Ulloa v Yambo
2014 NY Slip Op 30688(U)
March 11, 2014
Supreme Court, Suffolk County
Docket Number: 09-45498
Judge: Joseph C. Pastoressa
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[* 1]

SHORT FORM ORDER

INDEX No. 09-45498
CAL. No. 13-00002MM

SUPREME COURT - STATE OF NEW YORK
I.A.S. PART 34 - SUFFOLK COUNTY

COPY

PRESENT:

Hon. JOSEPH C. PASTORESSA
Justice of the Supreme Court

Mot. Seq. # 001 - MD

DELMI ESPERANZA ULLOA, as Administrator of the Estate of JOSE ANGEL UMANZOR, deceased,

Plaintiff,

- against -

EDWARD YAMBO, EDWARD M. YAMBO, M.D., P.C., MICHAEL CABEZON and SOUTHSIDE HOSPITAL,

Defendants.

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Upon the following papers numbered 1 to 19 read on this motion for summary judgment; Notice of Motion/ Order to Show Cause and supporting papers 1-12; 13-14; Notice of Cross Motion and supporting papers _; Answering Affidavits and supporting papers 15-17; Replying Affidavits and supporting papers 18-19; Other _; (~~and after hearing counsel in support and opposed to the motion~~) it is,

ORDERED that the motion (001) by defendants Michael Cabezon and Southside Hospital pursuant to CPLR 3212 for summary judgment dismissing plaintiff's complaint as asserted against them is denied.

This medical malpractice action arises out of the medical care and treatment rendered by the defendants to the plaintiff's decedent, Jose Angel Umanzor, allegedly causing him to die on December 15, 2007. It appears that the decedent came under the care of defendant Edward M. Yambo, M.D. on or about September 2005 through December 14, 2007, and under the care of Michael Cabezon and Southside Hospital on December 14, 2007. The decedent had been sent by Dr. Yambo to the emergency room at Southside Hospital on December 14, 2007, where he was diagnosed with new onset diabetes and released that evening. The 36-year-old decedent was found dead in bed on the morning of December 15, 2007. The autopsy report prepared by the medical examiner revealed that the decedent's cause of death was from diabetes mellitus with ketoacidosis and hyperglycemia.

The moving defendants seek summary judgment dismissing the complaint as asserted against them on the bases that they fully complied with the standard of care in rendering care and treatment to the decedent, and that the allegations of negligence were not the proximate cause of the decedent's death.

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 (Sillman v Twentieth Century-Fox Film Corporation, 3 NY2d 395 [1957]). The movant has the initial burden of proving entitlement to summary judgment (Winegrad v N.Y.U. Medical Center, 64 NY2d 851 [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 [1980]). The opposing party must assemble, lay bare and reveal its proof in order to establish that the matters set forth in its pleadings are real and capable of being established (Castro v Liberty Bus Co., 79 AD2d 1014 [1981]).

In support of this motion, the moving defendants have submitted, inter alia, an attorney's affirmation; the affidavit of Gregory Mazarin, M.D.; summons and complaint, answer, and plaintiff's verified bill of particulars; the transcripts of the examinations before trial of Delmi Esperanza Ulloa dated February 16, 2011 and continuing March 31, 2011 and April 28, 2011, Edward Yambo, M.D. dated February 1, 2011, and Michael Cabezon, M.D. dated July 30, 2012; a certified copy of the Southside Hospital emergency room record; a copy of the autopsy report by the office of the medical examiner dated December 20, 2007; and a drug screen report dated January 10, 2008.

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 [1998], app denied 92 NY2d 818, 685 NYS2d 420). To prove a prima facie case of medical malpractice, a plaintiff must establish that the 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 [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 [1998], app denied 92 NY2d 814; Bloom v City of New York, 202 AD2d 465, 465 [1994]).

Edward Yambo, M.D. testified as to his education and training, and work experience as a physician licensed to practice medicine in New York State and stated that he was previously board-certified in family practice. He had no independent recollection of the decedent, Jose Angel Umanzor. The decedent was first treated in his office on September 21, 2005 for a swollen and painful right foot and ankle. Blood work obtained revealed a cholesterol of 233, triglycerides of 245, uric acid of 8.7, and a non-fasting blood sugar of 133. The decedent returned for a visit on October 5, 2005, and he discussed the blood test results with him, told him to go on a diet, and placed him on Zocor. The decedent weighed 191 pounds and he was 5 feet 5 inches tall. He did not order another blood test. Dr. Yambo stated that the decedent could have had

an early diabetic prognosis, but he doubted it at the time. He set forth the dates that the decedent was seen at his office, the reason for the visits, and treatments prescribed, mostly relating to the decedent's complaints of neck and back pain. The decedent's visit was on October 5, 2007, for complaints of cervical pain. X-rays were ordered and done on October 8, 2007. Dr. Yambo testified that he received blood test results dated April 8, 2007 from a life insurance examination that the decedent underwent; however, the results were sent to him after the decedent's death. The blood test indicated that the decedent's blood sugar was 161 with a hemoglobin of 6.5, indicating that he had a chance of having diabetes. He did not know, however, if the test was fasting.

Dr. Yambo testified that he saw the decedent on December 7, 2007, at which time he was complaining of red and watery eyes for five days and chest discomfort. The physician's assistant student took a history indicating that the decedent had intermittent blurry vision and pulsating pressure chest discomfort for several weeks without identifiable cause of onset. The decedent denied nauseousness, vomiting, or diaphoresis. Dr. Yambo testified that his EKG machine was out for service so he could not obtain an EKG. In Dr. Yambo's opinion, Mr. Umanzor should have had an EKG on that date, but because he had no machine, his plan was to hook him up to a Holter monitor (EKG) for 24 hours the next day and then to send out the monitor chip for a reading. The decedent was instructed to return if his pain became worse. The decedent went to an ophthalmologist and had a head CT scan. Dr. Yambo stated that he did not send the decedent for an EKG that same day as his symptoms were not that significant. Dr. Yambo stated that his impression was pain, headaches, and visual changes. The CT scan of the head and the ophthalmology exams were normal. On December 12, 2007, he ordered an echocardiogram, but did not see the referral in his office record. The decedent returned on December 13, 2007 for placement of the Holter monitor. The decedent made no complaints and advised that he felt perfectly fine, and left with the monitor in place. He returned on December 14, 2007 to have the Holter monitor removed, at which time he complained that he was disoriented and had a headache for eight days. He had no chest pain or shortness of breath or diaphoresis. Dr. Yambo thought it best to send him to the hospital by ambulance and called 911 to have him taken to Southside to be seen, as it was the closest hospital.

Dr. Yambo stated that he did not have privileges at Southside Hospital, so, upon presentation, the patient then belongs to the hospital. He did not see the decedent at the hospital, but he learned of the decedent's death from the decedent's brother who advised him that he was seen at Southside Hospital, went home, and died the following day. Dr. Yambo stated that when he received a partial copy of the Southside Hospital emergency room record, he noted the decedent's blood sugar was 451, indicating that he had diabetes unless someone injected him with sugar. He did not speak to anyone at Southside Hospital after the decedent arrived there, and only called to advise that the decedent was coming in by ambulance with dizziness and light headedness and should have a further evaluation. Dr. Yambo stated that the autopsy report revealed that the decedent died of diabetic hyperglycemia with ketoacidosis. It was also noted that the decedent's heart was on the wrong side. He received the results of the Holter monitor on December 18, 2007, revealing no abnormal results. Dr. Yambo testified that in December 2007, he did not order any blood tests on the decedent. The decedent died on December 15, 2007. The decedent's brother picked up his medical records on January 3, 2008.

Michael Cabezon, M.D. testified that he was working at the Southside Hospital emergency room in 2007 as an attending physician, and was an employee of Southside Hospital. He was licensed to practice medicine in New York State in December 2007, and was board-certified in emergency medicine. The decedent presented to the emergency room at 15:20 with neurological complaints, and was sent by Dr.

Yambo for a CT scan. According to the notes listed in triage, the decedent "was having cognitive problems, opening doors, dizzy, balance off, [and] vision blurry" with symptoms for eight days but with no history of an injury. He was classified as an urgent visit. Dr. Cabezon examined the decedent and did not hear any abnormalities in the chest, heart, or abdomen. Dr. Cabezon stated that the decedent was intact neurologically, and that he was awake, alert, and oriented. His mucous membranes were dry, indicating that he could be dehydrated. Dr. Cabezon stated that he first started charting on the decedent's emergency room record at 16:07 hours on December 14, 2007 and ordered a CT scan, blood work including electrolytes, CBC, urinalysis, and a finger stick. Intravenous normal saline fluid was ordered as the finger stick blood sugar was 504, indicating hyperglycemia. The decedent's sodium was low which he felt was factitious hyponatremia. Chlorides were also low, related to dehydration. He felt the decedent had new onset diabetes and that the decedent's symptoms were related to the diabetes. The CAT scan of the brain was normal.

Dr. Cabezon testified that new onset diabetes was significant as it had not yet been treated. He ordered Meclizine for the dizziness, Metformin for the diabetes, and intravenous fluids to dilute the glucose. He did not consider any intravenous medications to lower his glucose. With a serum bicarbonate (CO2) of 26, and anion gap of 16, he felt the decedent was not in diabetic ketoacidosis. He described diabetic ketoacidosis as a condition which is caused when the body starts utilizing its own stores and cannot incorporate glucose into the cells. It forms acids, causing ketones in the blood, which can be fatal. He ruled out ketoacidosis as there were no laboratory values that indicated that he might be suffering from that condition, although it was part of his differential diagnoses. He did not consider that the decedent would go into diabetic ketoacidosis as he was being treated with intravenous fluids, Metformin 500 mg, and there was a trending down of his glucose. He noted that the urine glucose was 1,000, and protein was 75, both of which should be negative, indicating that his kidneys reached the threshold of his serum glucose being elevated and spilled into the urine. The findings did not indicate diabetic ketoacidosis as there were no ketones in his urine.

Dr. Cabezon stated that at 18:29, when he examined the decedent again, he documented that the decedent felt much better. The Accu-check at 18:54 was 391, and at 19:49 was 258. At 2006, his final primary diagnosis was new onset diabetes, and that the decedent was in stable condition and was to be discharged on Metformin twice a day, to which the decedent agreed. He did not consider keeping him at Southside Hospital until his glucose returned to normal levels because he received treatment. He was not given any Metformin to take home. There were no further tests done to determine if the decedent was still dehydrated at the time of his discharge. Dr. Cabezon had no opinion concerning when the glucose levels would become normal, and stated that the decedent was still hyperglycemic upon discharge. He did not consider ordering an EKG as the decedent had no cardiovascular complaints, his blood pressure was normal, and he was on no medication for hypertension. He was not aware that the decedent had recently worn a Holter monitor. He had no conversation with Dr. Yambo. It was only after the lawsuit was started that he learned the decedent passed away the following day. He was not aware that the decedent's cause of death was metabolic ketoacidosis.

Delmi Ulloa testified that she and the decedent were not married, that they resided together, and that she has two children with him, ten-year-old and five-year-old boys. He also had two other children, ages 17 and 18 whom he brought in from El Salvador. They resided with them, and he supported them. They now live with the decedent's brother. Their mother was Marilyn Moreno. He also had a daughter who was 20 years old and lives in El Salvador. The witness spoke through an interpreter as she speaks very little

English. The decedent was born in El Salvador on July 25, 1971, and died on December 15, 2007. He called her from Southside Hospital emergency room to let her know he was there on December 14, 2007. He advised her that he had a blood sugar of 500. She spoke to him again when they discharged him that evening, at which time he advised her he was calling his brother's wife, Sandra Umanzor, to pick him up and fill the prescription. He asked her to have dinner ready. He told her that the nurse at the hospital told him to be careful with the sugar in his blood. When he came home from Southside Hospital, he had nothing to test his sugar.

Ms. Ulloa stated that the decedent had rice and beef for dinner, and that he drank water. She saw him take medication when he got home. She did not notice him sweating or drinking anything else. His lips were white, and remained so that evening. He went to sleep at about midnight, and slept in a different room. About 12:15 a.m., she saw him lighting a fire and putting wood "in the chimney," which was something he would not usually do. They had no conversation. She did not know if he had anything to eat between midnight and the morning. She woke up at 9:30 a.m. and noticed he was not up. She went to wake him up so he could go to work, and found the decedent face down, naked. She noticed his pajama pants and the sheets were wet. His foot was stretched and stiff, and when she touched it, it was hard. She then went into the next room with the children and told them their father had died. She called her sister and relatives, and her husband's brother. She then called 911.

In her continued testimony, Ms. Ulloa testified that within a week prior to his death, the decedent did not complain of being nauseous. He was not vomiting, did not appear clammy and pale, and did not have a bluish tinge to his skin. He never complained about his heart. He did complain of feeling dizzy the week before when the "those little things" were installed on his chest "to monitor what his body was feeling." She never noticed him stumble when he was dizzy, but he told her that he had to go to bed early one evening. She was aware he was taking medication prescribed by Dr. Yambo for high cholesterol. She knew that the decedent had a swollen foot at some time in 2003 or 2004, causing him pain. She did not know if he was experiencing back pain, or if he was taking Vicodin. Sometimes he experienced headaches. The last two to three months before he died, he was eating less and losing weight. Sometimes he put himself on a diet because he was getting heavy as he weighed over 200 pounds. She stated that on the day he last saw Dr. Yambo, the decedent was feeling sluggish, didn't want to eat, and looked tired. He did not appear confused or in pain. He was not sweating and was speaking clearly. His eyes were not red and watery.

Gregory Mazarin, M.D., the expert for the moving defendants, averred that he is licensed to practice medicine in New York State, and has been board-certified in emergency medicine since 2001. He set forth the records and materials which he reviewed. He stated that the gravamen of the plaintiff's allegations is that the moving defendants failed to diagnose and treat blockage of the decedent's left coronary artery, as well as the failure to diagnose and treat new onset diabetes during the December 14, 2007 presentation to Southside Hospital emergency room, causing the decedent to suffer ketoacidosis, hyperglycemia, diabetic glomerulopathy, and death. It is Dr. Mazarin's opinion within a reasonable degree of medical certainty that the moving defendants acted within the standard of care in the treatment of the plaintiff's decedent.

Dr. Mazarin stated that the plaintiff's decedent was sent to the emergency room at Southside Hospital by Dr. Yambo for a CT scan relating to complaints of cognitive problems, opening doors, dizziness, and blurred vision for eight days. When Dr. Cabezon saw the decedent at 4:07 p.m., he confirmed the history and noted that the decedent had complaints of vertigo, head spinning, vison changes,

thirst, urine frequency, and no history of trauma. At 4:22 p.m., a finger stick revealed an elevated blood sugar of 504 (reference range 70-99). He was given Meclizine 50 mg for dizziness at 4:24 p.m. Thereafter, blood testing revealed an elevated blood sugar of 451, normal anion gap, and normal bicarbonate level. Intravenous fluids were administered. The head CT scan was normal. At 6:44 p.m., a finger stick blood test revealed a continued elevated blood sugar of 391, at which time the decedent purportedly stated that he felt better. Dr. Cabezon administered a third liter of intravenous fluid and ordered Metformin hydrochloride for the elevated blood sugar. The urinalysis at 6:52 p.m. revealed a urine glucose of 1000 and protein of 75, with negative ketones. At 7:58 p.m., a third finger stick revealed a blood sugar of 258. Dr. Cabezon diagnosed the decedent with new onset diabetes, and discharged him at 8:30 p.m. with instructions to follow up with Dr. Yambo in the morning, and to return to the emergency room if his condition worsened. He was also instructed to take Metformin hydrochloride 500 mg twice daily, and fluids were encouraged. Dr. Mazarin continued that when the plaintiff awoke the following morning, she found the decedent unconscious in bed, lying face down. His pajama pants and sheets were wet.

Dr. Mazarin concluded that the testimony of Dr. Cabezon, coupled with the Southside Hospital records, clearly establishes that the care and treatment rendered to the decedent by the moving defendants was well within the standard of care, and did not proximately cause the injuries or death of the decedent. Dr. Mazarin stated that new onset diabetes was suspected from the outset of the decedent's arrival at the emergency room. An EKG or sending cardiac markers was not indicated due to a lack of cardiac complaints. Despite the elevated glucose levels, the decedent had a normal bicarbonate level and anion gap, with no evidence of ketoacidosis, and there was no indication for inpatient hospitalization. It is noted, however, the Dr. Mazarin's opinions are conclusory and unsupported by his affidavit as he does not set forth the standard of care concerning under what conditions inpatient hospitalization is warranted or ruled out. Dr. Mazarin further stated that upon discharge, the decedent's blood sugar was improved at an appropriate level for discharge with a prescription for diabetic medication and instructions to follow up with his primary physician in the morning. Dr. Mazarin further opined that no action or inaction by the defendants in any way contributed to or caused the injuries for which the plaintiff is seeking to recover.

Based upon the foregoing conclusory opinion and failure to set forth the standard of care for a newly diagnosed diabetic, it is determined that the moving defendants have not established that their actions did not depart from the accepted standards of care and treatment and did not contribute to, or proximately cause, the alleged injuries and death of the plaintiff's decedent. "The affidavit of a defendant physician may be sufficient to establish a prima facie entitlement to summary judgment where the affidavit is detailed, specific and factual in nature and does not assert in simple conclusory form that the physician acted within the accepted standards of medical care" (Toomey v Adirondack Surgical Assoc., 280 AD2d 754 [2001][citations omitted]; Winegrad v New York Univ. Med. Ctr., 64 NY2d 851[1985]; Machac v Anderson, 261 AD2d 811 [1999]).

To rebut a prima facie showing of entitlement to an order granting summary judgment by the defendant, 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 [2004]; Domaradzki v Glen Cove OB/GYN Assocs., 242 AD2d 282 [1997]). "Summary judgment is not appropriate in a medical malpractice action where the parties adduce conflicting medical expert opinions. Such credibility issues can only be resolved by a jury" (Bengston v Wang, 41 AD3d 625 [2007]). It is further determined that the plaintiff 's

expert's affidavit raises factual issues and conflicting expert opinion which preclude summary judgment in any event.

The plaintiff's expert is a physician licensed to practice medicine in the State of Colorado, and is board-certified in emergency medicine and internal medicine. He set forth his education and training, as well as his work experience, and the records and materials which he reviewed. He stated that his opinions are limited to the moving defendants as Dr. Yambo has not moved for summary judgment. It is his opinion within a reasonable degree of medical certainty that defendants Michael Cabezon and Southside Hospital deviated and departed from the good and accepted standards of care and treatment of the plaintiff's decedent on December 14, 2007, and that those departures were a substantial factor in causing the decedent's injuries, pain and suffering, and his death on December 15, 2007.

The plaintiff's expert set forth the decedent's presentation to the emergency room at Southside Hospital on December 14, 2007 at 3:30 p.m., Dr. Cabezon's history obtained at 4:07 p.m., and the finding of an elevated blood glucose of 504 at 4:05 p.m., indicating the normal range is between 75-99 mg/dl. He further set forth the blood glucose of 451 at 5:22 p.m., 391 at 6:15 p.m., and 258 at 7:55 p.m., and noted that the decedent was discharged 25 minutes after the elevated blood glucose reading of 258 was obtained. He stated that treatment by Dr. Cabezon consisted of the administration of three liters of intravenous fluid, Metformin 500 mg, and Meclizine 50 mg, and discharge with a prescription for Metformin hydrochloride 500 mg. His diagnosis was new onset diabetes. The decedent was found unconscious in bed at 9:30 a.m. at home by the plaintiff the following morning. He was found deceased upon arrival of the ambulance staff. He stated that the decedent's cause of death, as per the medical examiner's autopsy report, was diabetes mellitus with ketoacidosis and hyperglycemia. The decedent's urine glucose was over 500. It was also found that he had significant atherosclerotic heart disease with near total occlusion of the proximal right coronary artery.

The plaintiff's expert opined that Dr. Cabezon and Southside Hospital staff departed from good and accepted standards of medical care and treatment of the decedent in failing to admit and monitor the decedent, in failing to achieve and maintain a reasonable blood glucose level prior to discharge, and in failing to perform an EKG. He continued that the standard of care required that the defendants should have admitted the decedent to stabilize his blood glucose and to achieve and maintain reasonable levels, as a patient with new onset diabetes needs to be monitored and treated until the blood glucose level returns to reasonable levels and remains there for two to three hours. Releasing the decedent while his blood glucose level was still elevated and not stabilized was a departure from the accepted standards of care. Discharging the decedent without any diabetes teaching and an assured next-day follow-up was also a departure from the standard of care for new onset diabetes. The plaintiff's expert opined that the defendants should have lowered the decedent's blood glucose to 200 or below, and then retested the levels at least two to three hours later to make sure the level was stabilized and did not significantly increase or decrease. A single reading of 258 upon discharge was not a reasonable level to justify the decedent's discharge, and a certain follow-up appointment should have been made with his PMD the following day.

The plaintiff's expert opined that had the defendants admitted the decedent and properly lowered his glucose levels, and monitored him until he was clearly stabilized, the decedent's death would have been avoided and he would not have suffered and died from diabetes mellitus with ketoacidosis. The decedent's urine glucose at death was over 500 and caused his fatal ketoacidosis. Not admitting and monitoring the

decedent were departures from the accepted standards of care and substantial factors in causing his death and pain and suffering.

The plaintiff's expert also opined that the defendants further departed from the standards of care and treatment in not performing an EKG as the decedent had a history of hypertension, hyperlipidemia, high cholesterol, and left shoulder pain. Given the history and the new onset diabetes, the standard of medical care dictated that an EKG be performed. Had they asked the decedent whether he had a recent EKG, he would have alerted them that his primary physician, Dr. Yambo, wanted an EKG, but his machine was out for service, and that the decedent had a recent history of chest pain just two days earlier. Additionally, given the decedent's complaints of dizziness, he should have been placed on the cardiac monitor as dizziness can be attributed to vertigo. It can also be related to cardiac arrhythmia and undiagnosed coronary artery disease. The failure to obtain an EKG and place the decedent on a monitor was a departure from the standard of care. The plaintiff's expert further stated within a reasonable degree of medical certainty that, given that the decedent had a near total occlusion of the right coronary artery, an EKG would have likely shown abnormalities, including ST segment elevation, ST segment depression, or other changes suggestive of undiagnosed coronary artery disease which could have dictated further monitoring and testing, up to and including a coronary angiogram. Thereafter, the decedent's coronary artery lesion could have been treated and he could have had a normal life expectancy.

The plaintiff's expert opined that the foregoing departures from the standard of care and treatment were the proximate cause of the decedent's death from diabetes mellitus and ketoacidosis, and his pain and suffering.

Based upon the foregoing conflicting expert opinions, summary judgment is precluded.

Accordingly, the motion (001) is denied.

Dated: March 11, 2014

HON. JOSEPH C. PASTORESSA, J.S.C.

____ **FINAL DISPOSITION** __X__ **NON-FINAL DISPOSITION**