

**Solano v Ronak Med. Care**

2013 NY Slip Op 30837(U)

April 22, 2013

Supreme Court, New York County

Docket Number: 108905/06

Judge: Alice Schlesinger

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SUPREME COURT OF THE STATE OF NEW YORK  
NEW YORK COUNTY

PRESENT: ALICE SCHLESINGER  
*Justice*

PART IA PART 16

Index Number : 108905/2006  
SOLANO, JULIAN  
vs.  
RONAK MEDICAL CARE  
SEQUENCE NUMBER : 004  
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 granted to the extent of severing and dismissing the cause of action sounding in lack of informed consent in accordance with the accompanying memorandum decision and is otherwise denied. Pre-trial conference on Wednesday May 29, 2013 at 10:30 a.m.

**FILED**

APR 24 2013

NEW YORK  
COUNTY CLERK'S OFFICE

*Alice Schlesinger*  
ALICE SCHLESINGER J.S.C.

Dated: APR 22 2013

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

- 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  
ANGELA M. SOLANO as the ADMINISTRATRIX of  
the goods, chattels and credits of JULIAN SOLANO,  
deceased; and BELGICA SOLANO

Plaintiffs,

Index No. 108905/06  
Motion Seq. No.004

-against-

RONAK MEDICAL CARE and GIRISH PATEL, M.D.,

Defendants.

**FILED**

**APR 24 2013**

-----X  
SCHLESINGER, J.:

NEW YORK  
COUNTY CLERK'S OFFICE

This action involves the death of Julian Solano from cancer of the throat.

Mr. Solano was diagnosed with Stage II infiltrated squamous cell carcinoma on the right vocal cord in November 2004. He died on May 23, 2007, when the cancer which had been treated came back and spread. He had chemotherapy and radiation, but it was too late to save his life.

The action is brought against Dr. Girish Patel, who was his primary care physician from January 1, 2003 to June 23, 2005. The plaintiff, who is Mr. Solano's daughter and administratrix of his estate, claims that more than a year before the cancer was diagnosed she and her father had both complained of various symptoms and events which should have raised a red flag to Dr. Patel, an internist, and should have led much earlier to Dr. Patel's referral of Mr. Solano to an otolaryngologist.

Before the Court now is a motion for summary judgment, and it is accompanied by an affirmation by Charles L. Bardes, a board certified internist and a professor of Clinical Medicine at Weill Cornell Medical College. His opinion is based on his review of the

medical records, examinations before trial, and relevant medical records in the case, as well as his own experience. Dr. Bardes' opinion is that Dr. Patel's treatment from 2003 through 2005 was in accordance with accepted standards of medical practice and further that nothing that Dr. Patel did or failed to do caused or contributed to Mr. Solano's diagnosis of Stage II cancer and his death.

Dr. Bardes goes on to discuss what he believes Dr. Patel's records show. According to those records, Dr. Patel was first informed of plaintiff's complaints of hoarseness on November 19, 2003, when the patient went to the office to get a pre-op clearance for a laryngoscopy with a biopsy of the neck. On that date, Mr. Solano told Dr. Patel that he had been hoarse for about 6-8 weeks. Also, he reported that he had lost 11 pounds. The physical examination on that date revealed a red and swollen pharynx. Dr. Patel also diagnosed mild chronic obstructive pulmonary disease (COPD). However, the blood test and EKG were normal, and Mr. Solano was cleared for that surgery.

Dr. Bardes then discusses what was not told to Dr. Patel at that November 2003 appointment. Specifically, he notes that the decedent never made any complaints that would have caused Dr. Patel to suspect a throat cancer. Symptoms for this condition would be throat pain, ear pain, hoarseness and coughing up blood. Dr. Bardes says that if any of these symptoms had occurred and lasted longer than a month, then a referral should have been made to an otolaryngologist.

Dr. Bardes continues that Mr. Solano last saw Dr. Patel on August 2, 2004. He again opines that the location of the cancer as described by Dr. Sulica was not in a location that could be seen by an internist during a physical examination because internists generally do not have instruments with this kind of visualization.

Further, Dr. Bardes, on the issue of causation, opines that a diagnosis of Stage II laryngeal cancer in November 2004 would have taken no different course than it did if it had been diagnosed a few months earlier in August 2004.

Finally, with regard to the claim that Dr. Patel failed to test Mr. Solano, Dr. Bardes says that the defendant did in fact offer to do blood tests on November 19, 2003, January 29, 2004 and August 2, 2004, but Mr. Solano refused.

Based on the affirmation from Dr. Bardes, a well-credentialed board certified internist, I find that the moving defendant has made out a *prima facie* case. Therefore, the burden shifts to the plaintiff to see if their submission convinces the Court that there are legitimate factual issues that need to be determined at a trial.

Counsel for the plaintiff attempts to do this by first pointing to the deposition testimony of the plaintiff Angela Solano. Specifically on page 43 of that examination, Ms. Solano stated that she accompanied her father to a September 2003 visit. She says that at that visit, her father complained that his throat was still hurting, as was his right ear. His voice was scratchy and hoarse. She states that she told Dr. Patel that her father's voice had deteriorated and that he had lost a great deal of weight.

Further on page 47 of her deposition, Ms. Solano states that things were getting very bad for her father. She states that his voice was almost not coming out. Also, he had pain in his throat and ear. She states again that she told Dr. Patel in November 2003 that her father's food intake was much less. Dr. Patel, however, said that everything was within normal limits. Ms. Solano also testified that she told Dr. Patel that her father was bleeding at night and that there were blood stains on his sheets either in 2004 or as far back as 2003. Further, she states that the decedent was bleeding from his mouth and everyday he would spit up blood.

Based on the above, counsel argues that this sworn deposition testimony alone shows that Dr. Patel failed to properly heed and document plaintiff's complaints and render appropriate care. However, he does not stop there. He also submits an affirmation from a Dr. Lulu Jimma. She says that she is a primary care physician in New Jersey. Unfortunately, she does not say too much more about her credentials. Also, as pointed out in the reply, since Dr. Jimma practices in New Jersey and says nothing about being licensed in New York, she is required by CPLR §2106 to submit a sworn affidavit rather than an affirmation. In fact, the Court does not even know whether or not Dr. Jimma is board certified.

However, when one gets to the substance of her affirmation, there is more; she provides the Court with relevant opinions. She has also reviewed the records and pursuant to that review points to the following: that the decedent had recurring nose and throat symptomology and anemia, reportedly for about two years. Despite these symptoms and some improvement arguably in November 2003, as late as January 29, 2004, Dr. Patel was still prescribing over-the-counter iron and vitamins and nothing else.

Dr. Jimma also points to Mr. Solano's history of smoking and moderate to heavy use of alcohol. In this regard, she states that there has been established a direct relationship between smoking and oral cancer. She also notes that anemia is unusual in men of the decedent's age. He was 68 in 2004. She says that anemia is usually associated with poor nutrition or a bleeding lesion. Here, the recurring anemia together with what Angela told Dr. Patel about her father's bleeding should have raised a red flag that a serious condition existed. She further states that anemia must be aggressively and promptly investigated and cannot be allowed to continue for a protracted period.

According to Dr. Jimma, the standard of care required Dr. Patel to make these connections and refer his patient to a laryngologist or hematologist to further investigate. She adds that if Dr. Patel had made such a referral, a laryngoscopy would have diagnosed cancer at an earlier stage. Also, Dr. Jimma states that the defendant failed to track plaintiff's weight loss adequately. Finally, before the November 2004 visit, the last time Dr. Patel physically examined Mr. Solano's ears, nose or throat was on March 19, 2003. In other words, this was a year and eight months before November 2004 when the cancer diagnosis was made. Dr. Jimma says with a reasonable degree of medical certainty that Dr. Patel departed from accepted standards of medicine by failing to make an appropriate referral when it was called for.

In reply, counsel not unexpectedly points out that pursuant to §2106 of the CPLR an affidavit was required from an out-of-state doctor. Therefore, counsel argues that I must reject the statement in its entirety and that without that affidavit, there is no valid opposition. Counsel also points out what was obvious — that Dr. Jimma failed to adequately present her credentials as well as her medical speciality. Of course, counsel is right about both of those things. However, at oral argument, I made it clear that despite these problems, plaintiff had provided enough for the Court to give plaintiff a further opportunity to cure those infirmities. In other words, I felt that the drastic remedy of striking Dr. Jimma's affirmation was much too harsh.

On the merits, defendant points out that according to Dr. Patel's records Mr. Solano only made three complaints to him regarding the runny nose and ear problems in almost two years. Therefore, they were not numerous as stated by the plaintiff's expert. On this point counsel points out that these were essentially seasonal complaints and occurred once each year.

Counsel also blames the decedent for repeatedly refusing blood tests offered to him by Dr. Patel. Therefore, if the defendant was unable to properly diagnose anemia, the decedent only had himself to blame. Counsel emphasizes that there were no documented persistent ENT problems. Finally, defendant says that Dr. Jimma's opinion with regard to proximate cause as to the diagnosis is speculative at best. The last point argued is that no information was given as to the cause of action on informed consent. Counsel is correct on this point.

At oral argument, I did communicate that defense counsel had made some good points, as noted above. However, I found that Dr. Jimma had provided enough relevant information to entitle counsel to provide more with regard to her credentials and experience in an sworn affidavit. That was done and an affidavit was submitted from Dr. Jimma. Here she states that she is licensed to practice medicine in New Jersey and that she serves as a primary care physician. With regard to her background, education and training, she states that she was first licensed to practice medicine in New York after completing her residency program in the Department of Family Medicine at Montefiore Medical Center in the Bronx in 2000. Then she served as Chief Resident and as an attending physician at Montefiore until 2005. She then obtained her license to practice medicine in New Jersey upon relocating to that state.

With regard to her practice in New Jersey, Dr. Jimma states that she has worked at various medical facilities including outpatient medical offices affiliated with St. Peter's University Medical Center in New Brunswick, NJ, Capital Health Systems in Bordentown, NJ, and Raritan Bay Medical Center in Perth Amboy, NJ.

She adds that since January 2013, she has been in private practice. With regard to the issues of licensure and board certification status, she says that she no longer holds

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a New York license because she is living and practicing medicine in New Jersey; therefore, she is now licensed there. With regard to board certification, she is board eligible and will be attempting to recertify this year. However, she says that she remains in good standing with every licensing and certification body that she has been involved in.

She also says that she has provided medical services to "tens of thousands of patients in the New York and New Jersey metropolitan area over the course of the last 13 years." She adds that she has treated "thousands of patients" who presented with a similar medical profile and symptomology as the decedent.

It is clear that as stated by Dr. Jimma she is familiar with the facts of this case. I say that because when she gives an opinion about a particular area, she inevitably cites either to the medical records of Dr. Patel or to the deposition testimony that he gave. However, she also says that she has read the plaintiff's bill of particulars, the deposition transcript of the plaintiff, medical records from Beth Israel Medical Center and from Dr. Kenneth Hu and others, as well as Dr. Charles Bardes' affirmation. She then proceeds to discuss in greater detail than she did in her original statement why her opinion is to a reasonable degree of medical certainty that Dr. Patel did depart from good and accepted standards of medical care during his treatment of Julian Solano. Further, she says that this departure was a significant factor in causing his untimely death.

Dr. Jimma concentrates on the multiple visits before Mr. Solano was diagnosed with Stage II infiltrating squamous cell carcinoma of the larynx in November 2004. She then points out with a great deal of specificity various times that Mr. Solano saw Dr. Patel and the continuation from year to year of his complaints with regard to his ear, nose and throat. In this discussion, she does not even refer to plaintiff's deposition wherein Angela Solano

testified that at many visits where she accompanied her father she related to Dr. Patel other symptoms which included bleeding from his mouth. As noted earlier, these complaints, if they were made, were not documented in Dr. Patel's records.

Its important to comment here that Mr. Solano was about 70 years old and Hispanic and did not speak English very well. Therefore, it is likely that his daughter did tell Dr. Patel other things which her father found it difficult to communicate. Dr. Jimma goes back to February 13, 2002, to the records of Dr. Patel where he diagnosed congested oropharynx, allergic rhinitis, upper respiratory inflammation, a cough lasting for two days, runny nose, stuffy nose and a posterior pharynx congestion with redness. She then shows that even though some of the symptoms had resolved according to defendant's March 19, 2003 records, other symptoms persisted and in January 2004 Dr. Patel made another diagnosis of rhinitis.

A further symptom which Dr. Jimma finds significant in addition to the recurring nose and throat symptomology was Mr. Solano's diagnosis of anemia during a period of almost two years. As noted earlier, Dr. Jimma believes that persistent anemia in a man of Mr. Solano's age had to be further explored because it could be significant for serious conditions. Therefore, on January 29, 2004, while Mr. Solano was again diagnosed by Dr. Patel as suffering from anemia, all Dr. Patel did to deal with this condition was to continue advising the decedent to take over-the-counter medications. On August 2, 2004, the last time Dr. Patel saw Mr. Solano before the cancer was diagnosed, the doctor again determined that the decedent was still suffering from anemia. Dr. Jimma points out that this was one year and eight months after anemia was first noted on December 24, 2002.

This expert's position can best be summed up in the following two paragraphs. In paragraph 42 she says:

Given Mr. Solano's history of nose and throat symptoms, as well as his protracted anemic condition, coupled with his history of tobacco and alcohol use, I can state to a reasonable degree of medical certainty that his profile was suspicious for a more serious condition like cancer.

In Paragraph 45 she says:

Had Dr. Patel heeded the obvious signs of Mr. Solano's condition (i.e. that a more serious condition was unfolding) and had at a minimum offered an ENT referral, it is my opinion that an immediate laryngoscopy would have been performed and that the malignant lesion would have been diagnosed at a much earlier stage thereby increasing Mr. Solano's survivability.

Finally, with regard to the quality of the treatment that Dr. Patel provided, Dr. Jimma notes that he did not regularly inspect those portions of Mr. Solano's body, his nose and throat and mouth that were the subject of multiple complaints. She points out that on page 263 of Dr. Patel's transcript he admitted that prior to November 2004, the last time he physically examined Mr. Solano's ears, nose or throat was on March 19, 2003, a year and eight months before.

In fairness to the moving party, I gave his counsel an opportunity to file a supplemental reply and to have the last word on the subject. Here counsel spends a good part of this document again finding fault with the plaintiff's expert. This attorney has done some investigation herself and brings to the Court's attention certain facts such as that Dr. Jimma had only a three year limited license in New York and that Dr. Jimma failed to disclose the kind of board certification she had which she says expired. Further on the alleged lack of probative value of the supplemental affidavit by Dr. Jimma is the criticism that despite Dr. Jimma's statement that she has treated thousands of patients presenting

with a similar medical profile as Mr. Solano, no details are given with regard to these other patients and counsel suggests that it is improbable that a practitioner for just 13 years would have had such experiences.

I said earlier that counsel spent most of the supplemental reply criticizing Dr. Jimma and questioning the sufficiency of her experience and knowledge to be able to opine in this case. What I should have said, however, is that counsel spent the entirety of her supplemental reply making such criticisms. Unfortunately for the defendant, I do not find these arguments convincing, nor do I share counsel's opinion that the plaintiff has failed to provide sufficient opposition to entitle her to a trial on the merits.

The First Department in several cases such as *Martino v. Bendo*, 93 AD3d 500 (2012) and *Rojas v. Palese*, 94 AD3d 557 (2012) deals with the subject of an expert who according to the defense lacks the qualifications to offer opinions in summary judgment motions. In those two cases, the court explains that the issue of the alleged lack of qualifications of plaintiff's experts goes to the weight of their testimony, not its admissibility. In other words, their qualifications are sufficient to allow the case to go forward and for a jury to hear what these physicians have to say.

I feel similarly in regard to this motion. Dr. Jimma may not have either the years or the experience or the association with well-known institutions that Dr. Bardes has, but she still is a licensed family doctor who, according to her statement, has a great deal of experience seeing patients like Mr. Solano and who has undoubtedly read the relevant record here carefully. Therefore, I find that she is entitled to opine here. Further, her statements, as to the alleged departure that Dr. Patel failed to give proper treatment to Mr. Solano and a proper referral at an earlier time and that this delay affected Mr. Solano's

survivability, are sufficiently stated so as to give the plaintiff her day in court. However, on the issue of informed consent, I do agree with the moving defendant and find that the plaintiff has not sufficiently spelled out a cause of action here.

Accordingly, it is hereby

ORDERED that defendants' motion for summary judgment is granted to the extent of severing and dismissing the cause of action for lack of informed consent and is otherwise denied; and it is further

ORDERED that counsel shall appear in Room 222 for a pre-trial conference on Wednesday, May 29, 2013 at 10:30 a.m. prepared to discuss settlement and select a firm trial date.

Dated: April 22, 2013

**APR 22 2013**

  
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J.S.C.  
**ALICE SCHLESINGER**

**FILED**  
**APR 24 2013**  
NEW YORK  
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