

Dyson v Tewari

2011 NY Slip Op 33427(U)

December 23, 2011

Sup Ct, NY County

Docket Number: 102630/10

Judge: Alice Schlesinger

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SUPREME COURT OF THE STATE OF NEW YORK
NEW YORK COUNTY

IA PART 16

PRESENT: ALICE SCHLESINGER
Justice

PART _____

Index Number : 102630/2010
DYSON, ROBERT
VS.
TEWARI, ASHUTOSH
SEQUENCE NUMBER : 001
SUMMARY JUDGMENT

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

The following papers, numbered 1 to _____, were read on this motion to/for _____

Notice of Motion/Order to Show Cause — Affidavits — Exhibits _____ | No(s). _____
Answering Affidavits — Exhibits _____ | No(s). _____
Replying Affidavits _____ | No(s). _____

Upon the foregoing papers, it is ordered that this motion is *for summary judgment*
is denied in accordance with the
accompanying memorandum decision.

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

FILED

DEC 27 2011

NEW YORK
COUNTY CLERK'S OFFICE



ALICE SCHLESINGER, J.S.C.

Dated: DEC 23 2011

- 1. CHECK ONE: CASE DISPOSED NON-FINAL DISPOSITION
- 2. CHECK AS APPROPRIATE: MOTION IS: GRANTED DENIED GRANTED IN PART OTHER
- 3. CHECK IF APPROPRIATE: SETTLE ORDER SUBMIT ORDER
- DO NOT POST FIDUCIARY APPOINTMENT REFERENCE

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

-----X
ROBERT DYSON and CARMEN DYSON,

Plaintiffs,

-against-

ASHUTOSH TEWARI, M.D., RAJIV YADAV, M.D.,
JOHN/JANE DOE and NEW YORK PRESBYTERIAN
HOSPITAL,

Defendants.

-----X
SCHLESINGER, J.:

Index No. 102630/10
Motion Seq. No. 001

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In this medical malpractice action, the defendant Dr. Ashutosh Tewari performed a robotic prostatectomy on April 24, 2009, on the plaintiff Robert Dyson. He was then discharged from New York Presbyterian Hospital the day after, on April 25. This procedure was performed because Mr. Dyson had earlier been diagnosed with cancer of the prostate.

No one disputes that Dr. Tewari had discussed various treatment options with Mr. Dyson who had chosen this kind of surgical procedure. In fact, no party really disputes that Dr. Tewari included injury to surrounding organs as one of the risks of the procedure. Also, Mr. Dyson signed a consent form.

What is in issue, however, is Dr. Tewari's choice of an intraoperative suprapubic catheter or drain. This catheter is inserted surgically through the abdomen into the patient's bladder, as opposed to a urethral catheter inserted directly into the patient's penis.

It is the plaintiff's position that this suprapubic catheter should never have been used, and that its use caused a perforation in the bowel. Also, with regard to this issue, plaintiff argues that Dr. Tewari never obtained an informed consent from Mr. Dyson because the doctor never informed the patient that such a procedure was a more risky one that could cause such an injury, although it should be noted here that the doctor's choice

of this procedure was communicated to Mr. Dyson before the surgery. The counter-argument on this point is one based on Dr. Tewari's opinion. He states very strongly that the premise that a suprapubic catheter is riskier and can cause injury, is false. Therefore, it would not be appropriate to tell the patient about any such risk.

After Mr. Dyson was discharged on April 25, he returned to the hospital three days later on April 28 with complaints of nausea, stomach fullness and a brown foul-smelling discharge from the drain. In the emergency room a CT scan was performed that showed a small bowel obstruction as well as a bowel perforation. A repair was made and the perforation was closed. Mr. Dyson did suffer an infection from the release of bowel material and was kept in the hospital until May 8. On May 22, 2009, an interventional radiologist removed pelvic drains that had been placed during the repair surgery. Since this last procedure, Mr. Dyson seems to be cancer free and well.

It is on these facts that Dr. Tewari and the defendant hospital are moving for summary judgment. The motion is supported with an affidavit from the defendant himself, Dr. Ashutosh Tewari. Dr. Tewari has excellent credentials and identifies himself as an expert in the field of robotic prostatectomy. He states that at the time of the surgery in question, he had done about 4,000 of these procedures. In a somewhat self-serving manner, he states that he did everything in accordance with good and accepted standards for this kind of procedure. He also says that he obtained informed consent from Mr. Dyson and specifically told him that the risks of a robotic prostatectomy included injury to the bowel. In addition to what has already been discussed, it should be noted that Mr. Dyson testified that he would have undergone the procedure if he had known that he could have suffered a bowel injury.

In the moving papers, Dr. Tewari states he performed within proper standards and that the perforation was not caused by his use of a suprapubic catheter. But it is the contention of plaintiff's expert, a board certified urologist, that this kind of a catheter, placed through an incision of the abdomen directly into the bladder, is a far riskier procedure and should only be used in exceptional circumstances. The expert says that this was not such an exceptional circumstance. This expert goes on to say that it was this placement of the suprapubic catheter that caused the perforation of the bowel.

What has to be noted here, and it is critical to my decision, is that the approximately 0.5 cm perforation of the bowel occurred at the jejunum. The jejunum is a part of the small intestines but it is the upper part of the small intestines right below the stomach. Therefore, one of the most important arguments made by the moving defendants here, and never addressed much less addressed satisfactorily by plaintiff's expert, is that the placement of the suprapubic catheter in the bladder is nowhere near the jejunum. According to defendants' papers, to perforate the jejunum by inserting the catheter in the bladder would be an anatomical impossibility.

As indicated above, plaintiff's expert does not address this point at all, at least directly. However, what he seems to suggest is that this injury occurred because Dr. Tewari placed this catheter blindly. In other words, since it is clear that an ultrasound was not used with regard to the placement of this catheter, the expert says he must "assume" that Dr. Tewari could not have seen what he was doing.

However, Dr. Tewari in a reply affidavit, as well as in his deposition testimony, states that he did not need an ultrasound because he had direct visualization of the area. Therefore, he says he saw the bladder and the placement of the catheter, and also would have seen any bowel perforation if one had occurred.

Dr. Tewari also states that there was visualization because he had filled up the bladder with a saline solution earlier in the procedure, making visualization possible. However, on this point plaintiff's expert disputes Dr. Tewari's account of filling the bladder. He says that because there is no reference in the operative report to filling the bladder, the doctor did not do it. Plaintiff's expert opines that a surgeon in Dr. Tewari's position would be obligated to mention this part of the procedure in his operative report. Thus, the plaintiff argues in opposition that since there was no mention of filling up the bladder by Dr. Tewari, it is fair to assume that there was no such filling up and without filling up, the doctor would not have had visualization of the area. Furthering this argument, the expert says that the procedure was blind and that the insertion of the catheter in a blind manner must have caused the perforation in the jejunum.

The plaintiff also argues that the discharge of Mr. Dyson on April 25, 2009, was improper. According to the plaintiff, who testified to this at his deposition, he was in a great deal of pain the night of April 24 into April 25 and on the day of discharge as well. He also says that there was a discharge from the drain and that the dressing was already saturated at the time of his discharge.

However, Mr. Dyson did not call the doctor or the hospital until Monday, April 27. On April 28 he went to the Emergency Room and was admitted. Also, the hospital records do not support what Mr. Dyson says with regard to complaints of pain or of oozing at the wound site. Rather, the records indicate that on the day of discharge April 25, there was no record of pain and the bandages near the wound site were dry and clean.

More significantly, it is the defendant's position that even if the discharge was too early, no injury resulted. Dr. Tewari indicates that the same repair procedure would have

had to have been done, if his patient had remained in the hospital. In other words, there was no greater injury as a result of the patient's having left the hospital and returned several days later through the emergency room.

Finally, it is the plaintiff's contention that informed consent was never obtained because Dr. Tewari never specifically told Mr. Dyson that the use of an intraoperative suprapubic catheter was riskier than a normal catheter through the penis and that the former was more likely to result in a bowel injury.

However, the defendant responds by making several points. First, he says that in fact an intraoperatively placed suprapubic catheter is not riskier and is not more likely to cause a bowel injury. Therefore, there was no reason to, and he did not, inform Mr. Dyson of this. Secondly, he insists as referred to earlier, that the placement here of a suprapubic catheter had nothing to do with the perforation of the jejunum because of the anatomical impossibility. Finally, the defendant notes that Mr. Tyson acknowledges that he would have gone ahead with the procedure even if he had been advised that a bowel injury could occur. Here, plaintiff does not recall specifically whether Dr. Tewari told him this. But Dr. Tewari insists that he always tells his patients this information, and the same is documented in his records. Therefore, the argument is made that plaintiff's informed consent cause of action must fail because there is no testimony either from an expert or more significantly from Mr. Dyson that he would not have gone ahead with the procedure involving a suprapubic catheter if he had been told that the use was risky and could cause a bowel injury. In other words, the logic of the argument is that Mr. Dyson's decision to proceed with the surgery would not have been different if he had been told that this kind of catheter could cause the same kind of injury that the procedure could cause, as he had stated that he would have gone ahead with the surgery and the fact that he did.

Discussion

This Court does not appreciate a moving defendant in a medical malpractice summary judgment motion acting as his own expert. That is what the defense did here by submitting affidavits in both its moving papers and its reply authored by Dr. Tewari. I am aware that Appellate Divisions in other Departments seem not to be bothered by it. Yet despite my aversion to this kind of motion practice, I do believe I must consider it. In considering it, it is appropriate to evaluate the credentials of the affiant and of course the content of his submission, while always keeping in mind that it is a self-serving statement by a party interested in the outcome of the case, or here the motion. So while considering it, I probably would give it lesser weight because of this obvious bias than I would give to a statement from an independent expert, arguably having no dog in the fight.

Here, I have seriously considered Dr. Tewari's affidavit. There is no question that he has excellent credentials and a tremendous amount of experience in the area in issue. He states that he began performing robotic prostactectomies in the year 2000 and that last year alone he performed approximately 500. He is Board Certified by the American Board of Urology and is now Director of the Prostate Cancer Institute and the Le Frank Robotic Surgery Center. He has also authored hundreds of published peer reviewed articles and has trained other urologists around the world with respect to the performance of robotic prostactectomies. In fact, at oral argument on the motion, his attorney suggested there was probably no one in this field with greater experience or better credentials. Still I do not approve of the practice.

However, having expressed this opinion, ultimately it is content that controls, and the most significant factor, one not truly open to opinion, is where the injury occurred

relative to where the malpractice allegedly took place. Specifically the defendant Dr. Tewari states the following in paragraphs ¶¶ 17, 18 and 19:

17. I am aware that plaintiffs are taking issue with the placement of the suprapubic catheter in this case, specifically claiming that this was done incorrectly and led to a bowel perforation. It is my opinion that this claim has no merit.

18. Regarding placement of the suprapubic catheter, the patient remains in the Trondelenburg position, meaning that his head is 45 degrees lower than the area of the surgery. This allows the abdominal structures to move upwards. Thereafter, the pubic bone is identified and a "dent" is created under the skin. The suprapubic drain is placed through the dent and straight into the bladder. The catheter is then sutured into place.

19. I opine with a reasonable degree of medical certainty that placement of the suprapubic catheter did not cause or contribute to the bowel perforation Mr. Dyson experienced because the perforation occurred at the jejunum which is not anatomically close to the bladder, the organ where the suprapubic catheter was placed. Moreover, there was no need to use an ultrasound during placement of the suprapubic catheter because placement was done intraoperatively under direct visualization. Ultrasound assists with "blind" placement of suprapubic catheters, which was clearly not the case here...

But in opposing the motion, an expert urologist, also Board Certified and seemingly well-credentialed and experienced, simply avoids this issue. In other words, never once in his 21 paragraphs, of which the majority deals with the use of the suprapubic catheter, does this physician deal with the anatomy issue. This expert does agree that a catheter is always used in a radical prostate procedure. But time and again, all he states is that a

suprapubic catheter is an alternative approach to the use of a urethral catheter but the latter "is the preferable method to drain the bladder during a prostaticectomy" (¶10). But he never explains why the suprapubic catheter is not preferred and "is performed only when placement of a urethral catheter is contraindicated or unsuccessful" (¶11).

More important, he does not explain precisely how a perforation to the jejunum can occur with the insertion of this kind of catheter through the abdominal wall into the bladder, considering where these anatomical structures are relative to each other. That is why, despite Dr. Tewari's sworn statement that he had complete visualization without ultrasound, the expert says that he probably did not and that rather it was a blind procedure. Further here, he then attempts to bolster this conclusion that the surgeon was acting without visualization by saying that there was no confirmation in the report regarding the insertion of this catheter and how it was inserted. Here he says, in a somewhat circular fashion, "as explained below, the fact that the surgeon perforated the bowel means that it is likely that this surgical procedure was not properly performed" (¶15).

His explanation below, in ¶16, is that he had to have been negligent and not filled the bladder as a target because first he did not specifically mention that and second:

the fact that Dr. Tewari perforated the bowel during the catheter placement is circumstantial evidence that it was not just filled and expanded. Because if the bladder is filled a skilled surgeon should never perforate the bowel during the insertion of the suprapubic catheter.

So in other words, because there was an injury not anywhere near to the bladder, and because he believes that Dr. Tewari must have caused it, then the doctor must have done the procedure blindly without visualization and by not filling up the bladder.

In Reply, Dr. Tewari challenges the main points in the opposition regarding the use of suprapubic catheters and their risks. He also points out that in his initial affidavit and at his deposition, both sworn documents, he attested that the placement was not blind, that he had clear visualization and that his routine was always to fill the bladder up before the catheter is placed. He explains why this was done here.

This case is extremely troubling. However, any analysis necessarily turns on the fact that the defendant has the burden of proof on summary judgment, a significant burden considering that he is seeking the drastic remedy of depriving the plaintiff of his day in court. On the merits, this Court finds that defendant has failed to meet its burden, although the issue is a close one.

For example, while plaintiff's expert fails to specifically address Dr. Tewari's assertion that the jejunum is not close to the place where he inserted the catheter, Dr. Tewari does not emphasize that point until he states in his Reply that a perforation is "anatomically impossible." Plaintiff's expert, with no right to a Sur-Reply, could not address that forceful statement. Further, Dr. Tewari's point is undermined to a degree by his acknowledgment in ¶18 of his affidavit (quoted above) that the placement of the patient in the Trondelenburg position, with the head 45 degrees lower than the surgical area, causes the abdominal structures to shift.

What is more, and quite significantly, Dr. Tewari makes no effort whatsoever to explain how the perforation could have occurred. The records establish that there was a perforation. If he firmly believed that the insertion of the catheter did not cause the perforation, he was obligated to offer some medically convincing explanation as to what did. It was not enough to simply reject the theory offered by the plaintiff's expert as to the

lack of visualization. The fact remains that the jejunum was perforated during the course of the surgery, and Dr. Tewari was the one who performed the procedure.

Regarding the claim of early discharge, factual issues exist as to Mr. Dyson's condition on the date of discharge, as his recollection differs from the statements in the hospital record and plaintiff's expert opines that the early discharge allowed Mr. Dyson's condition to worsen. Similarly, the informed consent cause of action withstands dismissal, as it turns on the issue of risks attached to the use of the suprapubic catheter, and this Court finds, as noted above, that the defendant failed to adequately explain that issue.

Accordingly, it is hereby

ORDERED that the motion for summary judgment by defendants Ashutosh Tewari, MD., and New York Presbyterian Hospital is denied and counsel are directed to appear for a pre-trial conference prepared to select a trial date on January 18, 2012 at 9:30 a.m.

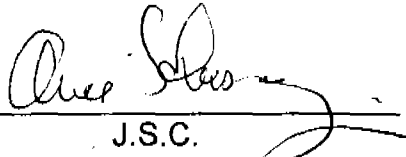
Dated: December 23, 2011

DEC 23 2011

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