

Smith v St. Charles Hosp.

2011 NY Slip Op 32562(U)

September 22, 2011

Supreme Court, Suffolk County

Docket Number: 02-30582

Judge: Ralph T. Gazzillo

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The defendants, Lee M. Shangold, M.D., William Sher, M.D., Litman, Sher & Shangold, M.D., P.C. s/h/a Lee M. Shangold, M.D., P.C., seek summary judgment dismissing the complaint as asserted against them on the bases that they did not depart from good and accepted standards of care during their care and treatment of the plaintiff, that the surgery was properly carried out, that it was appropriate to perform a total thyroidectomy, that alternative therapy would not have been appropriate, that the standard of care does not require the use of nerve monitoring equipment during surgery, the proper incision site was utilized, and that injury to the superior laryngeal nerve is a known and accepted risk of the surgery.

The proponent of a summary judgment motion must make a prima facie showing of entitlement to judgment as a matter of law, tendering sufficient evidence to eliminate any material issues of fact from the case. To grant summary judgment it must clearly appear that no material and triable issue of fact is presented (*Friends of Animals v Associated Fur Mfrs.*, 46 NY2d 1065, 416 NYS2d 790 [1979]; *Sillman v Twentieth Century-Fox Film Corporation*, 3 NY2d 395, 165 NYS2d 498 [1957]). The movant has the initial burden of proving entitlement to summary judgment (*Winegrad v N.Y.U. Medical Center*, 64 NY2d 851, 487 NYS2d 316 [1985]). Failure to make such a showing requires denial of the motion, regardless of the sufficiency of the opposing papers (*Winegrad v N.Y.U. Medical Center*, *supra*). Once such proof has been offered, the burden then shifts to the opposing party, who, in order to defeat the motion for summary judgment, must proffer evidence in admissible form...and must “show facts sufficient to require a trial of any issue of fact” (CPLR 3212[b]; *Zuckerman v City of New York*, 49 NY2d 557, 427 NYS2d 595 [1980]). The opposing party must assemble, lay bare and reveal his proof in order to establish that the matters set forth in his pleadings are real and capable of being established (*Castro v Liberty Bus Co.*, 79 AD2d 1014, 435 NYS2d 340 [1981]).

In support of motion (006), the defendants have submitted, inter alia, an attorney’s affidavit, copies of the summons and complaint, defendants answers and plaintiffs’ verified bills of particulars; plaintiff’s certified medical records maintained by the defendants; the affirmation of the defendants’ expert Dr. Charles P. Kimmelman; release pertaining to St. Charles Hospital dated June 9, 2009; the signed transcripts of the examinations before trial of Lee M. Shangold, M.D. dated August 27, 2009 and William Sher, M.D. dated December 11, 2009; and the unsigned transcripts of the examinations before trial of Susan Smith and Thomas Smith, both dated August 19, 2008. The unsigned copies of the deposition transcripts are not in admissible form as required by CPLR 3212 (*see Martinez v 123-16 Liberty Ave. Realty Corp.*, 47 AD3d 901, 850 NYS2d 201 [2d Dept 2008]; *McDonald v Maus*, 38 AD3d 727, 832 NYS2d 291 [2d Dept 2007]; *Pina v Flik Intl. Corp.*, 25 AD3d 772, 808 NYS2d 752 [2d Dept 2006]); proof of service pursuant to CPLR 3116 has not been demonstrated, and they are not considered on this motion.

The requisite elements of proof in a medical malpractice action are (1) a deviation or departure from accepted practice, and (2) evidence that such departure was a proximate cause of injury or damage (*Holton v Sprain Brook Manor Nursing Home*, 253 AD2d 852, 678 NYS2d 503[1998], *app denied* 92 NY2d 818, 685 NYS2d 420). To prove a prima facie case of medical malpractice, a plaintiff must establish that defendant’s negligence was a substantial factor in producing the alleged injury (*see Derdiarian v Felix Contracting Corp.*, 51 NY2d 308, 434 NYS2d 166 [1980]; *Prete v Rafla-Demetrious*, 221 AD2d 674, 638 NYS2d 700 [1996]). 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, 489 NYS2d 47 [1985]; *Lyons v McCauley*, 252 AD2d 516, 517, 675 NYS2d 375 [1998], *app denied* 92 NY2d 814, 681 NYS2d 475; *Bloom v City of New York*, 202 AD2d 465, 465, 609 NYS2d 45 [1994]).

Lee M. Shangold, M.D. testified to the effect that he is currently licensed in New York State and is board certified in ear, nose and throat medicine and sleep medicine. In 2001, he was affiliated with Littman, Sher and Shangold, M.D., P.C., which is engaged in the practice of ear, nose and throat medicine (ENT). He first saw Susan Smith on October 23, 2000, on a referral from her primary physician, Ken Fishberger, for evaluation of a thyroid nodule previously diagnosed by ultrasound. He performed a routine ENT exam, which he described, and palpated the thyroid nodule at the inferior aspect of her right thyroid gland. He advised Ms. Smith that it should be further evaluated and recommended an ultrasound fine-needle aspiration biopsy and a thyroid scan. She refused the scan but consented to the biopsy. She returned five months later to his office for a pre-operative visit as the pathology report of November 14, 2000, by Dr. Nevaro, revealed that the aspiration biopsy was consistent with thyroiditis or inflammation of the thyroid. On November 15, 2000, Dr. Shangold called Ms. Smith and recommended a repeat ultrasound in three to four months and to continue the Synthroid, a thyroid medication ordered by Dr. Fishberger. On February 26, 2001, he spoke with her advising her that the repeat ultrasound showed the thyroid nodule was slightly smaller on the Synthroid. He recommended that she either continue on the Synthroid and have repeat ultrasounds or undergo surgery to determine the specific location of the nodule. The surgery he recommended was a right hemithyroidectomy, possible total thyroidectomy. She returned on March 30, 2001 for a pre-operative visit. He conducted an indirect laryngoscopy to determine the function of the vocal cords prior to surgery. He also discussed alternatives to surgery and the risks of surgery, which included a change in voice.

Dr. Shangold stated that he advised Ms. Smith that there were two nerves on either side of the thyroid which control sound. He continued that the main nerve goes to the vocal cord and injury to it will cause a change in the voice, hoarseness, or a weak, breathy voice. If both nerves are damaged, then a tracheotomy may be required. He also explained that there is a smaller nerve that has the function of controlling the ability to yell or sing, and if injured, could contribute to some vocal fatigue. He also advised that there are four small glands around the thyroid gland, the parathyroids, that control calcium metabolism. He continued that a normal life is possible as long as one half of those parathyroids remain functioning, and the risk only comes into play with a total thyroidectomy. He performed about 200 thyroidectomies prior to performing Ms. Smith's on April 2, 2001, at St. Charles Hospital, and never utilized nerve monitoring equipment during the surgical procedures as it was not the standard of care in 2001. Dr. Sher assisted during the surgical procedure. Dr. Shangold described the surgical procedure and instruments utilized during Ms. Smith's surgery.

Dr. Shangold testified that after the incision and clamping veins or arteries, and locating the superior parathyroid glands, he looked for the recurrent laryngeal nerve tracking to the cricothyroid joint. The laryngeal nerve, after being fully identified, was separated from the surrounding thyroid tissue. With the two parathyroid glands and the recurrent laryngeal nerve fully in view, the remaining attachments of the thyroid gland were separated, and the hemithyroid was sent to pathology for frozen section. It appeared to be a benign goitrous nodule. A discrete 1.5 cm. left hemithyroid nodule was

found. Dr. Shangold testified that Ms. Smith had opted pre-operatively for a total thyroidectomy if a left hemithyroid nodule was palpated, so it was performed. No surgical complications were encountered. She was discharged on April 3, 2001.

Dr. Shangold testified that Ms. Smith returned on April 9, 2001 for a post-operative visit and complained of neck discomfort. He stated she was recovering nicely and her voice was clear. When he saw her postoperatively on April 18, 2001, she complained that her neck was "pulling with swallowing" which he stated could be a normal post-operative complaint. He discussed her final pathology reports on that day, advising her that she had two malignant tumors in her thyroid gland. One was a papillary carcinoma and the other was a medullary carcinoma. He recommended follow-up with Dr. Fishberger and an oncologist because of the medullary carcinoma. He contacted Dr. Fishberger and spoke with Dr. Brand, an endocrinologist, to determine what blood work would be necessary. He then gave her a prescription for the specific blood work referable to her medullary carcinoma. Dr. Sher saw Ms. Smith on April 26, 2001 for complaints of the "feeling of tightness" in her neck. Dr. Shangold then saw Ms. Smith again on May 9, 2001, at which time she complained of "skin pulling and swallowing." He thought the subcutaneous tissue might have attached to the strap muscles underneath the subcutaneous tissue under the incision, causing her symptoms. He saw her again on June 11, 2001 as it is the routine of their office to see patients with thyroid cancer at a minimum of every six months. On that visit she complained of "warmness over her anterior neck" which was symptomatic for possible infection. She also complained of "tingling of her jaw, lips, and extremities" which was significant for symptoms relating to decreased calcium level after a total thyroidectomy. He stated that her calcium level the morning after surgery was fine, and that it was unusual for there to be a drop in the calcium level two months later. He therefore considered hypocalcemia levels or hyperventilation as possible causes for her complaints. He did not consider it indicative of nerve damage. He also considered the possibility of infection relating to the feeling of warmth in her neck. He ordered a calcium level and gave her a prescription for Keflex, an antibiotic, in case she needed it.

Dr. Sher testified to the effect that he is physician licensed to practice medicine in New York State and Florida, and is board certified in otolaryngology and head and neck surgery. He was a partner with Dr. Shangold since 1995. He assisted Dr. Shangold in the surgery on Susan Smith on April 2, 2001. After the dissection on the right side was completed, the parathyroid glands were examined to determine that they had good color and adequate blood supply. The recurrent laryngeal nerve was examined to determine that it was intact, still in its bed, with good blood supply. He continued that the recurrent laryngeal nerve is usually identified in a groove between the trachea and the esophagus and it is further usually identified at the mid or anterior portion of the thyroid gland and that it is cephalad or superior to where it enters the larynx. Damage to the nerve is considered a risk of the procedure. When asked if it would be expected to see damage to the laryngeal nerve during or immediately following the surgical procedure, Dr. Sher testified that at times the nerve is not fully intact as there might be fibers that are splayed off the main trunk in cases of cancers invading the nerve or where nodules are adherent to the nerve. After surgery, the patient would be hoarse, have a breathy voice, and some other complaints, such as pitch changes. The decision to perform a total thyroidectomy was made after the frozen section on the right lobe was obtained. When he saw Ms. Smith after surgery on April 26, 2001, she complained that her throat felt tight. Physical examination, including an indirect laryngoscopy was performed to view the larynx with a mirror. He considered her complaint to be a normal post-operative complaint.

Charles P. Kimmelman, M.D., the defendants' expert, has affirmed that he is licensed to practice medicine in New York State and is board certified in otolaryngology since 1979. He sets forth the records and materials reviewed in rendering his opinions, and opines with a reasonable degree of medical certainty that the medical care provided to the plaintiff by the defendants did not deviate from the accepted standards of medical or surgical care at any time, and was not the proximate cause of any injuries allegedly sustained by the plaintiff. Dr. Kimmelman states that post-operatively, Ms. Smith had complaints of voice range reduction and reduced sensation in swallowing, subsequently diagnosed by the non-party physician, Dr. Peak Woo, as a left superior nerve palsy.

Dr. Kimmelman set forth the history and treatment rendered by the defendants, including a total thyroidectomy by Dr. Shangold on April 2, 2001, assisted by Dr. Sher. General anesthesia was administered and the plaintiff was placed with her neck extended. A cervical collar incision was made in the direction of relaxed skin tension lines to gain access to the thyroid and achieve adequate visualization of the areas to be dissected. He opines that the location of the incision was entirely appropriate, and states the basis for that opinion, and further opines that it would not cause injury to the laryngeal nerve. Dr. Kimmelman continues that the remainder of the surgery was performed in accordance with the proper standard of care. He specifically sets forth what was done and states that Dr. Shangold properly identified the important structures, including the parathyroid glands and the recurrent laryngeal nerve, which were appropriately separated and divided from the left hemithyroid. When the left hemithyroid gland was palpated and found to have a 1.5 cm nodule, a total thyroidectomy was conducted, as discussed with the plaintiff prior to the surgery. Dr. Kimmelman set forth that all significant structures were properly identified, the surgical technique used in removing the thyroid was proper and in accordance with the standard of care. Dr. Kimmelman further opines that the use of laryngeal nerve monitoring equipment is not necessary to safely perform this particular surgery and the standard of care did not require its use, as it could actually increase the risk of damage to the laryngeal nerve.

Dr. Kimmelman continues that the pathology revealed papillary carcinoma and medullary carcinoma. He stated that medullary carcinoma is rare and lethal, and its proper treatment is surgical removal by way of a total thyroidectomy. He states that had Dr. Shangold not removed the entire thyroid on April 2, 2001, the cancer would have progressed, making treatment in the future more difficult with less likelihood of eradication of the disease. Dr. Kimmelman opines that Dr. Shangold's treatment was instrumental in saving the plaintiff from a deadly cancer. He continues that post-operatively, Ms. Smith's complaints of neck discomfort, a pulling sensation on swallowing, and tingling in her jaw and lips on one occasion were mostly normal and expected post-operative complaints. He states that there was nothing that should have led the defendants to suspect a superior laryngeal nerve injury at that point in time, and that decreased calcium levels were properly considered as the cause of the tingling in the jaw and lips. Dr. Kimmelman opines that there was no delay in diagnosis attributable to the defendants.

Dr. Kimmelman concludes that injury to the superior laryngeal nerve is a known and accepted risk of the operation performed by the defendants and can occur despite the exercise of all due care. He states that this tiny nerve is located in close proximity to the thyroid gland, and is unavoidably and very frequently touched or manipulated during the course of dissecting and excising the thyroid gland. This unavoidable touching or stretching of the laryngeal nerve can affect its function, but the condition is usually temporary and the symptoms resolve. Dr. Kimmelman states that there is nothing in the manner

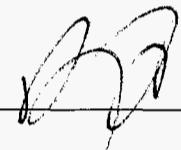
in which the defendants performed this surgery that increased the risk of injury to the nerve, and the fact that it may have occurred is not evidence of a deviation from the standard of care.

Based upon the foregoing, it is determined that the defendants have demonstrated prima facie entitlement to summary judgment dismissing the complaint as asserted against them on the issues of liability and proximate cause relating to the plaintiff's claim of injury to her laryngeal nerve.

To rebut a prima facie showing of entitlement by the defendants to summary judgment dismissing the complaint, the plaintiff must demonstrate the existence of a triable issue of fact by submitting an expert's affidavit of merit attesting to a deviation or departure from accepted practice, and containing an opinion that the defendant's acts or omissions were a competent-producing cause of the injuries of the plaintiff (see *Lifshitz v Beth Israel Med. Ctr-Kings Highway Div.*, 7 AD3d 759, 776 NYS2d 907 [2d Dept 2004]; *Domaradzki v Glen Cove OB/GYN Assocs.*, 242 AD2d 282, 660 NYS2d 739 [2d Dept 1997]). Here, the plaintiff has not opposed this motion and thus has not raised a triable issue of fact with regard to liability or proximate cause to preclude summary judgment from being granted to the moving defendants.

Accordingly, motion (006) is granted and the complaint is dismissed in its entirety with prejudice as asserted against Lee M. Shangold, M.D. William Sher, M.D., Litman, Sher & Shangold, M.D., P.C. s//h/a Lee M. Shangold, M.D., P.C.

Dated: 9/29/11



A.J.S.C.

FINAL DISPOSITION NON-FINAL DISPOSITION