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

PRESENT: LOBIS Justice PART 6

D'ANGIOLELLA, VINCENZO

- v -

WILLIAM BROWN, M.D., ETAL.

INDEX NO. 150467/07

MOTION DATE 8/30/11

MOTION SEQ. NO. 07

MOTION CAL. NO. ____

The following papers, numbered 1 to ____ were read on this motion to/for Summary judgment

	PAPERS NUMBERED
Notice of Motion/ Order to Show Cause — Affidavits — Exhibits ...	1-20
Answering Affidavits — Exhibits	21; 22-23
Replying Affidavits	24-30

Cross-Motion: ☐ Yes ☑ No

FILED

NOV 07 2011

NEW YORK
COUNTY CLERK'S OFFICE

Upon the foregoing papers, it is ordered that this motion

THIS MOTION IS DECIDED IN ACCORDANCE WITH THE ACCOMPANYING MEMORANDUM DECISION

Order

Dated: 11/3/11

JOAN B. LOBIS J.S.C.

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

Check one: ☐ FINAL DISPOSITION ☑ NON-FINAL DISPOSITION

Check if appropriate: ☐ DO NOT POST ☐ REFERENCE

☐ SUBMIT ORDER/ JUDG. ☐ SETTLE ORDER/ JUDG.

SUPREME COURT OF THE STATE OF NEW YORK
NEW YORK COUNTY: IAS PART 6

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VINCENZO D'ANGIOLELLA,

Plaintiff,

Index No. 150467/07

- against -

Decision and Order

WILLIAM BROWN, M.D., CONCORDE MEDICAL GROUP, PLLC, NICOLE WHITE, M.D., TISCH HOSPITAL - NEW YORK UNIVERSITY MEDICAL CENTER, and NEW YORK UNIVERSITY MEDICAL CENTER,

Defendants.

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JOAN B. LOBIS, J.S.C.:

In Motion Sequence Number 007, Nicole White, M.D., and NYU Hospitals Center s/h/a Tisch Hospital – New York University Medical Center and New York University Medical Center ("NYU") move, by order to show cause, for an order pursuant to C.P.L.R. Rule 3212, granting summary judgment dismissal in their favor on all causes of action on the grounds that no material issues of fact exist. Plaintiff opposes the motion.

In this action sounding in medical malpractice, plaintiff alleges that defendants negligently perforated his duodenum. On June 29, 2006, plaintiff (himself a physician) presented to the emergency room at NYU with complaints of severe epigastric pain. His white blood count was 16,000 and he was given antibiotics. A computed tomography (CT) scan with contrast of plaintiff's abdomen depicted that the gallbladder had wall thickening and a small stone within it. The impression was "gallbladder edema with cholelithiasis suggesting acute cholecystitis" (inflammation of the gallbladder), and clinical and ultrasound correlation was recommended. An ultrasound of plaintiff's gallbladder and biliary tract was performed. No stone was present on the

ultrasound exam, although the gallbladder wall had edema. The impression of the ultrasound was that the findings did not indicate acute cholecystitis, and that biliary colic could be considered. Dr. White diagnosed acute cholecystitis and performed an emergency cholecystectomy (gallbladder removal) on June 30, 2006. During the cholecystectomy, an intraoperative cholangiogram was performed by cannulating at the cystic duct (which extends from the gallbladder to the common bile duct) and injecting contrast dye. Dr. White was then able to view the flow of dye on a fluoroscopic monitor and, according to her records, she did not detect stones. The images from the cholangiogram, performed in real time during the cholecystectomy, were not preserved.

The next day, while recuperating at NYU, plaintiff had increasing bilirubin levels, abnormal liver chemistries, jaundice, and tachycardia. Dr. White called Dr. Brown for a biliary and gastroenterology consultation. Plaintiff's condition did not improve and Dr. Brown performed an endoscopic retrograde cholangiopancreatography ("ERCP") and sphincterotomy on July 1, during which Dr. Brown removed impacted debris and stone fragments from the common bile duct. On July 2, 2006, plaintiff's bilirubin levels continued to be elevated, as were his amylase and lipase levels. On July 3, plaintiff had increased abdominal pain and an elevated white blood cell count. A CT scan was performed, the results of which indicated to Dr. White that plaintiff had a duodenal perforation; there was free retroperitoneal air in the second portion of the duodenum, a dilated common bile duct, and a dilated intrahepatic duct, consistent with a perforation. Dr. White performed a duodenal diverticulization on July 3, 2006, in an attempt to repair the perforation. During exploratory laparotomy, Dr. White observed retroperitoneal air along the duodenum and bile staining in the area, but no obvious hole. The operative report indicates that Dr. White suspected

that the hole was in the intrapancreating portion of the duodenum, by the ampulla. The diverticulization was performed; essentially, Dr. White diverted the fluid that could potentially go through the traumatized area by inserting a T-tube from the common bile duct, inserting a duodenal tube, creating a pyloric exclusion (closing off the pylorus), and inserting a gastroenterostmy tube. The area was flushed with saline. No other bile leakage was noted. The wound was closed with two Jackson Pratt drains. Dr. White testified at her deposition that a duodenum diverticulization is designed to heal over a period of approximately four weeks, during which time the pyloric exclusion gradually reopens, the anatomy normalizes, and the tubes are appropriately removed.

The records indicate that plaintiff tolerated the diverticulization and was discharged on July 13, 2006, on a liquid diet. Very shortly after he was discharged, he traveled to Italy, where plaintiff is originally from and where his family resides. He was accompanied by a medical escort service and, upon arrival, was immediately admitted to Monaldi Hospital in Naples. His physicians there told him that everything was normalizing and that he was fine. After two days, plaintiff was discharged from Monaldi Hospital to his family home. His condition was monitored by Dr. Corcione, a physician from Monaldi Hospital. In August 2006, he went to Paris for a week to seek care and treatment from Harry Bismuth, a gastroenterologist described by plaintiff as a renowned surgeon for hepatic transplant. By this point, plaintiff testified that he was slowly getting back to a normal diet and gaining weight, but he still had the gastrojejunostomy and T-tube implants. Dr. Bismuth performed a cholangiogram and removed some of the tubes. Plaintiff testified that Dr. Bismuth told him that his duodenum was still closed and that he should return in six months so that a further surgery could be performed to reestablish normal anatomy. Plaintiff testified that he did

not return to Dr. Bismuth in six months. In June 2008, plaintiff saw Dr. Bismuth for complaints of stomach ache, bile reflux, and needing to eat every three or four hours to the extent that his sleep was interrupted. Dr. Bismuth recommended surgery and referred plaintiff to a surgeon, Dr. Emond, at Columbia Presbyterian Hospital in New York. Plaintiff testified that Dr. Emond recommended surgery to remove the gastrojejunostomy and reestablish the duodenum; the surgery would also include an Roux-en-Y procedure to establish the bile duct. The surgery was performed in September 2008. Plaintiff testified that even after the September 2008 surgery, Dr. Emond told him that he would never have normal anatomy, that it would never be restored completely to the condition it was before, but that his symptoms would probably resolve.

Plaintiff alleges that Dr. White negligently performed the June 30, 2006 cholecystectomy. As a result of this negligence, plaintiff alleges that he was required to undergo the ERCP sphincterotomy, which resulted in a perforated duodenum and necessitated the duodenal diverticulization. Further, as a result of the alleged negligence, plaintiff contends that years later, he was "forced" to undergo the Roux-en-Y surgery to restore his anatomy to "normal." He alleges that he continues to suffer permanent injuries from defendants' malpractice.

Dr. White and NYU move for summary judgment, contending that their treatment of Mr. D'Angiolella was appropriate and in accordance with good medical and surgical practice; that plaintiff has failed to state a cognizable claim for lack of informed consent, as he signed consent forms for the procedures; that the doctrine of *res ipsa loquitur* does not apply to this case; and that plaintiff has failed to state a cognizable claim against NYU for negligent hiring, training or

supervision. At the outset, plaintiff makes no attempt to refute defendants' contentions that he has failed to state a claim against them for lack of informed consent or negligent hiring, training, or supervision. Plaintiff opposes the motion only on the issues of Dr. White's negligence and NYU's vicarious liability for the acts of Drs. White and Brown. Accordingly, it is appropriate to dismiss the claims sounding in lack of informed consent and negligent hiring, training, or supervision.

On a motion for summary judgment, a defendant in a medical malpractice action bears the initial burden of demonstrating that there was either no departure from the standard of care, or that any such departure did not proximately cause plaintiff's alleged injury or damage. King v. St. Barnabas Hosp., 87 A.D.3d 238, 245 (1st Dep't 2011). To satisfy that burden, the defendant must present expert opinion testimony that is supported by the facts in the record and addresses the essential allegations in the bill of particulars. Roques v. Nobel, 73 A.D.3d 204, 206 (1st Dep't 2010). If the defendant meets this initial burden, the "'nonmoving party need only raise a triable issue of fact with respect to the element of the cause of action or theory of nonliability that is the subject of the moving party's prima facie showing.'" Barnett v. Fashakin, 85 A.D.3d 832, 834 (2d Dep't 2011), quoting Stukas v. Streiter, 83 A.D.3d 18, 24 (2d Dep't 2011). To defeat a defendant's prima facie demonstration that its actions did not proximately cause the injuries alleged, a plaintiff must present expert opinion testimony that those actions were a substantial factor in bringing about the injury. Sisko v. New York Hosp., 231 A.D.2d 420, 422 (1st Dep't 1996).

In support of defendants' motion, they submit expert opinion evidence from Michael D. Lieberman, M.D., F.A.C.S., who states that he is a physician licensed to practice in New York

and board certified in surgery. Dr. Lieberman sets forth that his opinions are based on a review of all pertinent medical records, pleadings, and testimony, and that his opinions are rendered with a reasonable degree of medical certainty. He opines that when Mr. D'Angiolella presented to NYU, Dr. White properly diagnosed him with acute cholecystitis because the CT scan showed gallbladder wall thickening, fluid, and a small stone, and the ultrasound showed that the gallbladder wall was edematous. Dr. Lieberman further opines that a laparoscopic cholecystectomy was indicated based on Mr. D'Angiolella's presentation and was performed appropriately. He opines that Dr. White's technique of incising and separating the gallbladder from the cystic duct, milking the fine granular stones out of the cystic duct, and performing an intraoperative cholangiogram to study the condition of the common bile duct was proper surgical technique. In Dr. Lieberman's opinion, there is no evidence that Dr. White caused stones to escape into the common bile duct, but even if she did, it is not a departure from the standard of care not to remove all stones during a cholecystectomy, as a cholangiogram can miss stones. Dr. Lieberman states that it is standard practice to finish a cholecystectomy and then refer a patient for a subsequent ERCP to remove retained stones.

Dr. Lieberman also sets forth that the standard of care in 2006 did not require that still images from a cholangiogram be saved for further review. Based on his review of the evidence, Dr. Lieberman opines that Dr. White properly performed the cholangiogram and there was no need to save the images.

Dr. Lieberman opines that the location of the duodenum perforation and the timing of Mr. D'Angiolella's symptoms indicate that the duodenum was not perforated during Dr. White's

cholecystectomy on June 30, 2006. Further, he contends that the July 3, 2006 duodenal diverticulization surgery was indicated given the suspicion of perforation and performed with proper technique. While generally the pylorus re-opens naturally a few weeks after this type of procedure, Dr. Lieberman sets forth that in some rare cases, the pylorus never re-opens, but that this is not evidence of malpractice.

In opposition, plaintiff submits an affirmation from his expert (name redacted), who states that he/she is a physician licensed to practice in New York and board certified in general and thoracic surgery. The expert reviewed plaintiff's medical records, the parties' deposition transcripts, and the pleadings and bills of particulars in preparing his/her opinion. The expert's opinions are stated with a reasonable degree of medical certainty. The expert opines that when plaintiff arrived at NYU, he did not have acute cholecystitis. The expert sets forth that a patient who does not have acute cholecystitis does not need his gallbladder removed. Further, the expert states that the preoperative sonographic examination performed on plaintiff did not reveal gallstones in either the gallbladder or any of the ducts. In plaintiff's expert's opinion, it was a departure from good and accepted medical practice for Dr. White to perform the cholecystectomy in the first place.

Plaintiff's expert also opines that Dr. White performed the cholecystectomy in a negligent manner. The expert states that when a cholecystectomy is performed, the surgeon must make sure that the cystic duct leading from the gallbladder to the common bile duct is controlled to prevent extrusion and migration of stones from the gallbladder into the common bile duct. Plaintiff's expert states that in plaintiff's case, stones escaped the gallbladder during surgery because of improper surgical technique.

Plaintiff's expert opines that it was a departure from good and accepted medical practice for the hospital to fail to maintain copies of the intraoperative cholangiograms that Dr. White performed during the cholecystectomy. Alternatively, plaintiff's expert surmises that perhaps Dr. White never actually performed the intraoperative cholangiogram; if so, that would be a violation of good and accepted medical practice.

Finally, plaintiff's expert concludes that "the above referenced departures" by Dr. White "caused an injury to [plaintiff's] biliary tract and resulted in further injuries and complications, including the need for further and extensive operative intervention [to plaintiff]."

In reply, at the outset, the moving defendants argue that plaintiff's opposition should not be considered because he failed to serve it on defendants pursuant to the deadlines set in the order to show cause. Although plaintiff's papers were undeniably late, the prejudice to defendants was remedied when the court allowed them two weeks after oral argument to submit a reply. Accordingly, the court will consider the merits of plaintiff's opposition papers.

Defendants also argue that plaintiff has raised a new theory of liability not heretofore pled by alleging that it was a departure from the standard of care for Dr. White to remove plaintiff's gallbladder on June 30, 2006. However, the complaint advances a number of allegations of medical negligence and the bill of particulars against Dr. White particularly alleges that she was careless and negligent in permitting and/or allowing an unnecessary surgical procedure to be performed. Further, Dr. White's expert already opined that the laparoscopic cholecystectomy was indicated based on plaintiff's presentation. It does not appear that plaintiff is advancing a new theory of liability.

There are two distinct procedures that Dr. White performed: the June 30, 2006 cholecystectomy, and the July 3, 2006 duodenal diverticulization. Plaintiff failed to provide any expert opinion testimony regarding the July 3, 2006 duodenal diverticulization surgery, which defendants' expert opined was indicated and was performed with proper technique. Accordingly, as the moving defendants made out a prima facie showing that no issues of fact exist as to plaintiff's claim sounding in medical malpractice related to the July 3, 2006 duodenal diverticulization, it is appropriate to dismiss any claims related to this procedure.

As to the June 30, 2006 choclecystectomy, although the moving defendants did make out a prima facie case of entitlement to summary judgment as to this claim, plaintiff has raised issues of fact sufficient to preclude summary judgment as to the claim related to this procedure. While the moving defendants' expert evaluated the records and opined that the cholecystectomy was warranted, plaintiff's expert states that he/she did the same and reached the opposite conclusion, opining that the cholecystectomy should never have been performed in the first place. Since the decision to perform the cholecystectomy started the course of treatment that plaintiff underwent at NYU, there is, in essence, a "battle of the experts" raising issues of fact as to this issue. Further, issues of fact sufficient to preclude summary judgment remain as to whether the cholecystectomy was performed in accordance with the standard of care and whether the performance of the cholecystectomy proximately impacted plaintiff's subsequent course of treatment or caused his alleged injuries.

Accordingly, it is hereby

ORDERED that the motion of Nicole White, M.D., and NYU Hospitals Center is partially granted, to the extent of dismissing the claims in the complaint sounding in lack of informed consent and negligent hiring, training, and supervision against these two defendants; and it is further

ORDERED that the motion is further partially granted, to the extent of dismissing the claims in the complaint arising from the July 3, 2006 duodenal diverticulization; and it is further

ORDERED that the remainder of the relief requested in the motion is denied; and it is further

ORDERED that the parties shall appear for a pre-trial conference on November 29, 2011, at 9:30 a.m.

Dated: November 3, 2011

JOAN B. LOBIS, J.S.C.