At Part 80 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 20th day of September 2024.

P R E S E N T:

HON. GENINE D. EDWARDS,

Justice.

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SHARABA-MARIA GRANNUM,

Plaintiff,

- against -

KELLY J. HALSTEAD, M. D., and NEW YORK-PRESBYTERIAN BROOKLYN METHODIST HOSPITAL,

Defendants.

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DECISION AND ORDER

Index No. 523806/19

Mot. Seq. Nos. 4-5

The following e-filed papers read herein: NYSCEF Doc Nos.:

Notice of Motion/Cross Motion, Affirmations/Affidavits, and Exhibits 86-103; 112-131
Affirmations/Affidavits in Opposition. 110; 132
Reply Affirmations 135; 142; 143

In this action to recover damages for medical malpractice, lack of informed consent, and negligent hiring/supervision, Sharaba-Maria Grannum ("plaintiff") moves and New York-Presbyterian Brooklyn Methodist Hospital ("Methodist") cross-moves, respectively, for summary judgment. The remaining defendant, Kelly J. Halstead, M.D. ("Dr. Halstead"), did not move for summary judgment, nor did she take any position in connection with the instant motions. Plaintiff effectively abandoned her claims of lack of informed consent and negligent hiring/supervision as against Methodist. *See Clarke v. New York City Health & Hosps.*, 210 A.D.3d 631, 177 N.Y.S.3d 681 (2d Dept. 2022); *114 Woodbury Realty, LLC v. 10 Bethpage Rd., LLC*, 178 A.D.3d 757, 114 N.Y.S.3d

100 (2d Dept. 2019). The remainder of this Decision and Order addresses plaintiff's claims sounding in medical malpractice as against Methodist.

Background

Plaintiff's Hospitalization at Methodist from April 28, 2017 to May 2, 2017

Plaintiff, a private patient of Dr. Halstead, underwent an abdominal myomectomy at Methodist on April 28, 2017.[1] She was hospitalized at Methodist from the day of surgery on April 28th through May 2nd. At 6:42 PM on May 2nd, which was her fourth post-operative day, she was discharged home with instructions to follow up with Dr. Halstead as an outpatient. At discharge, Methodist sent to the wrong pharmacy the scripts for plaintiff's pain medications: Percocet 5/325 mg and Ibuprofen 600 mg ("Percocet" and "Ibuprofen," respectively).

Plaintiff's ER Visit to Methodist on May 3, 2017 (The Fifth Post-Operative Day)

At 12:05 PM on May 3rd, approximately eighteen hours after her discharge from Methodist, plaintiff returned by ambulance to Methodist's emergency room ("ER") with the principal complaint of severe abdominal pain on the scale of 10 of 10.[2] She had not taken her Percocet and Ibuprofen since the time of her discharge from Methodist

[1] All references are to calendar year 2017, unless otherwise indicated.

[2] Methodist's records for plaintiff's May 3rd ER visit (the "ER records"), pages 1, 3, 6, and 10 of 44. When quoting from medical records and the parties' expert submissions, the Court spelled out abbreviations and corrected typographical errors.

approximately 18 hours earlier because (as noted) the underlying scripts were sent to the wrong pharmacy.

Plaintiff's vital signs in the triage[3] were as follows: (1) she was tachycardic with the pulse of 112 beats per minute; (2) she was tachypneic with the respiration rate of 22 breaths per minute; and (3) her shock index (meaning her heart rate of 112 beats per minute, as divided by her systolic blood pressure of 109) was 1.03, which was outside the normal range of 0.5 to 0.7.[4] At 12:18 PM, she was triaged by nonparty nurse Elena Purnell ("Nurse Purnell") as an emergent case at the "recommended" ESI Level 2.[5] In the triage, Nurse Purnell ordered an "urgent EKG" for plaintiff.[6]

At 12:20 PM, plaintiff was briefly assessed (but was not examined) by nonparty ER attending Aric Kupper, M.D. ("Dr. Kupper"). He took umbrage with (and so documented) plaintiff's repeated refusal "to answer [his] questions about her pain until she receive[d] pain medications."[7] At 12:20-12:21 PM, Dr. Kupper ordered a double (or

[3] ER records, pages 7, 19, and 41 of 44.

[4] Affirmation of plaintiff's infectious diseases expert Alan J. Stein, M.D. ("Dr. Stein"), in Opposition to Methodist's Cross-Motion for Summary Judgment and in Reply to Methodist's Opposition to Plaintiff's Motion for Summary Judgment, dated January 16, 2024, ¶ 14. Because plaintiff first proffered Dr. Stein's affirmation in opposition to Methodist's cross-motion, the Court did not consider Dr. Stein's affirmation as part of her prima facie showing of entitlement to summary judgment.

[5] ER records, page 9 of 44.

[6] ER records, page 8 of 44.

[7] ER records, page 29 of 44 (Dr. Kupper's "Teaching-Supervisory Addendum-Brief" noting that "[plaintiff] [r]epeatedly declin[ed] to answer questions about her pain until she receives pain meds.").

two-tablet) dose of Percocet (instead of the standard dose of one tablet)[8] and the standard one-tablet dose of Ibuprofen,[9] all of which plaintiff took in the ER sometime between 12:21 PM and 12:31 PM. Dr. Kupper (on the basis of his brief assessment but without examining plaintiff) attributed both her severe pain as well as her concerning vital signs, exclusively to her lack of "pain medicine since leaving [Methodist the day prior,] secondary to [the] pharmacy [mix-up]."[10]

At 12:31 PM, plaintiff was examined by nonparty physician assistant Kamini Ramcharit ("PA Ramcharit").[11] Before examining plaintiff, PA Ramcharit, at 12:22 PM canceled Nurse Purnell's order for an urgent EKG.[12] Upon her physical examination, PA Ramcharit noted in the GI portion of the "review of systems" section that plaintiff was suffering from "abdominal pain."[13] PA Ramcharit's review of plaintiff's "other

[8] The one-time administration to plaintiff of two tablets of Percocet 5/325 (Oxycodone/Acetaminophen) equaled a total of 10 mg of Oxycodone and 650 mg of Acetaminophen. The combination of 10 mg of Oxycodone and 650 mg of Acetaminophen was the maximum single-tablet strength of Oxycodone/Acetaminophen then in production. *See* Prescribing Information for Percocet, as approved in 2006 by the Federal Drug Administration (available at https://www.accessdata.fda.gov/drugsatfda_docs/label/2006/ 040330s015,040341s013,040434s003lbl.pdf [last accessed September 3, 2024]).

[9] ER records, pages 15, 38, and 39 of 44. The single order for the double, two-tablet dose of Percocet appeared on pages 19, 31, and 39 of the ER records.

[10] ER records, pages 5 and 17 of 44 (Dr. Kupper's "ED Brief Initial Assessment").

[11] ER records, pages 18-20 of 44 (PA Ramcharit's "ED Note PA/NP"). Plaintiff, while in the ER, was not seen or examined by any resident physician. It appeared that PA Ramcharit, as a physician's assistant, functioned in place of a resident physician or nurse practitioner in the ER. *See* ER records, page 22 of 44.

[12] ER records, pages 15 and 34 of 44.

[13] ER records, page 18 of 44.

systems . . . [was] otherwise negative."[14] PA Ramcharit confined the "differential diagnosis" portion of her examination note to the single diagnosis of "[a]bdominal pain, status post-myomectomy."[15]

Approximately one hour later, at 1:35 PM, PA Ramcharit revisited plaintiff at bedside and documented the following: "[plaintiff's] pain is relieved, [plaintiff] states she feels better, still has mild pain, wound looks well, steri-strips in place, no discharge."[16] PA Ramcharit's "impression and plan" was "[a]bdominal pain (ICD10-CM R10.9, Discharge, Medical)," with "R10.9" indicating "unspecified abdominal pain" under the ICD10-CM classification.[17]

At 1:42 PM, approximately one hour after taking her double dose of Percocet, as augmented by Ibuprofen, plaintiff's vital signs were re-measured, as follows: (1) she was still tachycardic with the pulse of 100 beats per minute; (2) she was no longer tachypneic because her respiration rate was then at 19 breaths per minute (which was at the cusp of the upper range of 20 breaths per minute for the normal respiration rate); (3) she was then hypertensive (on the systolic side) at 134/74; and (4) her shock index

[14] ER records, page 18 of 44.

[15] ER records, page 19 of 44.

[16] ER records, page 19 of 44.

[17] ER records, page 20 of 44.

(meaning her heart rate of 100 beats per minute, divided by her systolic blood pressure of 134) was 0.75, which was still outside the normal range of 0.5 to 0.7.[18]

At 2:11 PM, PA Ramcharit discharged plaintiff home with instructions to follow up with Dr. Halstead in three to five days.[19] According to PA Ramcharit, plaintiff's condition at the time of discharge was "stable."[20] Concurrently with plaintiff's discharge, PA Ramcharit sent, to the appropriate pharmacy, the new scripts for Percocet at the standard dose of one (not two) tablets every six hours for five days, and for Ibuprofen at the standard dose of one tablet four times per day for ten days.[21] Subsequently, Dr. Kupper appended an addendum to PA Ramcharit's note concurring with the latter's assessment that: (1) plaintiff's abdominal pain was solely surgery-related; (2) her ER visit was due exclusively to the pharmacy mix-up at discharge resulting in her not having pain medications readily available; and (3) no work-up of any type was required before her discharge.[22] Plaintiff's total stay at Methodist's ER on May 3rd lasted approximately two hours from 12:05 PM to 2:11 PM.[23]

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[18] ER records, page 41 of 44.

[19] ER records, pages 12-14, 20, 24-26, and 28 of 44. Plaintiff acknowledged (by signature) her ER discharge instructions at 2:11 PM. PA Ramcharit's discharge instructions from Methodist's ER included a copy of the identical post-myomectomy care instructions that plaintiff received upon discharge from Methodist the day before.

[20] ER records, page 20 of 44.

[21] ER records, pages 11, 16, and 38-39 of 44.

[22] ER records, page 29 of 44.

[23] ER records, page 1 of 44.

The Aftermath (The Eighth and Ninth Post-Operative Days)

May 4th and May 5th passed uneventfully, with plaintiff staying home and taking her Percocet with Ibuprofen. At 2:31 PM, on May 6th, the eighth post-operative day, plaintiff arrived, by ambulance, at nonparty Brookdale University Hospital ("Brookdale"), following a "sudden onset of acute abdominal pain that started at 5 am [on May 6th, and] resolved status-post [pain medication,] and recurred at 9 am. [Plaintiff] described the pain as epigastric, 10/10, constant, 'gas-like,' radiat[ing] bilaterally to [both] sides with dysuria."[24] In Brookdale's ER, plaintiff received "a total of 6 doses of pain medication[s,] including [K]etamine, [D]ilaudid, [M]orphine, and [T]oradol," before she could even be examined.[25] A contrast-enhanced abdominal/pelvic CT scan "reveal[ed] a transmural defect through the posterior wall of the uterus with large[,] well defined adjacent air-containing fluid collection[,] presumably abscess[,] extensive fluid and air throughout the abdominal cavity with diffuse peritonitis."[26] On the morning of May 7th, which was the ninth post-operative day, plaintiff underwent an exploratory laparotomy with the post-operative diagnoses of

[24] Brookdale's records, page 1165. Dysuria is defined as "[d]ifficulty or pain in urination." Stedman's Medical Dictionary, Entry No. 275670 (online edition).

[25] Brookdale's records, page 1166.

[26] Brookdale's records, page 1166. Peritonitis is the "[i]nflammation of the peritoneum." Peritoneum, in turn, is defined as "[t]he serous sac, consisting of mesothelium and a thin external layer of irregular connective tissue, that lines the abdominopelvic cavity and covers most of the viscera contained therein; it forms two sacs: the peritoneal (or greater) sac and the omental bursa (lesser sac) connected by the omental foramen." Stedman's Medical Dictionary, Entry Nos. 673150 and 673080, respectively.

"[d]iffuse abdominal and pelvic peritonitis; [n]o perforation identified."[27] The operative report indicated, in relevant part, "[n]o specific identifiable source of perforation noted, consistent with a surgical peritonitis."[28] The operative report further stated, "[o]f note, [the] Pfannenstiel wound [*i.e.*, the initial incision that Dr. Halstead made for the abdominal myomectomy] [was] found to be draining upon closure of the midline incision; [the wound was] tunneling 10 cm to the left and 8 cm to the right – packed by [Brookdale's] general surgery team."[29]

Approximately one month later, on June 8th, plaintiff was discharged home from Brookdale. Her discharge diagnoses were as follows: (1) peritonitis; (2) uterine abscess; (3) post-operative intra-abdominal abscess; (4) lower abdominal pain; (5) perforation of uterus; and (6) sepsis.[30] The subsequent course of plaintiff's medical complications is not relevant at this stage of litigation.

On October 31, 2019, plaintiff commenced the instant action against (as relevant herein) Methodist, alleging that it was medically negligent (or was vicariously liable, as applicable) in connection with: (1) her hospitalization at Methodist from April 28th through May 2nd (the "hospitalization claim"); and (2) her ER visit to Methodist on May

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[27] Brookdale's records, pages 242 and 243.

[28] Brookdale's records, page 242.

[29] Brookdale's records, page 242.

[30] Brookdale's records, page 1167.

3rd (the "ER-visit claim"). After discovery was completed and a note of issue was filed, both plaintiff and Methodist timely moved and cross-moved, respectively, for summary judgment. On April 5, 2024, the Court took both motions on submission and reserved decision. The recitation of the well-established summary-judgment standard of review in medical malpractice cases is omitted from this Decision and Order in the interest of brevity. Additional facts are stated when relevant to the discussion below.

Discussion

Plaintiff's Hospitalization Claim

Methodist made a prima facie showing of its entitlement to judgment as a matter of law by submitting an affirmation of its obstetrician, Gary L. Mucciolo, M.D. ("Methodist's expert obstetrician"), who opined that, for the hospitalization at issue from April 28th through May 2nd, Methodist did not depart from the accepted standard of care and that, in any event, any alleged departures were not a proximate cause of plaintiff's injuries. *See Belotti v. North Westchester Hosp.*, ___ A.D.3d ___, ___ N.Y.S.3d ___, 2024 N.Y. Slip Op. 04121 (2d Dept. 2024); *Starre v. Dean*, 229 A.D.3d 728, 215 N.Y.S.3d 490 (2d Dept. 2024). Methodist's expert obstetrician further opined that Methodist's employees acted under the supervision and control of Dr. Halstead (who was plaintiff's private attending physician), that Dr. Halstead's orders were not contraindicated, and that Methodist did not commit any independent acts of negligence.

See Pezulich v. Grecco, 206 A.D.3d 827, 169 N.Y.S.3d 680 (2d Dept. 2022); *Doria v. Benisch*, 130 A.D.3d 777, 14 N.Y.S.3d 95 (2d Dept. 2015). In opposition, plaintiff failed to raise a triable issue of fact in connection with her hospitalization claim. *See Ciceron v. Gulmatico*, 220 A.D.3d 736, 197 N.Y.S.3d 564 (2d Dept. 2023); *Bhuiyan v. Germain*, 211 A.D.3d 667, 179 N.Y.S.3d 339 (2d Dept. 2022).[31]

Plaintiff's ER-Visit Claim

Neither party is entitled to summary judgment with respect to plaintiff's ER-visit claim. As to the departure element of plaintiff's ER-visit claim, there were triable issues of fact (as raised by the parties' competing expert opinions in the fields of emergency medicine, obstetrics, and infectious diseases) as to whether PA Ramcharit and Dr. Kupper (collectively, the "ER providers") departed from the applicable standard of care by failing (before discharging plaintiff from Methodist's ER on May 3rd) to: (1) consider infection as part of her differential diagnosis; (2) check the results of her white blood cell counts from her immediately preceding hospitalization at Methodist;[32] (3) perform a pelvic examination (in particular, an internal pelvic bimanual examination); (4) order laboratory work with complete blood count; (5) consult with Dr. Halstead

[31] Plaintiff, in effect, did not contest dismissal of her hospitalization claim because her experts exclusively addressed her ER-visit claim.

[32] Dr. Kupper's deposition transcript, page 98, lines 4-5 (testifying that it typically took "probably between 30 to 60 seconds" "to get to [a patient's] labs [and] to review them" from the patient's prior hospitalization).

and/or another obstetrician while she was still in the ER; (6) have plaintiff undergo an abdominal and pelvic CT scan; and, most fundamentally, (7) diagnose plaintiff with an infection (or infections) which (according to plaintiff's experts but vigorously disputed by Methodist's experts) she was suffering from at the time.

Further, as to the causation element of plaintiff's ER-visit claim, there were also triable issues of fact (as raised by the parties' competing expert opinions) as to whether plaintiff's *uterine* infection – assuming that such an infection existed and had been diagnosed during her ER visit to Methodist on May 3rd – could have been confined to her uterus (by way of an intravenous treatment with systemic antibiotics and/or performing an urgent surgical intervention) and thereby stopped from spreading to her peritoneum and abdominal cavity (which, in turn, caused peritonitis and sepsis); and whether plaintiff was suffering from a *pelvic* MRSA-type of infection since her April 28th surgery and, if so, whether the ER providers' failure to diagnose plaintiff with the MRSA during her May 3rd ER visit caused and/or contributed to the progression of such infection to peritonitis and sepsis.[33]

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[33] As plaintiff's infectious-diseases expert explained (in ¶¶ 16-19 of his affirmation in opposition to Methodist's motion):

[¶ 16] "The culture of MRSA obtained at Brookdale was of bodily fluid, indicating infection deep within the abdomen/pelvis and not on the skin, as opined by [Methodist's infectious-disease expert]. . . .

[¶ 17] A patient with MRSA bacteremia (bacteria in the blood) for instance, would rapidly become septic; [plaintiff] fortunately was not bacteremic; her infection development was totally consistent with a developing post-operative pelvic abscess. . . .

[¶ 18] [A healthcare provider] prescribes broad spectrum antibiotics empirically and immediately to cover the most

(footnote continued)

"Summary judgment is not appropriate in a medical malpractice action where the parties adduce conflicting medical expert opinions." *Ivey v. Mbaidjol*, 202 A.D.3d 1070, 163 N.Y.S.3d 589 (2d Dept. 2022) (internal quotation marks omitted). "Such credibility issues can only be resolved by a jury." *Feinberg v. Feit*, 23 A.D.3d 517, 806 N.Y.S.2d 661 (2d Dept. 2005). Likewise, "[w]hether a diagnostic delay affected a patient's prognosis is typically an issue that should be presented to a jury." *Wiater v. Lewis*, 197 A.D.3d 782, 153 N.Y.S.3d 176 (2d Dept. 2021).

It should be noted that this Court did not consider the exhibits annexed to the reply affirmations. *Pena v. Geisinger Community Medical Center*, 209 A.D.3d 663, 174 N.Y.S.3d 873 (2d Dept. 2022).

The Court considered the parties' remaining contentions and found them either moot or without merit in light of its determination. All relief not expressly granted is denied.

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likely organisms, and then adjusts the coverage once the causative pathogen(s) is [or are] identified. The bacteriology of postoperative pelvic infections is well known and includes MRSA. Thus, [broad spectrum] antibiotics effective against MRSA such as Vancomycin would typically be included in an empirical antibiotic regimen for a post-operative pelvic infection. . . .

[¶ 19] The consequence of not timely starting empiric antibiotics on May 3rd . . . resulted in progression of a pelvic infection to an abscess and associated peritonitis causing major damage to [plaintiff] and necessitating two years of surgeries because of the difficulty in eradicating the deep-seated damages of this infection."

Conclusion

Based on the foregoing, it is

ORDERED that plaintiff's motion for partial summary judgment on the issue of liability as against Methodist is denied in its entirety, and it is further

ORDERED that Methodist's cross-motion for summary judgment is granted to the extent that: (1) plaintiff's claims grounded on lack of informed consent and negligent hiring/supervision as against Methodist are dismissed without opposition; (2) plaintiff's medical malpractice claim as against Methodist, to the extent that such claim is predicated on her hospitalization at Methodist from April 28, 2017 through May 2, 2017, is dismissed; and the remainder of Methodist's cross-motion is denied, and it is further

ORDERED that, to avoid doubt, plaintiff's medical malpractice claim as against Methodist shall proceed, and remains unaffected, to the extent such claim is predicated on her emergency room visit at Methodist on May 3, 2017, and it is further

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

ORDERED that the parties are directed to appear virtually for an Alternative Dispute Resolution Conference on October 31, 2024, at 12PM.

This constitutes the Decision and Order of the Court.

ENTER,

Hon. Genine D. Edwards
J. S. C.