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SHORT FORM ORDER

INDEX No. 07-17356
CAL. No. 09-01077-MM

SUPREME COURT - STATE OF NEW YORK
I.A.S. PART 34 - SUFFOLK COUNTY

PRESENT:

Hon. JOSEPH C. PASTORESSA
Supreme Court

MOTION DATE 8-26-09
ADJ. DATE 10-7-09
Mot. Seq. # 002 - MG

JAROSLAW SAWICKI,	:	PETER P. TRAUB, ESQ.
	:	Attorney for Plaintiff
Plaintiff,	:	107 Grand Street, 4th Floor
- against -	:	New York, New York 10013
	:	
PAUL J. DAVEY, M.D.,	:	GALLAGHER, WALKER BIANCO, et al.
	:	Attorneys for Defendant
Defendant.	:	98 Willis Avenue
		Mineola, New York 11501

Upon the following papers numbered 1 to 22 read on this motion to strike answer; Notice of Motion/ Order to Show Cause and supporting papers (002) 1 - 14 ; Notice of Cross-Motion and supporting papers_; Answering Affidavits and supporting papers 15-20 ; Replying Affidavits and supporting papers 21-22 ; Other___; (~~and after hearing counsel in support and opposed to the motion~~) it is.

ORDERED that this motion (002) by the plaintiff, Jaroslaw Sawicki, for an order striking the answer of the defendant Paul J. Davey, M.D. for the spoliation of evidence is granted and the answer of Dr. Davey is struck with prejudice and he is precluded from offering testimony on his behalf at trial.

In this action for medical malpractice alleged to have been committed by the defendants, Southampton Hospital and Paul J. Davey, M.D., the plaintiff, Jaroslaw Sawicki, seeks an order striking the answer of Paul J. Davey, M.D. on the basis that defendant Dr. Davey intentionally shredded the plaintiff's medical records. This action against Southampton Hospital has been discontinued.

New York Education law §6530(32) provides that all patient records must be retained for at least six years. 8 NYCRR 29.2(a) (3) provides that it is unprofessional conduct for a physician to fail to maintain or retain patient records for at least six years.

"Spoliation is the destruction of evidence. Although originally defined as the intentional destruction of evidence arising out of a party's bad faith, the law concerning spoliation has been extended to the nonintentional destruction of evidence. Under New York law, spoliation sanctions are appropriate where a litigant, intentionally or negligently, disposes of crucial items of evidence... before the adversary has an opportunity to inspect them. Dismissal is a viable remedy for loss of a key piece of evidence that thereby precludes inspection. Drastic sanctions are not necessarily unduly harsh sanctions when a critical item of

evidence is not preserved," (**Kirkland et al v New York City Housing Authority et al,** 236 AD2d 170 [1st Dept 1997]).

Spoliation of evidence occurs when a party alters, loses, or destroys key evidence before it can be examined by the other party's expert. Spoliation was originally limited to the intentional destruction of evidence arising out of a party's bad faith, however, spoliation has since been expanded by the courts to include the destruction of evidence based on negligence since a party's negligent loss of evidence can be just as fatal to the other party's ability to present a defense. The trend toward the expansion of sanctions for the inadvertent loss of evidence recognizes that such physical evidence often is the most eloquent impartial witness to what really occurred and further recognizes the resulting unfairness inherent in allowing a party to destroy evidence and then to benefit from that conduct or omission, (**Cordero v St. Vincent's hospital and Medical Center of New York,** 2008 Misc Lexis 3315; 239 NYLJ 102 [Supreme Court of New York, New York County 2008]). The spoliation doctrine is distinguished from sanctions to dismiss under N.Y. CPLR 3126 in that it is applied even if the destruction of key evidence occurs through negligence rather than willfulness, and even if the evidence is destroyed before the spoliator became a party, provided it is on notice that the evidence might be needed for future litigation" (**Klein et al v Seenauth et al,** 180 Misc2d 213 [Civil Court of the City of New York, Queens County 1999]).

Sanctions should not be imposed if the offending party offers a "reasonable excuse" for noncompliance with certain discovery demands, particularly if an effort is made to provide other relevant discovery (**Cordero v St. Vincent's Hospital and Medical Center of New York,** supra). Dr. Davey testified that he is board certified in otolaryngology and head and neck surgery and is on staff at Southampton Hospital and Peconic Bay Hospital and was initially employed by Dr. Anthony Caruso for four years with the understanding that he was to become a partner with Dr. Caruso. After a falling out with Dr. Caruso, he went into private practice in Southampton and maintained an office in Riverhead as well, and in January 2007, he went to Peconic Ear, Nose, Throat and Facial Plastic Surgery in Aquebogue, New York. The files of his patients were transferred from the Riverhead office to the Aquebogue office and were placed in the basement and retrieved when needed to see a returning patient in Aquebogue. He felt referring to the file was of value to provide continuity of care, to review past history and to keep a line of treatment on a patient. Upon seeing the patient in Aquebogue, his procedure was to have the record scanned into the computer and disposed of by shredding the records by his front desk people. There was no physician supervision for the procedure. He first saw Mr. Sawicki in March 2006. In June 2007, when copies of Mr. Sawicki's medical records were requested, he noticed an "incompleteness of the record" in that part of the chart was missing in the computer. Unable to locate the actual records, he obtained some information from Southampton Hospital, MDNY, and his billing service, Physician's First, and then started another paper file for Mr. Sawicki. He did not know how he obtained the Southampton Hospital records as he stated he did not have an authorization from the plaintiff to obtain his records. He did not try to obtain any computer records from his Riverhead office as the computer was not plugged in. For him, he stated, the computer is nonfunctional and he couldn't get it to boot up but he did not testify that he tried to have someone obtain the records on his behalf. Dr. Davey further testified that there was no procedure in place to ensure that the medical records were properly scanned into the computer at his new office and he did not oversee or supervise any of the scanning. No procedure was in place to maintain the written records for any period of time before they were shredded and he did not oversee the shredding. No affidavit has been submitted by any of his employees who were responsible for scanning and shredding records to determine that in fact the original records were actually shredded. Here defendant Davey has failed to maintain the

plaintiff's medical records for the time required by the Education Law and has negligently deprived the plaintiff of critical evidence for the plaintiff's expert to properly evaluate the records for medical malpractice to determine when or how the alleged injury occurred. The failure to exercise reasonableness in the preservation of the evidence is evidence of negligence (**Nationwide Insurance Co et al v Rocklyn Fuel Oil Corp.,** 7 Misc3d 1003A [Supreme Court of New York, Nassau County 2005]; **Cummings v Central Tractor & Farm Country, Inc**, 281 AD2d 792 [3rd Dept 2001]; **Kirkland v New York City Housing Authority,** supra). Here it is determined that the defendant, by his failure to supervise or establish a procedure for the preservation of his patient's medical records has negligently permitted the destruction of the plaintiff's medical records which he was required to preserve for a six year period. His excuses for not preserving the records, or failure to make further attempts to obtain the records from his old computer, is not reasonable given his statutory obligation. Nor has he submitted the affidavit from the person responsible for scanning the records or shredding the records. Those records obtained by him from MEDNY cannot be authenticated by the company which is allegedly out of business.

The plaintiff's expert has set forth that he is a physician licensed to practice medicine in the State of New York and board certified in Surgery and plastic surgery. Plaintiff's expert states he reviewed the limited medical records of Dr. Davey, the records of Dr. Caruso, the MRI's taken at Peconic Bay Medical Center, and the cat scan taken at Southampton Hospital and states the plaintiff was under the care of Dr. Davey from March 20, 2006 to January 15, 2007. Sometime in January 2007, Dr. Davey's medical records concerning his prior care and treatment of Mr. Sawicki became unavailable. On September 19, 2006, September 21, 2006, September 28, 2006, October 5, 2006 and October 19, 2006, Dr. Davey performed nasal/sinus endoscopic procedures in his office on Mr. Sawicki, and pursuant to the testimony of Dr. Davey, these procedures entailed the risks of anosmia (loss of olfaction sensation) which results in the inability to perceive smells. These in-office procedures entailed in some cases cutting and debridement of tissue in and about the September 13, 2006 surgical site, and may have included the removal of some bone material. The September 13, 2006 procedure performed by Dr. Davey consisted of a bilateral total ethomoidectomy, bilateral maxillary sinusotomy, bilaterial sphenoidotomy, bilateral frontal sinusotomy, and septoplasty. The office records and other indicia of the nature of the procedure, the discussions with the patient, any problems encountered, and the precise nature of what was done, seen, and removed were shredded around January 2007, and there are no other written records of the nature of these procedures, the findings upon entering the surgical sites, and the matters or issues surgically confronted. Only Dr. Davey's billing records for the post-operative period were available. The CAT scan of February 2007 revealed that the middle turbinates were crushed or partially removed. Plaintiff's expert also states that according to the subsequent treating physician, "there was a great deal of surgery performed on the nose. The middle turbinates were crushed or partially removed. Some of the olfactory fibers were probably removed with the medial wall of the middle turbinate causing the anosmia." Plaintiff's expert states that the medical conditions revealed by the February 2007 CAT scan and as found by Dr. Caruso, could have been caused during any of the five procedures performed by Dr. Davey, and without the office notes and records and in-office operative reports which Dr. Davey failed to maintain, it is impossible for him to determine what, or if specific acts of malpractice were committed by Dr. Davey, when those acts may have been committed, and whether they resulted in the resultant anosmia, and it is equally impossible for him to determine when the various medical findings were brought into being or opine with any degree of medical certainty, when, what and how Mr. Sawicki's injuries were caused or created. Thus, the plaintiff has established that the records provided by the defendant Dr. Davey were inadequate (see, **Slakter v DeBuono et al**, 263 AD2d 695 [3rd Dept 1999]) and therefore do not convey objectively meaningful medical information concerning the

patient treated to other physicians (**Insler v State Board for Professional Medical Conduct,** 38 AD3d 1095 [3rd Dept 2007]). Further, the records, through the defendant's negligent failure to oversee the preservation of the plaintiff's medical records, have been shredded and not maintained as required by law. It is further determined that the plaintiff has been severely prejudiced by the defendant's failure to preserve the plaintiff's records.

The Supreme Court has broad discretion to determine the appropriate sanction for spoliation of evidence, which determination will only be disturbed upon a clear abuse of that discretion (**Steuhl et al v Home Therapy Equipment,** 23 AD3d 835 [3rd Dept 2005]). Where critical items of evidence are willfully disposed of by a litigant before an opposing party has an opportunity to review and inspect, elementary fairness may require that the pleading be dismissed. The determination to strike a party's pleadings is a matter of discretion, given the critical nature of the missing evidence at hand. A trial court's failure to grant that ultimate sanction can constitute an abuse of discretion (**Abulhasan v Uniroyal-Goodrich Tire Company et al,** 14 AD3d 900 [3rd Dept 2005]). In the instant action, the plaintiff has not had the opportunity to inspect the post-operative records. Defendant Dr. Davey has opined in a conclusory and unsupported manner that he did not depart from standards of care. However, the defendant's conclusory and unsupported opinion is insufficient to establish that his care and treatment of the plaintiff conformed with good and accepted medical practice and he has not submitted the affidavit or affirmation of an expert on his behalf. The defendant has testified that he cannot state what the actual care and treatment he rendered to the plaintiff was except for endoscopy and debridement, or the results thereof during the post-operative period, and he has no independent recollection of his care and treatment during that period. Therefore, his opinion that he did not depart from good and appropriate medical practice is unsubstantiated by him. Except as to matters within the ordinary experience and knowledge of laymen, expert medical opinion is necessary to prove a deviation or departure from accepted standards of medical care and that such departure was a proximate cause of the plaintiff's injury (*see,* **Fiore v Galang**, 64 NY2d 999 [1985]; **Lyons v McCauley,** 252 AD2d 516 [2nd Dept 1998], *app denied* 92 NY2d 814; **Bloom v City of New York,** 202 AD2d 465 [2nd Dept 1986]). Dr. Davey has not established, as a matter of law, that he did not depart from good and accepted standards of medical care in treating Mr. Sawicki.

Dr. Davey further testified as to the risks and complications associated with the surgery of September 13, 2006 and stated that those risks and complications were also associated with the post-operative surgical procedures he performed on the plaintiff in his office on September 14, 21, and 28, 2006 and October 5, 2006 wherein he performed nasal debridement via nasal/sinus endoscopy and cleaning out the sinuses for blood and sometimes bone chips. On October 19, 2006 he performed a diagnostic nasal endoscopy using a flexible scope and "wiggled in the sinuses" to take a look at them. However, he had no independent recollection of his findings and testified that there was a remote risk for the same damages from injury to the skull base but not the orbit, and that the risk was less than during the surgery or during the post-operative procedures for sinus endoscopy and cleaning out the sinuses. He did not know whether Mr. Sawicki had complaints of loss of smell by that date. The next visit was on either November 30, 2006 or December 21, 2006 for which there are no records either. The plaintiff's final visit with Dr. Davey was January 15, 2007 after which he came under the care and treatment of Dr. Caruso.

In determining the appropriate sanction, the essential issue is the resulting prejudice to the adversary (**Nationwide Insurance Co et al v Rocklyn Fuel Oil Corp.,** supra). In the instant action it has been demonstrated that the defendant disposed of the records in a manner inconsistent with regulatory

requirements (**Smith v New York City Health and Hospitals Corporation, et al,** 284 AD2d 121 [1st Dept 2001]). The purpose behind the requirement that a proper record be kept for each patient, N.Y. Comp. Codes R. & Regs. tit. 8 §29.2(a)(3) is in part to ensure that meaningful information is recorded in case the patient should transfer to another professional or the treating practitioner should become unavailable. A medical record that fails to convey objectively meaningful medical information concerning the patient treated to other physicians is inadequate (**Mucciolo v Fernandez,** 195 AD2d 623 [3rd Dept 1993]). The court is permitted to shape a penalty in each case adequate to its own particular facts (**Baker v General Mills Fun Group, Inc. et al,** 101 Misc2d 193 [Supreme Court of New York, Special Term, New York County 1979]), and may preclude an expert from testifying at trial (**State Farm Mutual Automobile Insurance Company, a.s.o Nancy Meyer v AAAA Bestway Tires & Service, Inc.,** 2006 NY Slip Op 52386U, 14 Misc3d 1202A [Civil Court of the City of New York, Trial Term, Kings County 2006]) and may strike pleadings (**Baglio et al v St. john's Queens Hospital et al,** 203 AD2d 341 [2nd Dept 2003]).

Based upon the totality of the evidence submitted, and prejudice to the plaintiff in that his expert is unable to determine the appropriateness of the care and treatment administered to the plaintiff in the post-operative period based upon the lack of records, and Dr. Davey's own testimony that the risks and complications associated with the surgery are the same associated with the surgical post-operative procedures he performed on the plaintiff, it is determined that the appropriate sanction in this action is to strike the defendant's answer and to preclude the defendant Dr. Davey from offering testimony on his behalf at the time of trial as records essential to the care and treatment of plaintiff are not available, thus severely prejudicing the plaintiff.

Accordingly, motion (002) is granted and Dr. Davey's answer is struck with prejudice and he is further precluded from offering testimony on his behalf at the time of trial.

Dated: November 25, 2009

HON. JOSEPH C. PASTORESSA

____ FINAL DISPOSITION __X__ NON-FINAL DISPOSITION