</sup> Contrary to plaintiff's contention (in ¶¶ 21 of her SOF), the patient did not, at the time, have "tachypnea (abnormal breathing)." Rather, the patient's respiration rate at the December 21<sup>st</sup> visit was within the normal range of between 18 and 20 breaths per minute. Methodist's records at 003416 and 003426.

Methodist's records at 003424 and 003428. Notwithstanding this presenting history, Dr. Mundy took a completely different approach to the patient's presentation by diagnosing her with a "? [questionable] zoster." Methodist's records at 003430. To that end, Dr. Mundy prescribed the patient an antiviral (Valtrex) and a steroid (Prednisone) for "Herpes Zoster." Methodist's records at 003418, 003422, 003430-003431. Dr. Mundy discharged the patient from the ED with instructions to follow up with her primary care physician and to come back if her symptoms worsened. Methodist's records at 003418; Methodist's SOF, ¶¶ 9-10; plaintiff's SOF, ¶¶ 22-23.<sup>13</sup>

#### **December 27<sup>th</sup> (Visit to the Primary Care Physician)**

On December 27<sup>th</sup>, the patient visited her primary care physician, nonparty Jean D'Augustine (Dr. D'Augustine), with complaints of lower back/left hip pain that worsened with movement. She informed him that she had recently gone to Methodist's ED for abdominal pain, and that her CT scan of the abdomen was negative for a mass. Upon physical examination, Dr. D'Augustine noted that the patient was not in acute distress, that her lungs were clear without wheezes, that her heart rate and rhythm were normal, and that she was clinically stable on presentation. Nonetheless, Dr. D'Augustine noted that the patient was

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<sup>13</sup> The parties' disagreement as to whether Dr. Mundy did (or did not) offer the patient to be admitted to Methodist during her December 21<sup>st</sup> visit must be resolved in plaintiff's favor (*i.e.*, that he did not offer her to be admitted during that visit). The reasons for the Court's conclusion were two-fold. First, nothing in Methodist's records (which were silent on the subject of the patient's admission) corroborated in any way Dr. Mundy's self-serving deposition testimony that he offered the patient to be admitted. Second, it was not the Court's "function on a motion for summary judgment . . . to resolve issues of fact or to determine matters of credibility." *Moonilal v. R.C. Church of St. Mary Gate of Heaven*, 225 A.D.3d 592, 206 N.Y.S.3d 686 (2d Dept. 2024). Rather, "[i]n determining a motion for summary judgment, evidence must be viewed in the light most favorable to the nonmoving party [*i.e.*, plaintiff here], and all reasonable inferences must be resolved in [her] favor." *Id.*

exhibiting tenderness in her left hip and lower mid-back, which he attributed to osteoarthritis or osteonecrosis. Methodist's SOF, ¶ 11; plaintiff's SOF, ¶ 24.<sup>14</sup>

#### **Early Morning of December 31<sup>st</sup> (Fourth and Final Emergency Visit to Methodist)**

At 2:44 am, on December 31<sup>st</sup>, the patient once again presented to Methodist's ED, with the complaint of generalized body pain of 8/10. After a preliminary assessment by the ED team, she was diagnosed with "back pain" and "pain [-] generalized," and was prescribed Toradol and Morphine. Methodist's records at 010157- 010158; Methodist's SOF, ¶ 12; plaintiff's SOF, ¶ 25.

At 5:09 am, the patient was examined by ED physician (and since-dismissed defendant) Eric Abrams, M.D. (Dr. Abrams).<sup>15</sup> Dr. Abrams obtained the patient's medical history and performed a review of her systems. Methodist's records at 010166. The patient complained to Dr. Abrams that she had been suffering from lower back pain for one week, but that, overnight to December 31<sup>st</sup>, her pain worsened and became "unbearable." Methodist's records at 010163 and 010182. According to the patient, she felt "as if she [was] having a [sickle cell] crisis." Methodist's records at 010182. Her pain was described in the medical chart as musculoskeletal in nature: "Back pain, Muscle pain, Joint pain." Methodist's records at 010182. The patient identified no other areas of pain in her body. Nor did she complain of chest pain, shortness of

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<sup>14</sup> It was unclear from the record what treatment (if any) Dr. D'Augustine provided to the patient during her December 27<sup>th</sup> visit. Dr. D'Augustine's "SOAP" note (with the word "SOAP" serving as the acronym for the "Subjective," "Objective," "Assessment," and "Plan" components of his note) – as included by Methodist in support of its motion – omitted the "Plan" component of his note. Plaintiff, in her opposition to Methodist's motion, failed to fill the gap that Methodist left.

<sup>15</sup> Plaintiff's claims as against Dr. Adams were discontinued by stipulation, dated July 2, 2018.

breath, coughing, nausea, vomiting, or dizziness. Methodist's SOF, ¶ 13; plaintiff's SOF, ¶ 26.<sup>16</sup>

During her December 31<sup>st</sup> visit, the patient's vitals were within the normal range. She did not have a fever, her oxygen saturation was 98%, and her respiratory rate remained within the normal range of 20 breaths per minute. Methodist's records at 010162, 010164, 010183, and 010184. After listening to the patient's lungs with a stethoscope, Dr. Abrams found that: (1) her "[b]reath sounds [were] equal; (2) she had a "[s]ymmetrical chest wall expansion"; (3) her "[r]espirations: [were] regular"; (4) her "[b]reath sounds [were heard in the] bilateral, anterior, posterior, upper lobe, middle lobe and base(s)" of her lungs; and (5) she had no "rales," "rhonchi," or "wheezes" present. Methodist's records at 010184. According to Dr. Abrams, the patient: (1) had a regular heart rate and rhythm; (2) had a normal peripheral perfusion without edema; and (3) exhibited "no costovertebral angle tenderness."<sup>17</sup> Methodist's records at 010184; Methodist's SOF, ¶ 14; plaintiff's SOF, ¶ 27.

Dr. Abrams concluded that his physical examination of the patient was "unremarkable," and that her laboratory values did not demonstrate "hemolysis."<sup>18</sup> Methodist's records at 010184. Nonetheless, Dr. Abrams was concerned by the fact that the patient had "require[ed]

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<sup>16</sup> As noted, plaintiff's contention that the patient was tachypneic (*i.e.*, that her respiration rate was excessive) during (among others) her December 31<sup>st</sup> visit was refuted by Methodist's records at 010162, 010164, and 010253.

<sup>17</sup> As Dr. Abrams explained (at page 177, lines 10-19 of his deposition transcript), a "costovertebral angle" represented "the angle [at] which the lower ribs meet the vertebrae; it's typically where the kidneys are located"; and that his phrase "no costovertebral angle tenderness" meant that he did not believe that "the patient's kidneys were inflamed."

<sup>18</sup> "Hemolysis" means an "[a]lteration, dissolution, or destruction of red blood cells in such a manner that hemoglobin is liberated into the medium in which the cells are suspended, *e.g.*, by specific complement-fixing antibodies, toxins, various chemical agents, tonicity, alteration of temperature." Stedman's Medical Dictionary, entry 401680 "hemolysis."

multiple doses of pain medication[s].” Methodist’s records at 010184. With that concern in mind, Dr. Abrams ordered two radiologic studies: (1) a chest X-ray; and (2) a CT scan (with IV contrast) of her abdomen/pelvis. The first radiologic study – the chest X-ray – found that the patient’s “[l]ung volumes [were] slightly decreased,” and that her “[l]ungs show[ed] increased patchy lower lobe bilateral airways/interstitial prominence.” Methodist’s records at 010191. The interpreting radiologist’s impression was that the “patchy lower lung predominant airway/interstitial prominence could [have] be[en] secondary to [the] mild edema or infectious/inflammatory disease.” Methodist’s records at 010191.

The patient’s second radiologic study – her abdominal/pelvic CT scan with IV contrast – found (as relevant to this case) that her “[l]ung bases show[ed] dependent ground[-]glass opacity bilaterally.” Methodist’s records at 010189. The interpreting radiologist’s impression was (as relevant to this case) a “[p]atchy bibasilar ground [-] glass opacity, potentially edema.”<sup>19</sup> Methodist’s records at 010190; Methodist’s SOF, ¶ 15; plaintiff’s SOF, ¶ 28. To Dr. Abrams, the findings/impressions of the aforementioned CT scan were “unremarkable.” Methodist’s records at 010185.

After the chest X-ray and the abdominal/pelvic CT scan were performed and interpreted, Dr. Abrams re-examined the patient. Upon re-examination, Dr. Abrams found that the patient was not in acute distress, was “resting comfortably,” and was “well-appearing.” Methodist’s records at 010185. The patient, meanwhile, received Benadryl 25 mg at 4:50 am, followed by Dilaudid (Hydromorphone) 1 mg (intravenously) at 6:37 am, and finished with

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<sup>19</sup> “Ground-glass pattern” or “ground-glass opacity” means a “radiographic or CT appearance of hazy opacity that fails to obscure pulmonary vascular markings.” Stedman’s Medical Dictionary, entry 662710 “ground-glass pattern.”

Percocet 5/325 at 8:31 am, in each instance, for pain/analgesia. Methodist's records at 010195-010198.<sup>20</sup> Although the patient was charted for discharge home at 7:45 am on December 31<sup>st</sup>, she was actually discharged at 9:06 am. *Compare* Methodist's records at 010159 with Methodist's records at 010169 and 010177. On discharge, the patient was instructed to follow up with her primary care physician or, if symptoms worsened, to return to Methodist's ED. That was the patient's last visit to Methodist. Methodist's records at 010166; Methodist's SOF, ¶ 16; plaintiff's SOF, ¶ 29.

**Late Evening of Dec. 31<sup>st</sup> to Early Morning, Jan. 2<sup>nd</sup> (Terminal Hospitalization at SUNY)**

Thirteen hours later at 10:11 pm on December 31<sup>st</sup>, the patient was brought by ambulance to nonparty SUNY, complaining of generalized body pain (with the onset at 6 pm) at 10/10, and generally appearing in "severe distress," as well as "crying due to pain." SUNY's records at 0001, 0013, and 0016. After receiving pain medications, she underwent two radiology studies; a chest X-ray and a pulmonary CT scan with contrast, known as CT angiography or CTA.

The first radiology study – a portable, one-view chest X-ray, taken at 1:20 am on Sunday, January 1<sup>st</sup> – found that the patient's lungs were clear, without pleural effusion, and without a large pneumothorax, with the overall impression of "[n]o airspace opacity." SUNY's records at 0018-0019.

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<sup>20</sup> Methodist's records were inconsistent as to whether the patient received Toradol (Ketorolac) and Morphine in addition to Dilaudid (Hydromorphone) and Percocet, during her December 31<sup>st</sup> visit. According to one section of Methodist's records, the initial plan to give the patient Toradol and Morphine (as was charted at 5:20 am and 4:51 am, respectively, on December 31<sup>st</sup>) was scrapped in favor of the subsequently administered Dilaudid and Percocet. Methodist's records at 010198. Conversely, the "Intake and Output" section of Methodist's records indicated that the patient received each of Dilaudid, Toradol, and Morphine in the 12-hour period from 8 pm to 8 am on December 31<sup>st</sup>. Methodist's records at 010257.

The second radiologic study – her pulmonary CTA – proved problematic in terms of its final radiologic interpretation. A preliminary report of the patient’s CTA, prepared between 1:19 am and 3:03 am on January 1, 2017, by radiology resident Kayla Cort, D.O. (Dr. Cort), concluded (and Dr. Cort so advised the patient’s medical team) that the patient was not suffering from pulmonary embolism (PE). SUNY’s records at 0019. Dr. Cort’s preliminary finding that the patient’s CTA was negative for PE was noted by the patient’s medical team in her chart at 3:15 am and again at 7:39 am. SUNY’s records at 0020. Proceeding on the basis of Dr. Cort’s preliminary finding of no PE, the patient’s medical team diagnosed her with: (1) a “[v]aso-occlusive sickle cell crisis”; (2) an “[a]cute flare of chronic primary osteoarthritis involving the lumbosacral spine”; and (3) “[h]ypoxia.” SUNY’s records at 0020-0023, 0025; Dr. Zinn’s SOF, ¶¶ 4-6; plaintiff’s SOF, ¶¶ 35-37.

At 4:34 am on January 1<sup>st</sup>, the patient was in pain on the scale of 7/10, despite the prior administration of Toradol and Morphine. SUNY’s records at 0053 and 0051. At 4:35 am on January 1<sup>st</sup>, the patient received another dose of Morphine. SUNY’s records at 0056-0057. At 7:46 am on January 1<sup>st</sup>, the patient complained of pain/discomfort in her left lower back, with the pain scores of 5/10 and 9/10 at rest and with activity, respectively. SUNY’s records at 0137. At 9:45 am on January 1<sup>st</sup>, her oxygen saturation was 95%, with a normal respiration rate of 20 breaths per minute, albeit on 3 liters of oxygen by nasal canula. SUNY’s records at 0150.

Later on January 1<sup>st</sup>, Dr. Cort’s preliminary finding that the patient had not been suffering from PE was overridden by radiology attending defendant Dr. Zinn. After Dr. Cort finished her night shift and departed from SUNY at 8 am, Dr. Zinn started his shift at 9 am. Dr. Zinn’s deposition tr at page 25, lines 15-16; Dr. Zinn’s SOF, ¶ 7; plaintiff’s SOF, ¶ 38.

Between 9 am and 1:12 pm on January 1<sup>st</sup> (the exact time being in dispute<sup>21</sup>), Dr. Zinn reviewed the patient's CTA images and added a "Major Addendum" to Dr. Cort's preliminary report, which, together with the Major Addendum, constituted the "Final Report." SUNY's records at 0046. Dr. Zinn's Major Addendum read in full as follows: "Several small subsegmental pulmonary emboli are seen in the lower lobes. There is no evidence of right heart strain." SUNY's records at 0046.<sup>22</sup> According to Dr. Zinn, it was "unlikely for a subsegmental [PE] to result in death," particularly (as was the instance here) in the absence of the "right heart strain." Dr. Zinn's deposition tr at page 65, lines 3-5 and 13-16. Nonetheless, Dr. Zinn acknowledged that the "[p]atient's chest pain/hypoxia was secondary to multiple subsegmental PEs in her lower lung[s]." Dr. Zinn's SOF, ¶ 9; plaintiff's SOF, ¶ 40.

In a comprehensive note timed at 2:43 pm on January 1, 2017, resident Michael Lin, M.D. (Dr. Lin), echoing Dr. Zinn's opinion, attributed the patient's chest pain and hypoxia as being "secondary to [her] subsegmental PE." SUNY's records at 0134-0135. Dr. Lin started the patient on the anticoagulation therapy in the form of Apixaban (Eliquis). SUNY's records at 0135. It appeared that the patient received her first dose of Apixaban at 1:00 pm STAT (or immediately). SUNY's records at 0250 (stating that Apixaban was last administered to the patient at 1:00 pm on January 1<sup>st</sup>).

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<sup>21</sup> Compare Dr. Zinn's SOF, ¶¶ 8 and 10 with plaintiff's SOF, ¶¶ 39 and 41. It was undisputed, however, that at least by 1:11 pm on January 1<sup>st</sup>, Dr. Zinn advised of his PE finding to a "Dr. Kochie [and the] Red [T]eam Medicine." SUNY's records at 0046.

<sup>22</sup> As Dr. Zinn explained, "the lung is broken up into *lobes*. So those [pulmonary emboli] would be a lobar pulmonary embolism, and then the lobes are [further] broken up into *segments*, like there's three segments in the upper lobe, and then if an embolism went into a vessel supplying an entire segment[,] it would be called a segmental embolism, and [a] *subsegmental* embolism is [even] smaller than that." Dr. Zinn's deposition tr at page 62, lines 6-16 (emphasis added).

At 2:08 pm, January 1<sup>st</sup>, the patient was given a stronger anticoagulant, known as Enoxaparin (Lovenox), initially at 40 mg. SUNY's records at 0247 (stating that Enoxaparin 40 mg was last administered to the patient at 2:08 pm on January 1<sup>st</sup>).<sup>23</sup>

At 9:31 pm, January 1<sup>st</sup>, the patient's Enoxaparin was increased to 150 mg. At that time, she received her first (and last) dose of Enoxaparin 150 mg. SUNY's records at 0269.<sup>24</sup>

By 10:09 pm on January 1<sup>st</sup>, the patient's cardio-pulmonary condition deteriorated. Her oxygen saturation was low at 92%, despite receiving oxygen at 4 liters per minute by nasal canula. SUNY's records at 0121.<sup>25</sup> By that time, rapid response/intervention (known as Code 66) was ongoing since 7 pm when the patient was discovered with altered mental status, as well as being sweaty/clammy. SUNY's records at 0121-0123. The patient's lactic acid level was elevated, and she was started on antibiotics. SUNY's records at 0122.

At 10:38 pm on January 1, the patient failed to respond to the administration of injectable Narcan (Naloxone). SUNY's records at 0306, 0082, 0098, 0101, 0109, and 0121.

At 10:44 pm on January 1<sup>st</sup>, the patient was intubated and connected to a ventilator. SUNY's records at 0079 and 0305.<sup>26</sup> Although connected to the ventilator, she remained in cardio-pulmonary distress, with the elevated pulse rate of 133, 116, and 129 beats per minute;

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<sup>23</sup> Dr. Zinn's and plaintiff's concurrence (in ¶¶ 12 and 43 of their respective SOFs) that "[a]t 10:09 pm, the patient was switched from . . . [Apixaban] Eliquis . . . to . . . [Enoxaparin] Lovenox 150 mg." was contradicted by SUNY's medical records cited herein.

<sup>24</sup> The records further reflected that the Apixaban-to-Enoxaparin change, as well as the Enoxaparin increase, both occurred on or before 10:09 pm on January 1<sup>st</sup> when the patient was transferred from ED 71 to the stepdown unit in NS-81, Room 815-b. SUNY's records at 0119-0120.

<sup>25</sup> Compare the patient's reading of oxygen saturation of 90% on 3 liters of supplemental oxygen per minute by nasal canula, respiration rate of 33 breaths per minute, and pulse rate at 128 beats per minute, as was noted in the 10:00 pm nursing note of January 1. SUNY's records at 0159.

<sup>26</sup> The timing of intubation at 10:44 pm was consistent with resident Kerri Barry, M.D.'s note, timed at 10:45 pm on January 1<sup>st</sup>. SUNY's records at 0157.

the elevated respiration rate of 26, 27, and 42 breaths per minute; and hypertension at 157/102, 162/65, and 154/? (systolic pressure only, no diastolic pressure), at midnight, 2:00 am, and 3:00 am on January 2<sup>nd</sup>, respectively. SUNY's records at 0169, 0171, and 0172-0173, respectively.

At 11:01 pm on January 1<sup>st</sup>, attending intensivist defendant Dr. Fahmy, accompanied by resident Gregory Smith, M.D. (Dr. Smith), was consulted by the patient's medical team regarding (among other issues) her admission to the Medical Intensive Care Unit (MICU). SUNY's records at 0113-0115. Dr. Fahmy's SOF, ¶¶ 1, 8; plaintiff's SOF, ¶¶ 1, 8.

Dr. Fahmy's assessment and plan were to continue managing the patient in the stepdown unit because "MICU [did] not have ample nursing staff [that] evening to take on another patient. [The MICU team would] follow peripherally and attempt to accept [the patient] in the morning." SUNY's records at 0113.<sup>27</sup> In the meantime, Dr. Fahmy recommended that the patient: (1) undergo a brain CT scan to rule out an intracranial bleed in light of the patient's altered mental status and, if the CT was negative for an intracranial bleed (as eventually turned out to be the case), to continue with anticoagulation for PE; (2) obtain a cardiology consultation for the patient's troponemia (elevated troponin); and (3) continue antibiotics. SUNY's records at 0113-0115. Dr. Fahmy's SOF, ¶ 11; plaintiff's SOF, ¶ 11.

At 3:07 am on January 2<sup>nd</sup>, a Propofol drip was started. SUNY's records at 0301. As noted, the patient remained connected to the ventilator since 10:44 pm the previous night.

At 3:20 am, the patient was seen by a cardiology resident. The assessment and plan from the cardiology viewpoint included: (1) a "type II myocardial infarction likely in the

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<sup>27</sup> That the patient was "accepted to [M]ICU level of care at that point" (SUNY's records at 0082) did not mean that she was admitted to the MICU. As noted, the MICU was short of nurses at the time due to the holiday.

setting of PE [and] respiratory distress/hypoxia”; (2) “? [questionable] acute chest syndrome”; (3) “continue full dose anticoagulation for PE”; (4) “add aspirin 325 x1 now and continue 81 mg [aspirin] daily”; (5) “cardiac monitoring”; and (6) “obtain [a] 2D echocardiogram in the morning.” SUNY’s records at 0103-104.

At 3:29 am on January 2<sup>nd</sup>, the patient desaturated to 89%, despite ventilator support at the maximum oxygen delivery. SUNY’s records at 0174. Her heart rate jumped to 159 beats per minute, while her blood pressure correspondingly fell to 114/63. SUNY’s records at 0174.

At 3:46 am on January 2<sup>nd</sup>, Code 99 was called after the patient went into a cardio-pulmonary arrest. SUNY’s records at 0078 and 0082. She could not be revived and was pronounced dead at 4:35 am on January 2<sup>nd</sup>. SUNY’s records at 0081; Dr. Fahmy’s SOF, ¶¶ 12-13; plaintiff’s SOF, ¶¶ 12-13.

The patient’s preliminary cause of death was attributed to the “[a]cute chest syndrome,” with the January 2<sup>nd</sup> onset. SUNY’s records at 0081; Dr. Zinn’s SOF, ¶ 16; plaintiff’s SOF, ¶ 47.<sup>28</sup> The “acute chest syndrome” was also her primary discharge diagnosis, with “apnea” having been assigned as her secondary discharge diagnosis. SUNY’s records at 0081. SUNY’s records reflected that the patient was on telemetry monitoring (meaning that she was in the stepdown unit) from 7:42 pm on January 1<sup>st</sup> until her death at 4:35 am on January 2<sup>nd</sup>. SUNY’s records at 0304.

### Litigation

On March 8, 2018 (as expanded on April 9, 2018), plaintiff, as the Administratrix and sole distributee of her mother’s estate, commenced this action for medical malpractice and

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<sup>28</sup> A certificate of the patient’s death was not included in the court record.

wrongful death as against (among others) Methodist, Dr. Zinn, and Dr. Fahmy (collectively, defendants). Each defendant joined issue.

While this action was pending, plaintiff filed a claim sounding in medical malpractice and wrongful death as against SUNY in the Court of Claims. *See Evans v State of NY*, Claim No. 131824.<sup>29</sup> By Stipulation of Settlement and Discontinuance, so-ordered on October 6, 2020, plaintiff settled her claims against SUNY for the total sum of \$500,000.00, inclusive of the satisfaction/compromise of the Medicaid and Medicare liens against the patient's estate. *See Evans v State of NY*, Claim No. 131824, NYSCEF Doc No. 31. As a condition precedent to her settlement with SUNY, plaintiff agreed to withdraw all her claims in this action as against SUNY's residents, including residents Drs. Cort, Lin, and Smith (collectively, the SUNY residents). *See* Stipulation of Settlement, page 1. To that end, this Court, on August 4, 2020, "so ordered" a Stipulation of Discontinuance with Prejudice as against the SUNY residents (NYSCEF Doc No. 72). Plaintiff's settlement with SUNY did not release or otherwise affect her claims as against the SUNY attending physicians Dr. Zinn and Dr. Fahmy. Nor did it affect her claims against Methodist.

After discovery was completed and a note of issue was filed, defendants each timely moved for summary judgment. The Court heard oral argument on February 14, 2024 and reserved decision.

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<sup>29</sup> The Court took judicial notice of the Court of Claims proceeding. *See Kingsbrook Jewish Med. Ctr. v. Allstate Ins. Co.*, 61 A.D.3d 13, 871 N.Y.S.2d 680 (2d Dept. 2009) ("the concept of [judicial notice] has been applied to . . . [the] undisputed court records and files") (internal citations omitted); *Matter of Khatibi v. Weill*, 8 A.D.3d 485, 778 N.Y.S.2d 511 (2d Dept. 2004) (same).

### Standard of Review

“The essential elements of medical malpractice are (1) a deviation or departure from accepted medical practice, and (2) evidence that such departure was a proximate cause of injury.” *DiMitri v. Monsouri*, 302 A.D.2d 420, 754 N.Y.S.2d 674 (2d Dept. 2003). “On a motion for summary judgment dismissing the complaint in a medical malpractice action, the defendant [medical provider] has the initial burden of establishing the absence of any departure from good and accepted medical practice or that the plaintiff was not injured thereby.” *Hayden v. Gordon*, 91 A.D.3d 819, 937 N.Y.S.2d 299 (2d Dept. 2012).

Where a defendant makes a prima facie showing, “the burden shifts to the plaintiff to demonstrate the existence of a triable issue of fact” as to the elements on which the defendant met the prima facie burden. *Donnelly v. Parikh*, 150 A.D.3d 820, 55 N.Y.S.3d 274 (2d Dept. 2017) (internal quotation marks omitted). “General and conclusory allegations of medical malpractice, however, unsupported by competent evidence tending to establish the essential elements of medical malpractice, are insufficient to defeat a defendant [medical provider’s] summary judgment motion.” *Myers v. Ferrara*, 56 A.D.3d 78, 864 N.Y.S.2d 517 (2d Dept. 2008). “In order not to be considered speculative or conclusory, expert opinions in opposition should address specific assertions made by the movant’s experts, setting forth an explanation of 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) (internal quotation marks omitted).

Moreover, “where a physician opines outside his or her area of specialization, a foundation must be laid tending to support the reliability of the opinion rendered.” *Shectman*

*v. Wilson*, 68 A.D.3d 848, 890 N.Y.S.2d 117 (2d Dept. 2009). Unless “such foundation is laid, the expert’s opinion is of no probative value, and is therefore insufficient to meet a party’s burden on a summary judgment motion.” *Laughtman v. Long Is. Jewish Val. Stream*, 192 A.D.3d 677, 143 N.Y.S.3d 97 (2d Dept. 2021).

### Discussion

#### Methodist

Methodist established its prima facie entitlement to judgment as a matter of law dismissing all claims insofar as asserted against it through the affirmation of its expert, emergency medicine specialist Jeffrey Glassberg, M.D. (Dr. Glassberg), who opined that, based on his review of the medical records, the deposition testimony, and the pleadings, Methodist did not depart from good and accepted medical practice in the care and treatment of the patient, and that no alleged act/omission on its part caused or contributed to her alleged injuries and subsequent death.<sup>30</sup> See e.g. *Xie v. New York City Health & Hosps. Corp.*, \_\_\_ A.D.3d \_\_\_, \_\_\_ N.Y.S.3d \_\_\_, 2024 N.Y. Slip Op. 01909 (2d Dept. 2024); *Revellino v. Haimovic*, 216 A.D.3d 687, 187 N.Y.S.3d 790 (2d Dept. 2023).

In opposition, the affirmation of plaintiff’s expert, a board-certified internal medicine physician with a sub-specialty in pulmonary medicine, lacked probative value because he (or she) failed to aver that he (or she) had any specific training or expertise in emergency medicine, or how he (or she) was, or became, familiar with the applicable standards of care in the specialized area of emergency medicine.<sup>31</sup> See *Corujo v. Caputo*, 224 A.D.3d 729,

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<sup>30</sup> Dr. Glassberg’s Expert Affirmation, dated April 24, 2023, ¶¶ 16-18, 20-32.

<sup>31</sup> Plaintiff’s Expert Affirmation, dated June 21, 2023, ¶ 1. The entirety of plaintiff’s expert’s qualifications was set forth in a single paragraph of his/her affirmation which stated as follows: “I am a physician duly licensed to  
(footnote continued)

205 N.Y.S.3d 174 (2d Dept. 2024); *Laughtman v. Long Is. Jewish Val. Stream*, 192 A.D.3d 677, 143 N.Y.S.3d 97 (2d Dept. 2021); *Samer v. Desai*, 179 A.D.3d 860, 116 N.Y.S.3d 377 (2d Dept. 2020); *Daniele v. Pain Mgt. Ctr. of Long Is.*, 168 A.D.3d 672, 91 N.Y.S.3d 496 (2d Dept. 2019).

In any event, the opinions of plaintiff's internal medicine (IM) expert with respect to Methodist were conclusory and speculative, as illustrated by the citations from his/her affirmation as reproduced in the margin.<sup>32</sup> See *Valentine v. Weber*, 203 A.D.3d 992, 161 N.Y.S.3d 850 (2d Dept. 2022); *Scopelliti v. Westmed Med. Group*, 193 A.D.3d 1009, 146 N.Y.S.3d 656 (2d Dept. 2021).

Further, plaintiff's IM expert failed to address the specific assertions of Methodist's emergency-medicine expert as to: (1) the signs/symptoms of PE (or, more accurately, the lack thereof as exhibited by the patient during each of her visits to Methodist's ED); and (2) the significance of (or, more accurately, the absence of the key) radiologic findings on the patient's chest X-ray and the CT scans performed at Methodist. See *Weintroub v. Maimonides Med. Ctr.*, 222 A.D.3d 915, 202 N.Y.S.3d 269 (2d Dept. 2023); *Lamalfa v. New York Methodist Hosp.*, 202 A.D.3d 665, 158 N.Y.S.3d 628 (2d Dept. 2022).

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practice medicine in the State of New York. I am board certified in Internal Medicine, and have a sub-specialty in Pulmonary Disease[.] I have evaluated and treated patients with sickle cell disease and acute chest syndrome and am fully familiar with the standard of care pertaining to their management and prognosis as well as the interpretation of radiological imaging of the chest."

<sup>32</sup> See Plaintiff's IM Expert Affirmation, ¶ 4 ("It was incumbent upon [Methodist] to order a PE computed tomography angiography . . . beginning with the [patient's] first visit to [Methodist] and on [her] each subsequent visit. . . ."); ¶ 9 ("Had [the patient] undergone the CTA during any of the visits to [Methodist], to a reasonable degree of medical certainty, it is more likely than not that the PE's would have been diagnosed and treated with anticoagulation and that her death could have been prevented."); ¶ 42 (reiterates ¶ 9 word for word) (emphasis added).

Lastly, the plaintiff's expert's overgeneralization that the potentially life-threatening complications of PE militated in favor of a CTA so much so that a CTA should have been performed at every visit to Methodist, was improperly based on hindsight reasoning.<sup>33</sup> See *Samer v. Desai*, 179 A.D.3d 860, 116 N.Y.S.3d 377 (2d Dept. 2020); *Ortiz v. Wyckoff Hgts. Med. Ctr.*, 149 A.D.3d 1093, 53 N.Y.S.3d 189 (2d Dept. 2017).<sup>34</sup>

### Dr. Zinn

As stated, Dr. Zinn was the attending radiologist at SUNY who, upon review of the CTA films on January 1<sup>st</sup>, discovered that the patient was suffering from a PE and so informed her medical team. The parties disputed as to when Dr. Zinn interpreted the CTA and relayed his PE finding to the patient's medical team. Dr. Zinn maintained that he relayed his PE finding to the patient's medical team at 9:33 am because Dr. Lin's note, entered at that time (*i.e.*, at 9:33 am) indicated that the CTA results had been amended to reflect the PE finding. SUNY's records at 0133.<sup>35</sup> Further relying on the 9:33 am entry time of Dr. Lin's note, Dr. Zinn's expert opined (in ¶ 19 of the Medical Affirmation of Douglas S. Katz, M.D., dated April 21, 2023) that "Dr. Zinn reported the findings of subsegmental PEs to the attending physicians within 33 minutes after the start of his shift at 9 am."

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<sup>33</sup> Assuming that a CTA had been performed on the patient during any of her Methodist visits, plaintiff's IM expert failed to address whether such CTA would have detected a thrombosis in situ (as distinguished from PE).

<sup>34</sup> Notably, plaintiff's IM expert, despite emphasizing the patient's obesity, failed to address whether she was (or might have been) suffering from fat emboli from the infarcted bone marrow, rather than from (or, alternatively, solely from) PE, at her last Methodist visit (or at any of her prior visits to Methodist during the month of December).

<sup>35</sup> As noted, the Court cited to the version of SUNY's records e-filed under NYSCEF Doc No. 146 (rather than to the shorter version e-filed under NYSCEF Doc No. 101 and upon which Dr. Zinn relied). Although the relevant content of the two versions was the same, their respective pagination differed.

It cannot be overlooked, however, that resident Dr. Lin signed his note four hours later at 2:438pm on January 1<sup>st</sup>. SUNY's records at 0135. Further, as plaintiff's expert radiologist pointed out (in ¶ 10 of his/her affidavit, dated June 22, 2023), Dr. Zinn dated his "Major Addendum" to the CTA at 1:12 pm. SUNY's records at 0046.

In any event, Dr. Zinn's separate contention (in ¶ 12 of his expert's affirmation) that he reviewed the patient's CTA at 11:38 am on January 1<sup>st</sup> was factually wrong because at that time he reviewed and approved resident Dr. Cort's interpretation of the patient's chest X-ray (rather than her CTA). SUNY's records at 0044-0045.

Under the circumstances, it would fall within the quintessential jury functions to resolve the questions of fact and credibility as to when Dr. Zinn reviewed the patient's CTA, when he relayed his PE finding to the patient's medical team, and what effect (if any) the alleged delay on Dr. Zinn's part caused or contributed to the patient's injuries and death. *See Canales v. Arichabala*, 123 A.D.3d 869, 1 N.Y.S.3d 140 (2d Dept. 2014); *Knutson v. Sand*, 282 A.D.2d 42, 725 N.Y.S.2d 350 (2d Dept. 2001).<sup>36</sup>

### **Dr. Fahmy**

As noted, Dr. Fahmy was the attending intensivist at SUNY who, accompanied by his resident Dr. Smith, examined the patient at bedside at 11:01 pm on January 1<sup>st</sup>. Dr. Fahmy (by way of the expert affirmation of Mark Silberman, M.D., who was quadruple board-certified in internal, pulmonary, emergency, and critical care medicine<sup>37</sup>) established, prima facie, his entitlement to judgment as a matter of law dismissing all claims as against him. *See Santiago v.*

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<sup>36</sup> Dr. Zinn's counsel interposed no reply affirmation in further support of his motion.

<sup>37</sup> Dr. Silberman's Expert Affirmation, dated April 23, 2023.

*Abramovici*, \_\_\_ A.D.3d \_\_\_, 208 N.Y.S.3d 289, 2024 N.Y. Slip Op. 01831 (2d Dept. 2024);  
*Coscia v. Mosca*, 203 A.D.3d 695, 164 N.Y.S.3d 198 (2d Dept. 2022).

In opposition, plaintiff failed to raise a triable issue of fact as to Dr. Fahmy. Plaintiff's IM expert's initial contention (in ¶ 75 of his/her affirmation) that Dr. Fahmy "fail[ed] to ensure the administration of a therapeutic dose of Lovenox [Enoxaparin] as soon as he was consulted on [the patient's] case" at 11:01 pm on January 1<sup>st</sup>, was refuted by SUNY's records which reflected that the patient received the proper dose of Lovenox (Enoxaparin) 150 mg at 9:31 pm, or approximately 1½ hours before Dr. Fahmy's involvement. SUNY's records at 0269.

Plaintiff's IM expert's further contention (also in ¶ 75 of his/her affirmation) that "[Dr. Fahmy] fail[ed] to ensure [that the patient] be monitored under intensive care unit conditions," was incorrect for two reasons. First, at the time of Dr. Fahmy's visit to the patient at 11:01 pm on January 1, the patient already had been under telemetry monitoring in the stepdown unit since 7:42 pm. SUNY's records at 0304. Second, Dr. Fahmy had no control over (and could not compel) the patient's immediate admission to the MICU until the holiday-related shortage of nurses in the MICU was administratively resolved. SUNY's records at 0113.

Plaintiff's IM expert's final contention (in ¶ 76 of his/her affirmation) that "[h]ad Dr. Fahmy ensured the proper administration of a therapeutic dose of Lovenox [Enoxaparin] as soon as he was consulted on [the patient's] case and ensured that she be monitored under intensive care unit conditions, [she] would have gained the last window of opportunity of proper treatment she needed," would require a jury to impermissibly speculate as to proximate cause. *See Huertas v. Town of Smithtown*, \_\_\_ A.D.3d \_\_\_, \_\_\_ N.Y.S.3d \_\_\_, 2024 N.Y. Slip

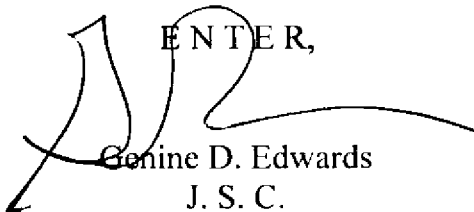


; and it is further

**ORDERED** that Methodist's counsel shall electronically serve a copy of this Decision and Order with notice of entry on the other parties' respective counsel and shall electronically file an affidavit of service thereof with the Kings County Clerk, and it is further

**ORDERED** that all parties shall appear for an Alternative Dispute Resolution Conference on June 13, 2024, at 10:00 a.m.

This constitutes the Decision and Order of the Court.

  
ENTER,  
Genine D. Edwards  
J. S. C.