Bernstein v Dinulescu

2008 NY Slip Op 30786(U)

March 12, 2008

Supreme Court, Nassau County

Docket Number: 8329-05/

Judge: Daniel R. Palmieri

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[* 1]

SHORT FORM ORDER

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NASSAU

Present:

HON. DANIEL PALMIERI
Acting Justice Supreme Court

---x

ISIDORE BERNSTEIN, as Executor of the Estate of RHODA BERNSTEIN,

Plaintiff,

-against-

STEFAN DINULESCU, M.D., COLIN J. POWERS M.D., ALAN T. SLEPIAN, M.D., LEE A. POMERANZ, M.D., and NORTH SHORE UNIVERSITY HOSPITAL AT SYOSSET,

Defendants.

---x

TRIAL TERM PART: 48

INDEX NO.: 18329/05

MOTION DATE:10-30-07
SUBMIT DATE:2-15-08
SEQ. NUMBER - 001

MOTION DATE: 10-31-07
SUBMIT DATE: 2-15-08
SEQ. NUMBER - 002

MOTION DATE: 11-27-07
SUBMIT DATE: 2-15-08
SEQ. NUMBER - 003

MOTION DATE: 11-21-07
SUBMIT DATE: 2-15-08
SEQ. NUMBER - 004

The following papers have been read on this motion:

Notice of Motion, dated 10-5-07..1
Notice of Motion, dated 10-10-07..2
Notice of Motion, dated 11-2-08..3
Notice of Motion, dated 10-24-08..4
affirmation in Opposition, dated 1-9-08...5
Reply Affirmation, dated 1-21-08...6
Physician's Affirmation (Dr. Robert Solomon, M.D.), dated 12-30-07......7
Physician's Affirmation (Dr. Eric Munoz, M.D.),dated 1-3-08..................8
Reply Affirmation, dated 2-14-08...9

This motion by defendant Lee A. Pomeranz, M.D., for an order pursuant to CPLR 3212 granting him summary judgment dismissing the complaint against him is granted, without opposition.

This motion by defendant Alan Slepian, M.D., for an order pursuant to CPLR 3212 granting him summary judgment dismissing the complaint against him is granted.

This motion by defendant Stefan Dinulescu, M.D., for an order pursuant to CPLR 3212 granting him summary judgment dismissing the complaint against him is denied.

This motion by plaintiff for an order pursuant to CPLR Article 16 precluding any defendant(s) from pursuing the benefits of Article 16 against any defendant against whom the complaint has been dismissed is granted, without opposition.

The plaintiff in this action seeks to recover damages for the wrongful death of Rhoda Bernstein. The decedent was admitted to defendant North Shore University Hospital at Syosset by Dr. Dinulescu on February 13, 2005 complaining of stomach pain. She died as the result of mesenteric ischemia on February 16, 2005, several hours after she was diagnosed with a small bowel obstruction.

Three of the defendant doctors seek summary judgment dismissing the complaint.

The law relevant to these motions is well established.

"On a motion for summary judgment pursuant to CPLR 3212, the proponent must make a *prima facie* showing of entitlement to judgment as a matter of law, tendering sufficient evidence to demonstrate the absence of any material issues of fact." *Sheppard-Mobley v King*, 10 AD3d 70, 74 (2d Dept. 2004), *aff'd. as mod.*, 4 NY3d 627 (2005), *citing Alvarez v Prospect Hosp.*, 68 NY2d 320, 324 (1986); *Winegrad v New York Univ. Med. Ctr.*, 64 NY2d 851, 853 (1985). "Failure to make such *prima facie* showing requires a denial of the motion, regardless of the sufficiency of the opposing papers."

Sheppard-Mobley v King, supra, at p. 74; *Alvarez v Prospect Hosp., supra*; *Winegrad v New York Univ. Med. Ctr., supra*. Once the movant's burden is met, the burden shifts to the opposing party to establish the existence of a material issue of fact. *Alvarez v Prospect Hosp., supra*, at p. 324. The evidence presented by the opponents of summary judgment must be accepted as true and they must be given the benefit of every reasonable inference. *See, Demishick v Community Housing Management Corp.*, 34 AD3d 518 (2d Dept. 2006), *citing Secof v Greens Condominium*, 158 AD2d 591 (2d Dept. 1990).

"The requisite elements of proof in a medical malpractice action are a deviation or departure from accepted practice and evidence that such departure was a proximate cause of injury or damages." *Perro v Schappert*, 47 AD3d 694, (2nd Dept. 2008), *citing Anderson v Lamaute*, 306 AD2d 232 (2nd Dept. 2003); *DiMitri v Monsouri*, 302 AD2d 420, 421 (2d Dept. 2003). "On a motion for summary judgment in a medical malpractice action, a defendant doctor has the burden of establishing the absence of any departure from good and accepted medical practice or that the plaintiff was not injured thereby." *Shahid v New York City Health & Hospitals Corp.*, 47 AD2d 800, *citing Rebozzo v Wilen*, 41 AD3d 457, 458 (2nd Dept. 2007); *Thompson v Orner*, 36 AD3d 791, 791-792 (2nd Dept. 2007); *Williams v Sahay*, 12 AD3d 366, 368 (2nd Dept. 2006). Once the defendant doctor establishes his entitlement to summary judgment, the burden shifts to the plaintiff to establish the existence of a triable issue of fact. *Shahid v New York City Health & Hospitals Corp., supra, citing Alvarez v Prospect Hosp.*, 68 NY2d 320, 324 (1986).

In that regard, "[t]o establish a *prima facie* case of medical malpractice, a plaintiff must establish that the physician's actions deviated from accepted medical practice and

that such deviation proximately caused his or her injuries." *Flaherty v Fromberg*, 46 AD3d 743, 745 (2nd Dept. 2007), *citing Thompson v Orner, supra*; *Texter v Middletown Dialysis Ctr., Inc.*, 22 AD3d 831 (2nd Dept. 2005); *Prete v Rafla-Demetrious*, 224 AD2d 674, 675 (2nd Dept. 1996). "To meet this burden, a plaintiff ordinarily presents expert testimony on the defendant's deviation from the requisite standard of care." *Flaherty v Fromberg, supra*, at p. 745, *citing Texter v Middletown Dialysis Ctr., Inc.*, 22 AD3d 831 (2nd Dept. 2005). "To establish proximate cause, the plaintiff must demonstrate '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." *Flaherty v Fromberg, supra*, at 745, *quoting Johnson v Jamaica Hosp. Med. Ctr.*, 21 AD3d 881 (2nd Dept. 2005); *Holton v Sprain Brook Manor Nursing Home*, 253 AD3d 852 (2nd Dept. 1998). "[T]he plaintiff's evidence may be deemed legally sufficient even if its expert cannot quantify the extent to which the defendant's act or omission decreased the plaintiff's chance of a better outcome or increased his injury 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 his injury." *Flaherty v Fromberg, supra*, at 745, *citing Barbuto v Winthrop Univ. Hosp.*, 305 AD2d 623, 624 (2nd Dept. 2003); *Wong v Tong*, 2 AD3d 840, 840-841 (2nd Dept. 2003); *Jump v Facelle*, 275 AD2d 345, 346 (2nd Dept. 2000). Accordingly, all that is required to establish the existence of a factual issue regarding proximate cause is evidence from which "a jury can infer that it was probable that some diminution in the chance of survival . . . occurred." *Jump v*

Facelle, supra, at p. 346, *citing Mortensen v Memorial Hosp.*, 105 AD2d 151 (1st Dept. 1984); *Provost v Hassam*, 256 AD2d 875 (3rd Dept. 1988); *Fridovich v David*, 188 AD2d 984 (3rd Dept. 1992).

When grounded on facts in the record, conflicting experts' opinions establish the existence of an issue of fact. *Feinberg v Feit*, 23 AD3d 517 (2nd Dept. 2005), citing *Shields v Baktidy*, 11 AD3d 671 (2nd Dept. 2004); *Barbuto v Winthrop Univ. Hosp.*, *supra*.

However, "[t]here is no basis for liability for medical malpractice unless the injured party can establish that he or she had a physician-patient relationship with the medical provider, as there is no legal duty in the absence of such a relationship." *Garofalo v State of New York*, 17 AD3d 1109, 1110 (4th Dept. 2005) *citing Gedon v Bry-Lin Hosps.*, 286 AD2d 892, 893-894 (2001), lv den. 98 NY2d 601 (2002); *Megally v LaPorta*, 253 AD2d 35, 40 (2d Dept. 1998). "Such a relationship 'is created when the professional services of a physician are rendered to and accepted by another person for the purposes of medical or surgical treatment.' " *Garafalo v State of New York*, 17 AD3d 1109, 1110 (4th Dept. 2005) *citing Lee v City of New York*, 162 AD2d 34, 36 (1990), lv den. 78 NY2d 863 (1991). "An implied physician-patient relationship can arise when a physician gives advice to a patient, even if the advice is communicated through another health care professional." *Quirk v Zuckerman*, 196 Misc.2d 496, 499 (Supreme Court Nassau County 2003) quoting *Raptis-Smith v St. Joseph's Medical Center*, 302 AD2d 246 (1st Dept. 2003); *see also, Lee v City of New York, supra*; *Cogswell v Chapman*, 249 AD2d 865 (3rd Dept. 1998); *Campbell v Haber*, 274 AD2d 946 (4th Dept. 2000).

The decedent presented at North Shore University Hospital at Syosset's emergency room at approximately 10:17 PM on February 13, 2005, complaining that she had been suffering from stomach pain since 4 PM that day. She had not had a bowel movement for two days. Dr. Rosenzweig evaluated her. Labs were run, an EKG was done and she was given Toradol for her pain. An x-ray of her abdomen was found "unremarkable" by the radiologist. There were no signs of ileus, obstruction or free air collections. At 11:50 PM the decedent complained of nausea but there was no vomiting. At approximately 12:15 AM on February 14, 2005, Dr. Rosenzweig contacted Dr. Dinulescu who admitted the decedent for observation. Via telephone, Dr. Dinulescu ordered intravenous 4.5 normal saline at 50 cc's per hour; various medications including Tylenol 650 mg daily; further labs; and, an abdominal sonogram.

Dr. Dinulescu saw the decedent between 8:30 AM and 9:30 AM on February 14, 2005. In addition to familiarizing himself with the patient's history, he learned that she had been seen by a surgeon in the emergency room who determined that she did not have a surgical abdomen. Dr. Dinulescu performed a physical examination. A 1x 6 systolic murmur was noted. The decedent's abdomen was diffusely tender, predominantly in the right upper quadrant. She did not have guarding. The rebound sign was absent. Bowel signs were present. An EKG was performed which was sinus bradycardia with a normal axis, left bundle branch block and her chest x-ray was negative. Her labwork was cell count 8.1, hemoglobin 13; hematocrit 40; platelets 253; Sodium 138; Potassium 4.6; Chloride 103; CO2 25; BUN 34; creatinine 1.4; glucose 206; and amylase 198. Dr.

Dinulescu's assessment at that time noted abdominal pain. He sought to rule out acute pancreatitis, peptic ulcer disease, ulcer disease, hypoglycemia, urinary tract infection and hypertension/left bundle branch block. Dr. Dinulescu's orders included NPO, IV Protonix, monitor glycemia, hydration, an abdominal sonogram and blood pressure control. He noted that the decedent might need an abdominal CT scan once her BUN improved. A GI consult was ordered. A later blood test done at 6:26 AM on February 14, 2005 showed a BUN of 30, creatinine 1.1, glucose 172, and amylase 126.

An abdominal sonogram performed on February 14, 2005 revealed that the pancreas was heterogeneous in its head, and there was possibly tiny gallbladder polyps and a small amount of ascites fluid in the abdomen. These findings suggest bilateral renal cysts. At approximately 3:15 PM on February 14, 2005, for the first time, Dr. Dinulescu ordered a CT scan with IV and oral contrast.

Dr. Hanfling performed the GI consult at approximately 9:15 PM and believed that the decedent had pancreatitis. That evening, Dr. Dinulescu ordered a surgical consult.

Dr. Philip Felice, the house attending doctor, saw the decedent on February 15, 2005 at approximately 12:15 AM. She was experiencing pain in the right paraumbilical area. Her abdomen was soft, non-distended with right paraumbilical and epigastric pain. Dr. Felice' s impression was to rule out a pancreatic mass. He ordered Demerol and an abdominal/pelvic CT scan in the morning.

In the early morning hours of February 15, 2005, the decedent developed hypotension and was transferred to the ICU. Dr. Dinulescu was notified and arrived at the hospital between 8:30 AM and 9:30 AM. He requested a surgical consult **STAT** and an

abdominal CT scan **ASAP**.

At his examination-before-trial, Dr. Dinulescu testified that he contacted Dr. Rochman at approximately 9:30 AM, however, Dr. Rochman informed him a half hour later that he could not perform a surgical consult immediately because he was caught up in the operating room. Dr. Dinulescu testified that he then called Dr. Slepian and that when Dr. Slepian returned his phone call, he described the decedent's situation, asked him to do a surgical consult, and he agreed. Dr. Dinulescu left the hospital shortly after the decedent was transferred to ICU. The abdominal/pelvic CT scan performed in the morning of the 15th revealed a possible obstruction in the small bowel.

The radiologist recommended a clinical correlation. The radiology report indicated and the radiologist Dr. Chu testified at his examination-before-trial that those results were reported to Dr. Slepian at approximately 11:45 AM. However, Dr. Slepian testified at his examination-before-trial that while he recalled being asked to see a very sick patient the day in question, he ultimately declined because he was leaving on vacation the next day and he would not be available for follow-up care if surgery was required. In fact, he testified that it was his custom and practice to decline to operate if he was going out of town for any length of time and would not be available for post-surgical follow-up. Dr. Slepian testified that he never saw the decedent or reviewed her chart or films. While Dr. Dinulescu testified that Dr. Slepian ultimately declined to treat the decedent because of his travel plans, he testified that Dr. Slepian advised him about the patient, to wit: that he believed that she might have a partial total small bowel obstruction and may progress to the point where she needed surgery, thus necessitating his declination to treat.

Defendant Dr. Powers testified at his examination-before-trial that he was first contacted about the decedent by his medical fellow, Dr. Pohlman, while he was in the operating room between 1PM and 2PM on February 15, 2005. He recalled giving instructions about starting IV fluids and continuing the decedent's resuscitation to Dr. Pohlman. Dr. Pohlman followed through on these orders at approximately 2:30 PM. Dr. Powers first saw the decedent around 2PM. He ultimately found that several issues needed to be addressed in order to make the decedent stable for general anesthesia and surgery.

The decedent died on February 16, 2005.

Defendant Dr. Pomeranz has established that he had no relationship at all with the decedent. His sole contact with the decedent consisted of a telephone conversation between his partner Dr. Rochman and Dr. Dinulescu at about 10:00 AM on February 15, 2005. Furthermore, while Dr. Dinulescu asked Dr. Rochman if he could perform a surgical consult, he replied that he could not because he was in the operating room. The Court finds that Dr. Pomeranz has established his entitlement to summary judgment and the plaintiff has not opposed the motion.

The allegations against defendant Slepian are that he committed medical malpractice, *inter alia*, in failing to properly consider a bowel obstruction; in failing to diagnose the plaintiff's decedent's small bowel obstruction; in failing to respond to requests for surgical consults; in ignoring a request for a STAT surgical consult on February 15, 2005; in failing to timely perform surgery; and, by abandoning the decedent.

Dr. Slepian has established that while he initially agreed to perform a surgical consult, it is clear that before he performed that consult he was advised of the results of the CT scan, *i.e.*, that surgery might be necessary, and that he then declined to participate in any way in the decedent's treatment because he would be unavailable for follow-up care. Dr. Slepian has established that he never examined the decedent or her records, nor did he give any advice to anyone regarding her treatment. Furthermore, the delay, if any, in ultimately procuring a surgical consult was not attributable to him. Dr. Slepian therefore has established his entitlement to summary judgment as well. The burden accordingly shifts to the plaintiff to establish the existence of a material issue of fact regarding the existence of a professional relationship to the decedent. This has not been accomplished.

Further, the plaintiff has established, at best, a *de minimus* contribution by Dr. Slepian to the delay in procuring a surgical consult, and the possibility that he may have told Dr. Dinulescu that surgery might be needed. Assuming that these events occurred, proximate cause therefore is lacking. Dr. Slepian's motion is granted and the complaint against him is dismissed.

With regard to Dr. Dinulescu, the plaintiff alleges that he was careless, negligent and departed from good and accepted medical practices, standards and procedures in his care and treatment of the decedent, and that his negligence proximately caused her demise. The plaintiff alleges , *inter alia*, that Dr. Dinulescu failed to obtain consults; to timely order the appropriate diagnostic tests including the CT scan; to treat the decedent's

conditions; and, more specifically, to diagnose and treat her small bowel obstruction and mesenteric ischemia.

In support of his motion for summary judgment, Dr. Dinulescu has submitted an affidavit by Dr. John Reilly, the Director of Internal Medicine at Mercy Medical Center. Having reviewed all of the pertinent medical and legal records, he concluded that Dr. Dinulescu did not depart from good and accepted medical standards in his care of the decedent nor were any acts or omissions by him a proximate cause of her demise. Dr. Reilly concluded that Dr. Dinulescu requested all of the appropriate consults in a timely fashion; established an appropriate differential diagnosis based upon the decedent's history, symptoms and diagnostic tests; and, ordered all of the appropriate diagnostic tests including but not limited to the abdominal CT scan with oral and IV contrast in a timely fashion given the decedent's symptoms, vital signs and history. He opines that at no time prior to the morning of February 15, 2005 when the decedent's condition changed was a STAT consult by a surgeon required or a STAT CT scan required. He further opines that Dr. Dinulescu ordered the appropriate fluids throughout the decedent's hospitalization, appropriately hydrated the decedent prior to ordering the CT scan with and without contrast, that given the decedent's signs and symptoms, diagnostic tests and history, Dr. Dinulescu did not misdiagnose the decedent with pancreatitis or fail to timely diagnose mesenteric ischemia or ischemic bowel.

Dr. Reilly opines that not only did the surgeon in the emergency room conclude that the decedent did not have a surgical abdomen, the x-ray which was "unremarkable"

was negative for a small bowel obstruction because there were no signs of ileus, obstruction or free air collections. He explains that Dr. Dinulescu's phone orders the morning of February 14, 2005 were appropriate, that IV fluids were properly ordered to prep and hydrate the decedent for a CT scan with oral and IV contrast, and that a CT scan without contrast was not then needed since the x-ray was negative for a small bowel obstruction. Dr. Reilly also found Dr. Dinulescu's physical examination of the decedent as well as his procurement of her history satisfactory. Dr. Reilly notes that the decedent's BUN and creatinine levels were appropriately decreasing after hydration, that Dr. Dinulescu's assessment on the morning of February 14, 2005 was accurate as were his orders, which included NPO, IV Protonix, monitor glycemia, hydration, an abdominal sonogram, blood pressure control, the possible need for a CT scan once her BUN improved and a GI consult.

Dr. Reilly notes that the abdominal sonogram was done in a timely fashion to rule out pancreatitis, coleocystitis and/or pancreatic tumor, that the results were consistent with pancreatitis, and that the decedent's diffusely tender abdomen predominantly in the upper right quadrant as well as her abdominal pain and nausea and her lab results which showed elevated pancreatic enzymes, i.e., amylase and BUN, were also consistent with acute pancreatitis.

Dr. Reilly observes that Dr. Dinulescu's order for a CT scan with IV and oral contrast at 3:15 PM on February 14, 2005 was appropriate since the decedent's creatinine and BUN had improved and she had become adequately hydrated. Dr. Reilly opines that

Dr. Dinulescu still did not need to order a surgical consult then as the decedent's abdomen was still not surgical. Dr. Reilly also notes that the decedent did not have signs of bowel obstruction or mesenteric ischemia, i.e., distended bowel, vomiting, diarrhea and possible fever and elevated white blood count when she presented at the hospital or on the afternoon of February 14, 2005. The GI consult was timely done by Dr. Hanfling at approximately 9:15 PM on February 14, 2005; that his impression was that the decedent had pancreatitis; that he ordered a CT scan; and, that he did not think a surgical consult was warranted at that time, either.

Dr. Reilly further explains that Dr. Dinulescu properly called for a surgical consult on the evening of February 14, 2005, and that a STAT consult was not warranted then. He notes that while he ordered a CT scan, the house attending Dr. Felice, who saw the decedent in the early morning hours of February 15th did not find that a STAT CT scan or STAT surgical consult was needed, either. In fact, Dr. Reilly notes that when Dr. Felice saw the decedent, she still did not have signs of an intestinal obstruction as her abdomen was soft and non-distended.

Dr. Reilly notes that the house attending physician did not discover that the decedent's status changed until the morning of February 15th. Thus, Dr. Reilly explains that when Dr. Dinulescu saw the decedent that morning, he appropriately had her transferred to ICU and ordered a surgical consult STAT and a CT scan ASAP. As for the alleged delay in obtaining the surgical consult, Dr. Reilly notes that Dr. Dinulescu contacted Dr. Rochman, who was not available; then Dr. Slepian, who also turned out to be unavailable; and, ultimately, Dr. Powers, who sent his surgical fellow Dr. Pohlman to

see the decedent. Dr. Reilly notes that Dr. Dinulescu appropriately continued to contact surgeons until he found one who was available.

Dr. Reilly notes that once it was ordered STAT, the CT scan was timely obtained. He further notes that Dr. Powers saw the decedent in the afternoon of February 15, 2005 and his differential diagnosis included pancreatitis, bowel obstruction and ischemic bowel/necrotic bowel. He believed that the bowel ischemia was secondary to the obstruction. Dr. Reilly notes that at his examination-before-trial, Dr. Powers testified that the decedent was not a candidate for surgery because she was not hemodynamically stable; she was hypovolemic; she was acidotic; she had early renal failure; and, her electrolytes were abnormal. Dr. Reilly concludes that Dr. Dinulescu properly acted in accordance with good and accepted practice by relying on the opinion the surgeon Dr. Powers who made his determination that the patient was not a candidate for surgery.

In view of the foregoing, the defendant Dr. Dinulescu has also established his entitlement to summary judgment, thereby shifting the burden to plaintiffs to establish the existence of a material issue of fact. The Court finds that the plaintiff has met his burden with regard to this defendant

In opposition, the plaintiff has submitted the affirmation of a Board Certified Radiologist who reviewed the pertinent consultation requests, medical records, films, reports and legal documents, and the affirmation of a Board Certified Surgeon, who has also reviewed the pertinent legal documents and medical records.

With regard to the abdominal x-ray series taken on February 13, 2005, and based on his personal review of these films, the plaintiff's expert radiologist agrees with Dr.

Howard Heimowitz to the extent that the bowel gas pattern is "unremarkable." However, he opines that such a series is not sensitive or specific enough to rule out small bowel obstruction as Dr. Reilly has, especially in the presence of other clinical signs and symptoms, *i.e.*, sudden onset pain, unremitting in nature and lack of bowel movement in two days, etc. Other studies, which are more sensitive and specific for diagnosis of such obstruction, *i.e.*, a CT scan, were not performed.

While he agrees with the findings reached in the report of Dr. William Chu concerning the abdominal sonogram taken on February 14, 2005, plaintiff's radiologist explains that while the possibility of pancreatitis was not totally excluded, this does not mean that pancreatitis was suggested by that sonogram study. He would have recommended a cross-sectional CT scan and/or follow-up sonogram, as Dr. Chu did.

Plaintiff's radiologist also affirms that the decedent's abdominal and pelvic CT scan revealed a small bowel obstruction pattern with multiple fluid-filled small bowel loops, with several air-fluid levels. He further notes that the stomach was distended with contrast and that the colon was filled with feces. He would have recommended a general surgical consult. More importantly, in his opinion, with a reasonable decree of medical certainty, "had the above-mentioned Abdominal [and Pelvic] CT scan[s] been performed 24+ hours earlier . . . [They] would have revealed findings showing a small bowel obstruction pattern, and warranting a general surgical consult, as such scan revealed when actually performed after 11:00 AM on February 15, 2005." His opinion is based on the findings of "multiple fluid filled small bowel loops, with several air-fluid levels,

distended stomach and colon filled with feces," as well as the decedent's ongoing signs and symptoms, *i.e.*, sudden onset pain, unremitting in nature and lack of a bowel movement in two days.

Plaintiff's expert surgeon notes that the decedent's BUN and creatinine levels decreased overnight due to hydration, but he nevertheless concluded that the decrease proved insufficient due to inadequate hydration. Plaintiff's expert surgeon further found that "[a]t the time Dr. Dinulescu examined Ms. Bernstein on February 14th, the differential diagnosis needed to include, among other things; obstructive, inflammatory, or ischemic gastrointestinal process, gastrointestinal mass (pancreatic tumor, intestinal mass, etc.), acute pancreatitis,[and] cholecystitis." He opines that "[t]he possibility of prompt surgical intervention could not be ruled out (exploratory laparotomy, etc.)." Thus, the plaintiff's expert surgeon explains that the decedent needed to be kept hemodynamically stable, i.e., adequately hydrated, in case gastrointestinal ailments were exacerbating her dehydrated state and prompt surgery was necessary.

It is his opinion, with a reasonable degree of medical certainty, that Dr. Dinulescu departed from accepted medical standards and practices on February 14th by ordering only 50 cc per hour of intravenous fluids to hydrate the decedent, and that he then compounded this departure by discontinuing the "clear liquids" diet at 9:00 AM on February 14th. He states that guidelines show that intravenous hydration of 75-100 cc per hour (½ normal saline) for 12 hours before and after contrast administration are recommended, the 50 cc of intravenous fluids per hour did not comply with these guidelines and constituted a

departure from accepted medical standards and practices. Plaintiff's expert surgeon notes that the decedent's blood labs at 7:19 AM on February 15 of BUN 54; glucose 226; and, creatinine 2.4 revealed a further dehydrated state with impaired kidney function. He further opines that the decedent's blood stats were not adequately monitored in violation of accepted medical standards and practices. He opines that had they been, more blood tests would have reflected the decedent's increasing BUN and creatinine levels and they could have been addressed sooner.

More importantly, plaintiff's expert surgeon opines that the decedent's creatinine level was normal on admission and that a CT scan with IV contrast could have and should have been done then. Similarly, the plaintiff's surgical expert faults Dr. Dinulescu for waiting six hours after seeing the decedent on February 14th to direct an abdominal CT scan especially since it had been advised after the abdominal sonogram. And, the plaintiff's surgical expert notes that to make matters worse, the test was not performed until Dr. Dinulescu re-ordered it the following day because Dr. Dinulescu never followed up on his February 14th request.

Thus, plaintiff's surgical expert opines "with a reasonable degree of medical certainty, [that] Dr. Dinulescu departed from accepted medical standards and practices . . . by failing to timely order the abdominal CT scan on February 14th, by failing to order this CT scan on a "STAT" basis; and, by failing to follow-up to see that this CT scan was timely performed." He declares that if Dr. Dinulescu had timely ordered the abdominal CT scan on February 14th after examining the decedent at 9:00 AM (instead of waiting

over six hours until 3:15 PM), ordered this scan "STAT," and timely followed up to see that the test was done in a "STAT" fashion, that there was a substantial chance that the scan would have been performed within two to four hours after the 9:00 AM exam. Plaintiff's surgical expert further notes that a gastrointestinal consult was ordered at 9 AM on February 14, 2005, but it was not performed until 9 PM that night. He opines that "Dr. Dinulescu was in charge of [the decedent's] care and treatment. [H]e allowed approximately 12 hours to pass before a gastrointestinal consult examined the [decedent], without following up to see that the consult saw [her]. Given the circumstances as mentioned above, this failure to follow-up by Dr. Dinulescu constituted a departure from accepted medical standards and practices in the community." In addition, plaintiff's surgical expert notes that under "clinical history," the request of February 14th at 9:44 PM for a CT scan of the decedent's pelvis lists "small bowel obstruction," thus showing that that was suspected even then, but there is no evidence of any follow-up. Plaintiff's surgical expert similarly faults Dr. Dinulescu for not following up on his surgical consult request of February 14th until the next morning.

Plaintiff's surgical expert notes that by the time the small bowel obstruction was diagnosed and a surgical consult was procured, the decedent was hemodynamically unstable for surgery. Dr. Powers testified at his examination-before-trial that surgery would have been reasonable had the decedent been stable.

It therefore is plaintiff's expert's opinion "with a reasonable degree of medical certainty, that the above-mentioned departures from accepted medical standards and

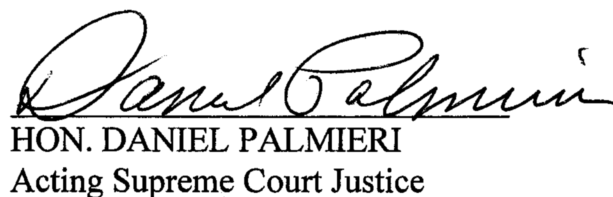
practices by Dr. Dinulescu were substantial factors in causing Ms. Bernstein : to not undergo an abdominal CT scan on February 14th while she was hemodynamically stable and a candidate for surgery (exploratory laparotomy, etc.); to be deprived of a substantial chance of being diagnosed with a small bowel obstruction on February 14th while she was hemodynamically stable and a candidate for surgery (exploratory laparotomy, etc.); of being deprived of a substantial chance of undergoing appropriate timely treatment (for example, exploratory laparotomy, etc.) while she was hemodynamically stable and a candidate for such intervention; [and] of being deprived of a substantial chance of avoiding, among other things, the peritonitis, and sequelae (metabolic acidosis, renal failure, shock) which resulted in her untimely death on February 16th." He explains that "[h]ad the small bowel obstruction been timely diagnosed on February 14th, accepted medical standards and practices required that the patient be closely monitored (e.g., intensive care setting), adequately hydrated, and followed by a surgeon with a substantial chance of intervening surgically while Ms. Bernstein was still hemodynamically stable (and surgery was still a viable option). The peritonitis and sequelae (metabolic acidosis, renal failure, shock, etc.) which occurred did not do so until February 15th."

Accordingly, the Court finds that plaintiff has demonstrated that issues of fact exist with regard to departures from accepted medical practice, and that these departures were a proximate cause of the decedent's injuries, leading to her demise. Summary judgment is therefore denied to Dr. Dinulescu.

This shall constitute the Decision and Order of this Court.

ENTER

DATED: March 12, 2008



HON. DANIEL PALMIERI
Acting Supreme Court Justice

ENTERED
MAR 14 2008
NASSAU COUNTY
COUNTY CLERK'S OFFICE

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