

Krin v Lenox Hill Hosp.
2011 NY Slip Op 30559(U)
March 8, 2011
Supreme Court, New York County
Docket Number: 112183/07
Judge: Alice Schlesinger
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SUPREME COURT OF THE STATE OF NEW YORK — NEW YORK COUNTY

IA PART 16
PART

PRESENT: ALICE SCHLESINGER
Justice

Index Number : 112183/2007
KRIN, KAREN
vs.
LENOX HILL HOSPITAL
SEQUENCE NUMBER : 004
STRIKE ANSWER

INDEX NO. _____
MOTION DATE _____
MOTION SEQ. NO. _____
MOTION CAL. NO. _____

this motion to/for _____

PAPERS NUMBERED

Notice of Motion/ Order to Show Cause — Exhibits ...

Answering Affidavits — Exhibits _____

Repeating Affidavits _____

Cross-Motion: Yes No

Upon the foregoing papers, it is ordered that this motion

by plaintiff based on spoliation of evidence is granted to the extent provided in the accompanying memorandum decision.

FILED

MAR 11 2011

NEW YORK COUNTY CLERK'S OFFICE

Dated: MAR 08 2011

Alice Schlesinger
ALICE SCHLESINGER J.S.C.

Check one: FINAL DISPOSITION NON-FINAL DISPOSITION

Check if appropriate: DO NOT POST REFERENCE

SUBMIT ORDER/ JUDG.

SETTLE ORDER/ JUDG.

MOTION/CASE IS RESPECTFULLY REFERRED TO JUSTICE FOR THE FOLLOWING REASON(S):

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NEW YORK

-----X
KAREN KRIN,

Plaintiff,

Index No. 112183/07
Motion Seq. No. 004

-against-

LENOX HILL HOSPITAL, THOMAS ROMO, III and
THOMAS ROMO, III, M.D., P.C.,

Defendants.

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SCHLESINGER, J.:

Before this Court is a motion by plaintiff Karen Krin to strike the defendant's (Dr. Thomas Romo, III) answer. Counsel claims that there has been spoliation of critical evidence. The evidence in question is the written operative report of the cosmetic portion of a surgical procedure performed by Dr. Romo on Ms. Krin on March 18, 2004. It is missing.

This issue had been before me on an earlier occasion. Counsel for the plaintiff had made a similar motion last year and on March 10, 2010, I had ordered certain interim steps to be taken. Further, I stated that if the report was still not found and turned over, plaintiff could move again, as she has. I also pointed out that as of that time, March 2010, and certainly as of the time plaintiff began her action in 2007, the six years mandated by New York State to retain medical and surgical records was still running.

I also characterized an affidavit Dr. Romo had submitted in opposition to the earlier motion as "insufficient and inadequate". I directed the defendants to make a thorough search for the report. If the report could still not be found, I directed a second deposition

of the doctor related to the document and his efforts to locate it. The report still was not found, and the second deposition did occur on July 15, 2010.

Now, as part of the opposition to this motion, Dr. Romo has submitted a much more detailed affidavit. In both the July deposition and the affidavit, he explains that the surgery on Ms. Krin's nose consisted of two distinct and separate parts, a functional one and a cosmetic one. It is clear that Dr. Romo today has no explicit recollection of what he did with regard to the two reports he prepared after these procedures. I say that because his statements on this subject solely rely on his "custom and practice". Based on this, he does prepare two separate operative reports for the functional and cosmetic parts of the surgery. Only the functional one is submitted to the patient's insurance company. He also states that pursuant to his custom and practice here, he also prepared a rhinoplasty worksheet or "template" that he relies upon in preparing the two reports. That template is available.

What is particularly interesting here is that the missing cosmetic report seems to have gone missing twice. Dr. Romo surmises this because in his review of his records and the Manhattan Eye, Ear & Throat Hospital records, he can only find one operative report, the functional one dictated and signed by him on May 29, 2004. But the procedure was on March 18, over two months earlier. In explanation, he says (at ¶¶17 and 18 of his affidavit):

"no doubt that I did originally dictate both the functional and the cosmetic reports, but for some reason the dictation either did not record properly or was erased or lost by the dictation service. I say this because it is not my custom and practice to wait two and a half months to dictate an operative report and it is clear that the hospital contacted me after March 18, 2004 and noted there was no operative report at all in the

record. In view of that, I redictated the functional report on May 29, 2004.

I also believe that on May 29, 2004, I redictated not just the functional report, but also the cosmetic report.

The testimony given at the second deposition was consistent with the above. Dr. Romo stated that it is the Hospital that takes care of the dictation of reports because they require such reports to be in the patient's hospital chart. Dr. Romo states his practice is to also put these records in his own patient office record after he is provided with copies from the Hospital.

What this action is all about is plaintiff's claim that while performing a nasal septal reconstruction and other related procedures on March 18, 2004, Dr. Romo implanted an infratip lobular graft in Ms. Krin's nose (along with other implants). According to Ms. Krin, after she was complaining about pain and infection in the nose, in a subsequent procedure one year later in March 2005, Dr. Romo, failed to remove this tip. The problem continued and worsened, leading Ms. Krin to see a different surgeon in November 2006, going to Chicago in 2007 to see still another doctor, who via multiple surgeries found and removed this tip. Soon thereafter, Ms. Krin stated she finally felt better. However, the multiple surgeries have left her seriously permanently disfigured.

Her counsel argues that since it was only the cosmetic part of the written report that mentioned the implantation of Medpor implants, as well as specific use of the infratip lobular graft and its precise anatomic location (Dr. Romo testified to this, i.e., the functional part of the written operative report dated May 29, 2004, does not include this information), the failure to have this to reference while he was performing the second surgery, one year

later, was related to and significant to his leaving the tip in her nose where it was allowed to fester and further infect. Thus, the missing report is important, he argues, in meeting his burden before a jury.

The defendant essentially argues three things in opposition. First, it was the Hospital's responsibility to keep and retain these reports. Second, that Dr. Romo has diligently searched for the report and has explained in detail these unsuccessful efforts. But, third and most important, Dr. Romo minimizes the importance of this or any cosmetic part of the written operative report.

In this regard, Dr. Romo, in both his affidavit and deposition, refers to a separate document, a rhinoplasty work sheet or a template which he created on March 18, 2004, soon after completion of the surgery and which he has retained in the patient's file. It is this template which he says contained all the necessary information, and upon which he relied, in fact, during the second surgery of March 2005. Further, he says the template illustrates the external approach revision rhinoplasty which he utilized using multiple porous polyethylene implants. There, he says, he indicates the location of each implant used.

In fact, he adds, presumably also pursuant to his custom and practice, his dictated operative reports are based on the templates which he creates. He then proceeds to describe in detail, I assume by referring to his template and the Manhattan Eye, Ear & Throat Hospital Operating Room record of March 18, 2004, that he inserted five Medpor implants utilized from three boxes of Medpor surgical implants. In this regard he describes the various categories of implants that he sculpted before inserting.

But still there is no cosmetic operative report.

Discussion

When evidence is missing, evidence which could significantly affect the manner in which an action is tried or its outcome and the defendant bears some responsibility for that loss, this may call for appropriate sanctions. Striking the answer of such a defendant is the most extreme sanction as it precludes that party from having his day in court. Such a remedy also results in an action not being resolved on its merits. Therefore, it should only be utilized when the spoliation is intentional and/or results in a party's inability to prove a prima facie case, in the case of a plaintiff [*Herrera v. Matlin*, 303 AD2d 198 (First Dep't 2003)] or to mount a defense, in the case of a defendant [*Randolph v. Warnecke*, 1 AD3d 731 (Third Dep't 2003)].

This cannot be said to be the situation here. Plaintiff is still able to articulate a claim against Dr. Romo and prove it, if she is able to show Dr. Romo negligently inserted the implant in the March 2004 surgery and/or negligently could not find it to remove in the second surgery of March 2005. But it may be harder because of the loss or perhaps nonexistence of the cosmetic operative report. The template may have been a useful guide for the defendant or a useful aid to the jury in understanding the hardware utilized. But it is not a substitute for a mandated operative report where a physician describes what he did and how he did it, as well as how the patient's operative field appeared.

Further, despite the fact that it was the hospital, Manhattan Eye, Ear & Throat, that took on the responsibility for having operative reports dictated and for keeping the originals while providing the surgeons with copies, Karen Krin was Dr. Romo's patient, for whom he has a file, and a copy of this mandated operative report, all parts of it, are expected to be

placed in this file. If this were not the case, how would a physician have a complete record of a patient's history. The history, including details of a prior surgery, his prior surgery may well be vital to his ability to provide continuing care.

Further, Education Law §6530, subd.32, requires doctors to keep records for a minimum of six years. This obligation is separate and apart from a hospital's obligation to retain records. These written operative reports, the functional and the cosmetic, are or should be part of Dr. Romo's records. But the cosmetic report is not there. The doctor must bear some responsibility for this loss because after he dictated it, which he says he did, he had an obligation to make sure it was completed and a copy provided to him as a record to be placed in his patient's file.

Therefore, at the very least, under these circumstances, the plaintiff is entitled to a missing document charge, PJI 1:77, at the conclusion of a trial of this action. Such a charge still allows the defendant to provide an explanation for the disappearance or nonexistence of such a document and his efforts to find it, but instructs the jury on what they can do if the explanation is found wanting. Because in the last analysis it is Dr. Romo, Ms. Krin's treating surgeon, who has a duty to make sure that he prepares a full account of his treatment, an account that is preserved.

This decision constitutes the order of this Court

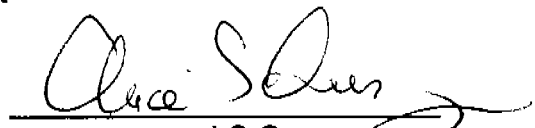
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J.S.C.

ALICE SCHLESINGER