Kemp v Hom
2017 NY Slip Op 31654(U)
August 2, 2017
Supreme Court, Suffolk County
Docket Number: 12012/11
Judge: Paul J. Baisley, Jr.
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Short Form Order

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

PRESENT:
HON. PAUL J. BAISLEY, JR., J.S.C.

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NICHOLAS KEMP, individually and NICHOLAS KEMP, as the Executor of the ESTATE OF MARYANNE KEMP,

Plaintiff,

-against-

STEPHEN HOM, M.D., MARC FINKELSTEIN, M.D., RAJIV SAXENA, M.D., AND CHS GOOD SAMARITAN HOSPITAL, INC., d/b/a GOOD SAMARITAN HOSPITAL MEDICAL CENTER,

Defendants.

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INDEX NO.: 12012/11
CALENDAR NO.: 201601555MM
MOTION DATE:6/1/17
MOTION NO.: 002 MD; 003 MD

PLAINTIFF'S ATTORNEY:
SULLIVAN & GALLESHAW, LLP
108-15 Crossbay Blvd.
Ozone Park, New York 11417

DEFENDANTS' ATTORNEYS:
SANTANGELO, BENVENUTO & SLATTERY
1800 Northern Blvd.
Roslyn, New York 11576

LAWRENCE, WORDEN, RAINIS & BARD P.C.
225 Broad Hollow Road, Suite 105E
Melville, New York 11747

LEWIS, JOHS, AVALLONE & AVILES
One CA Plaza, Suite 225
Islandia, New York 11749

Upon the following papers numbered 1 to 32 read on these motions for summary judgment: Notice of Motion/ Order to Show Cause and supporting papers 1-13; 14-25 ; Notice of Cross Motion and supporting papers ___ ; Answering Affidavits and supporting papers 26-28 ; Replying Affidavits and supporting papers 29-30; 31-32 ; Other___ ; it is,

ORDERED that the motion (motion sequence no. 002) of defendant Marc Finkelstein, M.D., and the motion (motion sequence no. 003) of defendant Rajiv Saxena, M.D., are consolidated for purposes of this determination; and it is

ORDERED that the motion (motion sequence no. 002) of defendant Marc Finkelstein, M.D., for summary judgment in his favor dismissing the complaint and all cross claims asserted against him is denied; and it is further

ORDERED that the motion (motion sequence no. 003) of defendant Rajiv Saxena, M.D., for summary judgment in his favor dismissing the complaint and all cross claims asserted against him is denied.

Nicholas Kemp, as executor of the estate of Maryanne Kemp, commenced this action to recover for personal injuries related to medical malpractice in the alleged failure to diagnose, treat, and properly manage Maryanne Kemp's diverticulitis. Issue has been joined, discovery is complete, and a note of issue has been filed.

Marc Finkelstein, M.D., moves for summary judgment in his favor dismissing the complaint and all cross claims asserted against him. In support of the motion Dr. Finkelstein

submits, among other things, copies of the pleadings; an expert affirmation of Heather Yeo, M.D.; medical records; his own deposition transcript; and the deposition transcripts of Nicholas Kemp, Rajiv Saxena, M.D., and Stephen Hom, M.D.

Rajiv Saxena, M.D., also moves for summary judgment in his favor dismissing the complaint and all cross claims asserted against him. In support of the motion Dr. Saxena submits an expert affirmation of Sanford R. Goldberg, M.D.; copies of the pleadings; his own deposition transcript; the deposition transcripts of Nicholas Kemp, Stephen Hom, M.D., Marc Finkelstein, M.D.; and plaintiff's medical records.

In opposition, plaintiff submits the expert affirmations of Brian C. Weiner, M.D., Douglas C. Boxer, M.D., and Michael Drew, M.D.

Medical records indicate that Maryanne Kemp presented to Good Samaritan Hospital emergency room on January 2, 2009 at 7:00 p.m. She arrived by ambulance with a complaint of several days of abdominal pain. Her prior medical history included a kidney transplant, hyperlipidemia, and hypertension. In the emergency room, an examination revealed non-radiating pain in her lower abdomen, pain on her right side and mild distention and tenderness. Emergency room physician notes indicate there was no rebound tenderness or guarding, and that plaintiff was awaiting another kidney transplant "if one becomes available." Laboratory results showed an elevated white blood count, and renal studies showed elevated BUN and creatinine levels. Plaintiff also had a fever of 99.1 degrees and weighed 250 pounds. At 11:43 p.m., a CT scan revealed pericoloic stranding at the sigmoid mesocolon of the lower left quadrant around the proximal/mid-sigmoid colon, suggesting acute colonic diverticulitis. Extraluminal air bubbles were noted in the CT report at the sigmoid mesocolon, which indicate perforated sigmoid diverticulitis, but there was no fluid collection or gross free air. At 11:50 p.m., plaintiff was diagnosed by Dr. Stephan Hom with acute sigmoid diverticulitis, a history of a kidney transplant, and renal failure.

On January 3, 2009, at 12:20 a.m., medical records indicate that Dr. Marc Finkelstein was called for a surgical consultation. Dr. Finkelstein testified that he examined plaintiff at 1:00 a.m. and noted her medical history as significant for a left kidney transplant in 2002. He testified that his physical examination revealed tenderness on the left side, with some guarding, but no rebound or peritoneal signs. He testified that his findings were consistent with acute colonic diverticulitis and he documented that plaintiff had been started on IV antibiotics in the emergency room. He testified that if there was no improvement from the IV antibiotics in 24 hours, surgery would be required.

At 8:35 a.m., plaintiff was seen by Dr. Stephen Bernhardt, a nephrologist. Dr. Bernhardt noted worsening kidney rejection and a high risk for any surgical procedure, and that he agreed with the recommendation for conservative treatment with IV antibiotics. Between 1:00 p.m. and 3:00 p.m., plaintiff was seen by Dr. Jennifer Castro, a surgeon providing weekend coverage for Dr. Finkelstein. Dr. Castro noted that plaintiff had no abdominal pain, no distention and minimal tenderness. She recommended continued IV treatment. At 5:00 p.m., plaintiff was examined by a gastroenterologist, Dr. Rajiv Saxena. Dr. Saxena testified that plaintiff's abdomen was soft, with

low abdominal tenderness and no rebound. His impression was diverticulitis and he agreed with the plan of IV antibiotics and a restricted diet.

On January 4, 2009, at 9:05 a.m., plaintiff was seen by Dr. Bernhardt, who noted she "feels better." He advised continued conservative management, including IV antibiotics. Between 9:30 p.m. and 12:30 p.m., plaintiff was seen by Dr. Castro, who noted no abdominal pain, no distention and no tenderness. Her impression was acute diverticulitis "clinically improving." On January 4, 2009, a hospitalist, Dr. Singh, noted "abdominal pain less compared to yesterday," and on January 5, 2009, he noted plaintiff had a bowel movement.

Dr. Finkelstein testified that he saw plaintiff on January 5, 2009, and her abdomen was soft, her white blood count had decreased from 19.9 to 16.5, and he discussed with plaintiff if she had a second episode of diverticular pain that she should treat at North Shore University Hospital, where her transplant nephrologist could be involved in her care.

At 11:45 a.m., gastroenterologist Dr. DiSanti examined plaintiff and recorded "no complaints of pain," tolerating a liquid diet, and "resolving diverticulitis/anemia." He ordered 10 to14 days of antibiotics and a colonoscopy once plaintiff recovered. At 9:30 p.m., Dr. DiSanti again examined plaintiff and noted no abdominal pain, plaintiff's abdomen was soft and nontender and her white blood count improved to 15.8. Dr. DiSanti's impression was resolving diverticulitis, improving. On January 6, 2009, plaintiff was seen by Dr. Hom and at 4:15 p.m. he noted her abdomen was soft and nontender. On January 7, 2009, Dr. Hom noted plaintiff's white blood count was down to 12.2. IV's were discontinued, and plaintiff was started on oral medications. On January 8, 2009, Dr. Hom noted plaintiff's abdomen was soft and nontender and her white blood count was now 8.8. Dr. Bernhardt also examined plaintiff and noted that she felt better.

On January 9, 2009, Dr. Hom noted that plaintiff's abdomen was soft and nontender and her white blood count was 4.3. Plaintiff complained of chronic back pain and constipation. Dr. Hom ordered a laxative and follow-up with the nephrologist. Plaintiff requested a transfer to North Shore University Hospital to see her treating nephrologist, Dr. Gittman. A bladder ultrasound and catheter were ordered due to urinary retention. On January 10, 2009, Dr. Hom reported that plaintiff's white blood count was 3.6 and that she complained of stomach discomfort. His assessment was perforated diverticulitis, that was "better clinically." On January 11, 2009, plaintiff was lethargic, in pain, and her abdomen was soft, with some tenderness. Her white blood count was 2.5. Plaintiff was diagnosed with end stage renal disease and on January 11, 2009, a catheter was placed for hemodialysis. On January 12, 2009, plaintiff was transferred to North Shore University Hospital. Dr. Hom's transfer notes indicate that plaintiff's abdomen was soft and nontender, that her abdominal pain improved during the hospitalization, but her renal function had deteriorated.

On January 12, 2009, at North Shore University Hospital, plaintiff was diagnosed with immune suppression, renal failure, history of transplant with vascular disease with acute diverticulitis with mild sigmoid mesocolon perforation managed medically. Dr. Bhaskaran, a North Shore University Hospital surgeon, ordered a repeat CT scan, and on January 13, 2009, that test revealed a large amount of retroperitoneal extraluminal gas with associated inflammatory changes consistent with perforated diverticulitis. On January 13, 2009, plaintiff underwent an

exploratory laparotomy, and drains and a vacuum were placed. On January 19, 2009, plaintiff was transferred to a surgical floor and she remained at North Shore University Hospital until her death on September 17, 2009.

To make a *prima facie* showing of entitlement to summary judgment in an action to recover damages for medical malpractice, a defendant must establish through medical records and competent expert affidavits that it did not deviate or depart from accepted medical practice in the treatment of the plaintiff or that it was not the proximate cause of plaintiff's injuries (*see Castro v New York City Health & Hosps. Corp.*, 74 AD3d 1005, 903 NYS2d 152 [2d Dept 2010]; *Deutsch v Chaglassian*, 71 AD3d 718, 896 NYS2d 431 [2d Dept 2010]; *Plato v Guneratne*, 54 AD3d 741, 863 NYS2d 726 [2d Dept 2008]; *Jones v Ricciardelli*, 40 AD3d 935, 836 NYS2d 879 [2d Dept 2007]; *Mendez v City of New York*, 295 AD2d 487, 744 NYS2d 847 [2d Dept 2002]). To satisfy this burden, the defendant must present expert opinion testimony that is supported by facts in the record and addresses the essential allegations in the bill of particulars (*see Roques v Noble*, 73 AD3d 204, 899 NYS2d 193 [1st Dept 2010]; *Ward v Engel*, 33 AD3d 790, 822 NYS2d 608 [2d Dept 2006]). Conclusory statements that do not address the allegations in the pleadings are insufficient to establish entitlement to summary judgment (*see Garbowski v Hudson Val. Hosp. Ctr.*, 85 AD3d 724, 924 NYS2d [2d Dept 2011]). A physician owes a duty of reasonable care to his or her patients and will generally be insulated from liability where there is evidence that he or she conformed to the acceptable standard of care and practice (*see Spensieri v Lasky*, 94 NY2d 231, 701 NYS2d 689 [1999]; *Barrett v Hudson Valley Cardiovascular Assoc., P.C.*, 91 AD3d 691, 936 NYS2d 304 [2d Dept 2012]; *Geffner v North Shore Univ. Hosp.*, 57 AD3d 839, 871 NYS2d 617 [2d Dept 2008]).

Failure to demonstrate a *prima facie* case requires denial of the summary judgment motion, regardless of the sufficiency of the opposing papers (*see Alvarez v Prospect Hosp.*, 68 NY2d 320, 5088 NYS2d 923 [1986]). Once the defendant makes a *prima facie* showing, the burden shifts to the plaintiff to produce evidentiary proof in admissible form sufficient to establish the existence of triable issues of fact which require a trial of the action (*see Alvarez v Prospect Hosp., supra*; *Kelley v Kingsbrook Jewish Med. Ctr.*, 100 AD3d 600, 953 NYS2d 276 [2d Dept 2012]; *Fiorentino v TEC Holdings, LLC*, 78 AD3d 911 NYS2d 146 [2d Dept 2010]). In a medical malpractice action, a plaintiff opposing a motion for summary judgment 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 (*see Bhim v Dourmashkin*, 123 AD3d 862, 999 NYS2d 471 [2d Dept 2014]; *Hayden v Gordon*, 91 AD3d 819, 937 NYS2d 299 [2d Dept 2012]; *Stukas v Streiter*, 83 AD3d 18, 918 NYS2d 176 [2d Dept 2011]; *Schichman v Yasmer*, 74 AD3d 1316, 904 NYS2d 218 [2d Dept 2010]).

Here, Dr. Finkelstein and Dr. Saxena have demonstrated a *prima facie* case of entitlement to summary judgment. Dr. Finkelstein's expert, Dr. Heather Yeo, opines that Dr. Finkelstein did not depart from good and accepted medical practice with regard to his surgical consultation and the treatment he rendered to plaintiff, and that the treatment he rendered was not a proximate cause of plaintiff's injuries and death. Dr. Yeo avers that at the time of Dr. Finkelstein's examination of plaintiff "there were no clear indications for immediate surgical intervention." She avers the CT scan was negative for abscess or colon perforation, and the plan for 24 hour IV antibiotics was reasonable and within the standard of good medical practice. Dr. Yeo states her review of the January 2, 2009 CT scan reveals "acute diverticulitis without a large amount of free

air," and the perforation was contained within the sigmoid mesocolon. Dr. Yeo opines that there were no findings on January 2, 2009 on the CT scan or on clinical evaluation that would warrant immediate surgical intervention, and that it was within the accepted standard of medical care to offer a trial of medical management to determine if it would resolve the diverticulitis. Dr. Yeo further avers plaintiff's downward trending white blood count was an indication that medications were addressing plaintiff's inflammation and infection and that her condition was improving.

Dr. Sanford Goldberg, Dr. Saxena's expert gastroenterologist, opines that Dr. Saxena's treatment and care of plaintiff was within the standard of good and accepted medical practice and that his treatment was not a proximate cause of plaintiff's injuries and death. Dr. Goldberg avers there were no clear indications for recommending surgical intervention at the time of Dr. Saxena's consultation and no indication for surgical intervention or a repeat CT scan at the time of his last contact with plaintiff on January 4, 2009. Dr. Goldberg avers that the January 2, 2009 CT scan does not show any free air under the diaphragm or liver which would indicate a gross colon perforation. He avers the finding of extraluminal air bubbles confined to the sigmoid mesocolon would confirm the diagnosis of diverticulitis, which can be managed medically. Dr. Goldberg avers that the appropriate treatment was IV antibiotics and that "plaintiff did not require immediate surgical intervention for the diagnosis of diverticulitis, and in fact, was high risk for any surgical procedure."

In opposition, plaintiff has raised triable issues of fact. Plaintiff's expert gastroenterologist, Dr. Brian Weiner, avers that Dr. Saxena's failure to repeat the CT scan in an immunosuppressed patient, like plaintiff, violated the standard of care as conservative treatment including antibiotics and a restricted diet would not resolve the underlying illness of diverticulitis with a perforation. He avers that plaintiff required aggressive treatment with surgical intervention. Dr. Weiner opines that plaintiff was morbidly obese, was immunocompromised and in kidney failure, and, therefore, would not be capable of resolving a mild case of diverticulitis with antibiotic therapy. He avers that closer monitoring by repeat CT scan and surgery were warranted. Dr. Weiner also maintains that Dr. Saxena's reliance on his physical examination of plaintiff was also a departure from good and accepted medical practice, because in a morbidly obese patient physical examination techniques are unreliable.

Dr. Douglas Boxer, plaintiff's expert radiologist, avers that the care and treatment rendered by Dr. Finkelstein and Dr. Saxena was not within the standards of good and accepted medical practice. Dr. Boxer avers that both doctors failed to order a follow-up CT scan and failed to aggressively treat plaintiff. He opines that Dr. Finkelstein and Dr. Saxena departed from good and accepted standards of medical practice in not fully appreciating the findings on the CT scan, not ordering follow-up imaging studies, and not realizing that conservative treatment in a medically compromised individual would not adequately treat perforated diverticulitis.

Finally, Dr. Michael Drew, plaintiff's expert surgeon, avers that the failure to order a repeat CT scan was a departure from good and accepted standards of medical practice, as was the failure to realize that plaintiff's physical condition would not properly reveal the severity of her illness. He avers that in morbidly obese patients "you will find minimal-to-no guarding or rebound tenderness," and "the symptoms the patient is experiencing are far more severe than is detectable from the physical examination." Dr. Drew avers "that the standard of care dictates you

not rely on physical examinations, subjective complaints and lab work but actually repeat the CT scan to keep a close watch over the condition taking place internally." Accordingly, based upon the issues of fact raised by plaintiff, the motions by Dr. Finkelstein and Dr. Saxena are denied.

Dated: August 2, 2017

HON. PAUL J. BAISLEY, JR.

J.S.C.