Grim v South Nassau Communities Hosp.
2009 NY Slip Op 31479(U)
June 29, 2009
Supreme Court, Nassau County
Docket Number: 209/06
Judge: Michele M. Woodard
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SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NASSAU

SCAN

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EDWARD W. GRIM II and KIMBERLY GRIM GARRITY, as Co-Administrators of the Goods, Chattels and Credits which were of EDWARD W. GRIM, Deceased, and EDWARD W GRIM II and KIMBERLY GRIM GARRITY, individually,

Plaintiffs,

-against-

SOUTH NASSAU COMMUNITIES HOSPITAL, GLENN MacDONALD, M.D., SRIDEVI BHUMI, M.D. and RICHARD FERSTENBERG, M.D.,

Defendants.

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MICHELE M. WOODARD, J.S.C.
TRIAL/IAS Part 14
Index No.: 209/06
Motion Seq. No.: 03
DECISION & ORDER

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Defendants SOUTH NASSAU COMMUNITIES HOSPITAL (hereinafter "SNCH"), GLENN MacDONALD, M.D., (hereinafter "Dr. MacDonald"), SRIDEVI ARAVABHUMI, M.D. s/h/a "Dr. Bhumi," (hereinafter referred to as "Dr. Bhumi"), and RICHARD FERSTENBERG, M.D. (hereinafter "Dr. Ferstenberg"), move by Notice of Motion for an Order pursuant to CPLR §3212 granting them Summary Judgment and dismissing Plaintiffs Complaint, with prejudice, on the ground that there are no material issues of fact that would warrant a trial.

This is a medical malpractice and wrongful death action in which the Plaintiffs allege that the Defendants were negligent in failing to timely diagnose and treat Plaintiff-decedent, EDWARD W. GRIM's, (hereinafter referred to as "Mr. Grim"), conditions including constipation and/or probable fecal impaction and/or possible torsion of the viscous. Plaintiffs further allege

that Defendants caused and allowed a perforation of Mr Grim's bowel during the administration of an enema, failed to inform Mr Grim of the risks associated with the enema, and failed to properly detect and treat the perforation. Plaintiffs contend that Defendants' deviations from accepted medical standards were the proximate cause of Mr Grim's death.

"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); *Winegard v New York Univ. Med. Ctr.*, 64 NY2d 851, 853 (1985). "Failure to make such a *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*; *Winegard v New York Univ. Med. Ctr.*, *supra*.

The pertinent facts are as follows:

All three above-mentioned Defendants are affiliated with SNCH. On October 29, 2004 Plaintiff was admitted to emergency room at SNCH, complaining of lower-back and hip pains. During this visit, Plaintiff was under the treatment of his primary care physician, Defendant MacDonald. Prior to this October visit, Mr Grim had an established history of constipation and difficulty moving his bowels. A CT-scan was conducted which revealed multilevel osteomyelitis (an infection of the bone marrow). On November 2, 2004, an MRI confirmed Dr. MacDonald's diagnosis of osteomyelitis. Plaintiff was prescribed Perocet for pain management.

On November 2, 2004, Mr. Grim continued to complain of constipation, and upon the request of Dr. MacDonald, he was referred to Dr. Ferstenberg, a Gastroenterologist (GI). On

November 3, 2004, Dr. Ferstenberg performed a GI consultation to evaluate decedent's complaints of constipation. Dr. Ferstenberg performed a rectal examination and removed soft stool. Dr. Ferstenberg then ordered an abdominal x-ray to determine evidence of any obstruction. Dr. MacDonald saw the decedent on November 4, 2004 at which time Mr. Grim complained of abdominal bloating. That same day, Dr. Ferstenberg ordered that the decedent receive two tap water enemas to be administered four hours apart. The enemas were administered by the hospital nursing staff, four hours apart, as Dr. Ferstenberg instructed. Upon completion of the enemas, Dr. Ferstenberg noted positive bowel sounds and passing of stool. The results from the November 3rd x-ray were available, which showed a non-specific gas pattern with marked colonic fecal retention.

On November 5, 2004 Dr. Ferstenberg noted bowel movements and positive bowel sounds. No laxatives were given to the decedent on that day because of a bone biopsy that was scheduled. The following day, Dr. Ferstenberg noted that decedent did not move his bowels. Dr. MacDonald met with the Mr. Grim on November 6, 2004 as well. At that time, he noted Mr. Grim was still constipated. On November 7, 2004, Dr. Ferstenberg's check-up revealed that Mr. Grim moved his bowels and that associated internal sounds were positive. Dr. Ferstenberg gave an order to begin a slow, 24-hour cycle of GoLYTELY (an oral laxative that draws water into the colon to induce bowel movements) the following day at 9:00 a.m.

On November 8, 2004, Dr. Bhumi, an associate of Dr. Ferstenberg and fellow gastrointestinal physician, took over the care of Mr. Grim. On that day, Mr. Grim was given a magnesium citrate (a chemical laxative) to induce bowel movements. Dr. Bhumi noted some response to the magnesium citrate.

On November 9, 2004, both Dr. MacDonald and Dr. Bhumi individually met with Mr. Grim. Dr. MacDonald's assessment noted that Mr. Grim's abdomen was soft and mildly distended, and that he was still complaining of stomach bloating. At that point, Dr. MacDonald determined that Mr. Grim suffered from a possible staph infection and continued constipation. Dr. MacDonald noted a potential treatment of antibiotics for the potential staph species, and the recommendations of the GI for the constipation. Dr. Bhumi's November 9th assessment was that Mr. Grim was still constipated with a mildly distended abdomen. Dr. Bhumi ordered a glass of GoLYTELY per nursing shift, a tap water enema to be performed later that evening, and an abdominal x-ray the following morning (November 10th) to assess the progress of fecal retention post-enema.

The enema was performed by the nursing staff at SNCH on November 9, 2004 at 10:20 p.m. The next day, the abdominal x-ray was performed and the results revealed free air under the left hemidiaphragm suggesting a perforation. The probable perforation led to a surgical consultation by Dr. Jason Green. Exploratory surgery was performed that same day by Dr. Green, which revealed a markedly dilated colon rectosigmoid to the anus, and a perforation in the proximal rectum and a twist in the proximal sigmoid consistent with an early volvulus. According to Dr. Green, the surgery was performed without complication and the patient was taken to the recovery room in stable condition.

At the request of Mr. Grim's family, Dr. Larry Good assumed care of Mr. Grim. Approximately one month passed after the successful surgery, Mr. Grim suffered complications that included infection, pulmonary problems, cardiac arrhythmias, gastrointestinal bleeding, and hypotension. On December 9, 2004 Mr. Grim's heart rate began decreasing. Various unsuccessful procedures were undertaken to stimulate Mr. Grim's heart. The decedent was eventually

pronounced dead on December 9, 2004, at SNCH by a medical resident. The cause of death was noted as cardiopulmonary arrest.

"To establish a *prima facie* case of liability in a medical malpractice action, a Plaintiff must prove (1) the standard of care in the locality where the treatment occurred, (2) that the defendant breached that standard of care, and (3) that the breach of the standard was the proximate cause of injury." *Sampson v Contillo*, 55 AD3d 588 (2d Dept 2008), citing *Nichols v Stamer*, 49 AD3d 832 (2d Dept 2008), quoting *Berger v Becker*, 272 AD2d 565 (2d Dept 2000). "In a medical malpractice action, the party moving for summary judgment must make a prima facie showing of entitlement to judgment as a matter of law by showing the absence of a triable issue of fact..." *Taylor v Nyack Hospital*, 18 AD3d 537 (2d Dept 2005) citing *Alvarez v Prospect Hosp., supra*. A moving defendant doctor has "the initial burden of establishing the absence of any departure from good and accepted medical practice or that Plaintiff was not injured thereby." *Chance v Felder*, 33 AD3d 645 (2d Dept 2006) quoting *Williams v Sahay*, 12 AD3d 366, 368 (2d Dept 2004), citing *Alvarez v Prospect Hosp., supra*; *Johnson v Queens-Long Island Medical Group, P.C.*, 23 AD3d 525, 526 (2d Dept 2005); *Taylor v Nyack Hospital, supra*; see also, *Thompson v Orner*, 36 AD3d 791 (2d Dept 2007).

If the moving.parties meet their burden, "in opposition, 'a Plaintiff must submit a physician's affidavit of merit attesting to a departure from accepted practice and containing the attesting doctor's opinion that the defendant's omissions or departures were a competent producing cause of injury,' " *Domaradzki v Glen Cove Ob/Gyn Assocs.*, 242 AD2d 282 (2d Dept 1997); *see also*, *Mosezhnik v Berenstein*, 33 AD3d 895 (2d Dept 2006). "To establish proximate cause, the plaintiff must present '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 injury." *Alicea v Ligouri*, 54 AD3d 784 (2d Dept 2008), quoting *Johnson v Jamaica Hosp. Med. Ctr.*, 21 AD3d 881, 883 (2d Dept 2005); *see also*, *Zak v Brookhaven Memorial Hosp. Medical Center*, 54 AD3d 852 (2d Dept 2008), citing *Lyons v McCauley*, 252 AD2d 516 (2d Dept 1998).

The moving Defendants have submitted the expert affirmation of Dr. Michael Goldstein, a board certified internal medicine physician and gastroenterologist. In light of the medical records, complaint, bill of particulars, and other supporting memoranda, Dr. Goldstein opines to a reasonable degree of medical certainty that the care and treatment Drs. MacDonald, Ferstenberg, and Bhumi provided to Mr. Grim were in accordance with good and accepted medical standards and did not proximately cause the death of Mr. Grim.

In response to Plaintiff's contention that Dr. MacDonald failed to examine or monitor the progress of the patient upon the GI consultation on November 3, 2004, Defendants assert the medical records from SNCH establish that Dr. MacDonald followed up with the patient four times after the GI consultation with Dr. Ferstenberg. Further, Dr. Goldstein opines with a reasonable degree of medical certainty, that the standard of care did not require Dr. MacDonald to see the patient on a daily basis after referring the patient to a specialist.

Plaintiffs' expert alleges that Dr. Ferstenberg departed from the standard of care by not performing a subsequent rectal examination after the initial rectal examination on November 3, 2004. Plaintiffs' expert asserts that a subsequent rectal examination may have revealed fecal impaction, since the initial rectal examination performed by Dr. Ferstenberg revealed the presence of soft stool. As Dr. Goldstein states, this is not consistent with fecal impaction. The records at SNCH indicate that while under the care of Dr. Ferstenberg, the patient moved his bowels over the

course of four consecutive days (November 3rd-7th). It is Dr. Goldstein's opinion, to a reasonable degree of medical certainty, that additional rectal examinations were not required given the fact that the patient was able to pass soft stool while under the care of Dr. Ferstenberg. Plaintiffs' expert further alleges that Dr. Ferstenberg and Dr. Bhumi departed from the standard of care by failing to supervise the nursing staff at SNCH to ensure that the enema was administered under proper protocol. It is Dr. Goldstein's opinion, with a reasonable degree of medical certainty, that the applicable standard of care did not require the doctors to supervise the trained nursing staff performing an enema. The Plaintiff's expert concedes that the November 4, 2004 enema was not the proximate cause of the perforation, and, as such, it cannot be argued that Dr. Ferstenberg and/or Dr. Bhumi deviated from the accepted medical practice based upon administration of the enema.

Plaintiff's expert further alleges that Dr. Bhumi failed to perform a rectal examination upon taking over care of the patient. Dr. Goldstein attests, to a reasonable degree of medical certainty that because the records at SNCH show that the patient had some bowel movement as a response to the magnesium citrate that was administered on November 8, 2004, this did not require Dr. Bhumi to perform a rectal examination for fecal impaction. Dr. Goldstein opines that Dr. Bhumi would not have been able to manually dis-impact the patient, as the impaction was in a location (proximal rectum) which could not have been accessed via manual dis-impaction. On the contrary, the Plaintiff's expert states that Dr. Green's ability to dis-impact the patient during surgery shows a failure by Dr. Bhumi to have done so during the course of treatment. According to Dr. Goldstein, this fails to take into account the location of the impaction, the passing of stool which suggested an impaction did not exist, and the invasive surgical procedure that was utilized to dis-impact the patient, as opposed to manual dis-impaction.

In a medical malpractice action, in opposition to defendant's Summary Judgment Motion, plaintiff must submit evidentiary facts or materials to rebut the *prima facie* showing of entitlement to Summary Judgment, *see Halbrook v United Hospital Medical Center*, 248 AD2d 358 (2d Dept 1981). In order to hold a physician liable for medical malpractice, the Plaintiff must demonstrate that the physician did not provide the level of care acceptable in the professional community in which he or she practices, *see Schrampf v State*, 66 NY2d 289 (1985).

Based on the facts of the case and testimony presented by the Defendants' expert, Dr. Goldstein, the moving Defendants, Dr. MacDonald, Ferstenberg, and Bhumi have established their *prima facie* case showing there are no triable issues of fact proving that Defendants deviated from the accepted medical standards of care in diagnosing and treating Mr. Grim. Upon this finding, the burden has shifted to the Plaintiffs to produce evidentiary proof in admissible form sufficient to establish material issues of fact which would warrant a trial. *Alavarez v Prospect Hosp. supra.*

The Plaintiff's have failed to meet this burden, as their expert's Affidavit is legally insufficient to rebut the Defendants' expert application because it fails to properly identify the expert's qualifications or departures of the accepted standards by the Defendants supported by testimony and evidence. "While it is true that a medical expert need not be a specialist in a particular field in order to testify regarding accepted practices in that field . . . the witness nonetheless should be possessed of the requisite skill, training, education, knowledge or experience from which it can be assumed that the opinion rendered is reliable." *Behar v Moren*, 21 AD3d 1045 (2d Dept 2005), quoting *Postlethwaite v United Health Servs. Hosps.*, 5 AD3d 892, 895 (2d Dept 2004). In the circumstances of this case, the Defendant's expert is a board certified gastroenterologist who has practiced in the field for over thirty years. On the other hand, the

Plaintiff's expert affidavit is devoid of any reference to his or her qualifications or expertise to assert any familiarity with the applicable standards of care to which they opine. "Where a physician opines outside of their area of specialization, a foundation must be laid tending to support the reliability of the opinion rendered." *Behar v Moren*, *supra*. For this reason, the Plaintiff's expert affidavit is of no probative value, entitling each Defendant-doctor to judgment as a matter of law.

Based on the foregoing, the applications for Summary Judgment in Motion Sequence #3 are **GRANTED** for the three Defendants GLENN MacDONALD, M.D., SRIDEVI ARAVABHUMI, M.D., and RICHARD FERSTENBERG, M.D., and the Plaintiff's Complaint is **DISMISSED** as to them.

This constitutes the **DECISION** and **ORDER** of this Court.

DATED: June 29, 2009
Mineola, N.Y.

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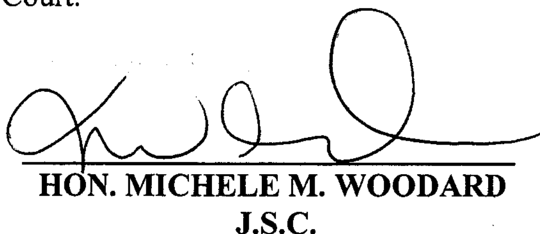

HON. MICHELE M. WOODARD
J.S.C.

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