

Nuzzi v Lieberman

2019 NY Slip Op 34947(U)

September 4, 2019

Supreme Court, Nassau County

Docket Number: Index No. 600888/16

Judge: Jeffrey S. Brown

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SHORT FORM ORDER

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NASSAU

PRESENT: HON. JEFFREY S. BROWN
JUSTICE

-----X TRIAL/IAS PART 11
DHANRAJIE NUZZI and FRANK NUZZI, as Guardian
of the person and property of VINCENT NUZZI, INDEX #600888/16

Plaintiff(s),
-against- Motion Seq. 7, 8
Motion Date 5.30.19
Submit Date 8.1.19

CARA LIEBERMAN, M.D., PROHEALTH CARE
ASSOCIATES, LLP, JERICHO PRIMARY CARE,
CHERYL DINGLAS, D.O. and WINTHROP UNIVERSITY
HOSPITAL,

Defendant(s).
-----X

Table with 2 columns: Papers Numbered, Papers. Rows include: Notice of Motion, Affidavits (Affirmations), Exhibits Annexed; Answering Affidavit; Reply Affidavit.

Defendants Cara Lieberman, M.D. and Prohealth Care Associates, LLP (Prohealth) move by notice of motion for an order granting summary judgment on plaintiff Dhanrajie Nuzzi's medical malpractice claims and on her lack of informed consent claim, as well as on the derivative claims asserted by plaintiff's spouse Vincent Nuzzi. Defendants Cheryl Dinglas, D.O. and Winthrop University Hospital cross-move for summary judgment dismissing all of plaintiff's claims as asserted against them in their entirety. Plaintiff does not oppose the cross-motion.

Plaintiff commenced this medical malpractice action on February 10, 2016 for injuries allegedly sustained during a laparoscopic-assisted hysterectomy performed by Dr. Lieberman on October 15, 2015. An order of default against Jericho Primary Care was entered on May 13, 2016, with damages to be assessed at the time of trial of this action.

By her bill of particulars, plaintiff alleges that defendant Dr. Lieberman failed to maintain a clear operative field, failed to properly identify and protect the plaintiff's anatomy during the surgery, failed to identify the plaintiff's ureter intra-operatively and failed to use a stent to identify its location. Additionally, the bill of particulars alleges that Dr. Lieberman failed to properly perform the hysterectomy procedure and improperly caused and subsequently failed to diagnose and treat a ureteral injury as well as an ovarian injury and a uterine artery injury. The bill of particulars further indicates that the defendant failed to determine the etiology and act upon a number of symptoms plaintiff's exhibited after surgery including abdominal pain and distention, hypotension, weakness, vomiting, and decreased bowel sounds. As a result of this alleged malpractice, plaintiff claims a number of injuries, including the need for an additional surgical procedure, partial ureteral resection, and the possibility of additional surgery in the future.

It is well established that '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 demonstrate the absence of any material issues of fact.' (*Alvarez v. Prospect Hosp.*, 68 N.Y.2d 320, 324 [1986]; see also *William J. Jenack Estate Appraisers & Auctioneers, Inc. v. Rabizadeh*, 22 N.Y.3d 470, 475-476 [2013]; CPLR 3212[b]). Once the movant makes the proper showing, 'the burden shifts to the party opposing the motion for summary judgment to produce evidentiary proof in admissible form sufficient to establish the existence of material issues of fact which require a trial of the action' (*Alvarez*, 68 N.Y.2d at 324). The 'facts must be viewed in the light most favorable to the non-moving party' (*Vega v. Restani Constr. Corp.*, 18 N.Y.3d 499, 503 [2012] [internal quotation marks omitted]). However, bald, conclusory assertions or speculation and '[a] shadowy semblance of an issue' are insufficient to defeat summary judgment (*S.J. Capelin Assoc. v. Globe Mfg. Corp.*, 34 N.Y.2d 338, 341 [1974]), as are merely conclusory claims (*Putrino v. Buffalo Athletic Club*, 82 N.Y.2d 779, 781 [1993]).

(*Stonehill Capital Management, LLC v Bank of the West*, 28 N.Y.3d 439 [2016]; see also *Fairlane Financial Corp. v Longspaugh*, 144 AD3d 858 [2d Dept 2016]; *Phillip v D&D Carting Co., Inc.*, 136 AD3d 18 [2d Dept 2015]).

"In order to establish the liability of a professional health care provider for medical malpractice, a plaintiff must prove that the provider "departed from accepted community standards of practice, and that such departure was a proximate cause of the plaintiff's injuries." (*Schmitt v Medford Kidney Ctr.*, 121 AD3d 1088, 1088 [2d Dept 2014] [quoting *DiGeronimo v Fuchs*, 101 AD3d 933, 936 [2d Dept 2012]]; *Fink v DeAngelis*, 117 AD3d 894, 896 [2d Dept 2014]; *Stukas v Streiter*, 83 AD3d 18, 23 [2d Dept 2011]). "A defendant seeking summary judgment in a medical malpractice action bears the initial burden of establishing, *prima facie*, either that there was no departure from the applicable standard of care, or that any alleged departure did not proximately cause the plaintiff's injuries." (*Michel v Long Is. Jewish Med. Ctr.*, 125 AD3d 945, 945 [2d Dept 2015], lv denied, 26 NY3d 905 [2015]; see also *Barrocales v*

New York Methodist Hosp., 122 AD3d 648, 649 [2d Dept 2014]; *Berthen v Bania*, 121 AD3d 732, 732 [2d Dept 2014]; *Trauring v Gendal*, 121 AD3d 1097, 1097 [2d Dept 2014]; *Stukas*, 83 AD3d at 23). “Once a defendant physician has made such a showing, the burden shifts to the plaintiff to demonstrate the existence of a triable issue of fact, but only as to the elements on which the defendant met the *prima facie* burden.” (*Gillespie v New York Hosp. Queens*, 96 AD3d 901, 902 [2d Dept 2012]).

“Establishing proximate cause in medical malpractice cases requires a plaintiff to present sufficient medical evidence from which a reasonable person might conclude that it was more probable than not that the defendant’s departure was a substantial factor in causing the plaintiff’s injury.” (*Semel v Guzman*, 84 AD3d 1054, 1056 [2d Dept 2011] [citing *Johnson v Jamaica Hosp. Med. Ctr.*, 21 AD3d 881, 883 [2d Dept 2005]]; *Goldberg v Horowitz*, 73 AD3d 691 [2d Dept 2010]; see also *Skelly–Hand v Lizardi*, 111 AD3d 1187, 1189 [2d Dept 2013]). A plaintiff is not required to eliminate all other possible causes. (*Skelly–Hand* at 1189).

“[G]eneral allegations that are conclusory and unsupported by competent evidence tending to establish the essential elements of medical malpractice are insufficient to defeat a defendant’s motion for summary judgment (citations omitted).” (*Bendel v Rajpal*, 101 AD3d 662, 663 [2d Dept 2012] [quoting *Bezerman v Bailine*, 95 AD3d 1153, 1154 [2d Dept 2012]]; see also *Savage v Quinn*, 91 AD3d 748, 749 [2d Dept 2012]; *Myers v Ferrara*, 56 AD3d 78, 84 [2d Dept 2008]).

In support of this motion, Dr. Lieberman and Prohealth submit the relevant deposition transcripts and medical records, together with the expert affirmation of Lawrence Lind, M.D. Dr. Lind is board certified in obstetrics and gynecology with a sub-certification in female pelvic medicine and reconstruction. By his review of plaintiff’s medical records, Dr. Lind ascertained that the plaintiff, then 50 years old, first presented to Dr. Lieberman’s office on August 20, 2015 for a second opinion regarding undergoing a hysterectomy. Her medical history was significant for two caesarean sections, irregular and heavy menses, and the presence of a fibroid uterus. Dr. Lieberman ordered a pelvic and transvaginal ultrasound and venipuncture. Plaintiff presented again on September 10, 2015 to review the sonogram results, which showed a small fibroid. According to Dr. Lind, the options of medical management and alternatives to a hysterectomy were reviewed. Plaintiff opted to undergo a laparoscopic assisted vaginal hysterectomy and the procedure was scheduled for October 15, 2015.

Plaintiff saw Dr. Lieberman for pre-surgical consultation on October 8, 2015, during which a handwritten drawing of a uterus was used to explain the nature of the procedure. In particular, Dr. Lieberman’s note of the visit states: “The procedure was explained to the patient in full detail . . . The patient was given ample opportunity to ask questions, all of which were answered to the best of my ability. The patient demonstrated an understanding of the step-by-step procedure. The patient was also made aware of the inherent risks, including but not limited to infection, bleeding, damage to surrounding organs including bladder or bowel and ureter, with potential need for subsequent surgery. Patient is also aware of the increased risk of hemorrhage,

of the need for blood transfusion and the possibility of mortality with any surgical procedure. The patient is also aware of the risk of having to convert to a laparotomy. Full informed consent obtained.”

On October 15, 2015, the plaintiff underwent a laparoscopic-assisted vaginal hysterectomy, left salpingo-oophorotomy, and right salpingectomy performed by Dr. Lieberman with the assistance of Cheryl Dinglas, D.O. at Winthrop University Hospital. The operative report, prepared by Dr. Dinglas noted a laparoscope was inserted through the trocar sheath and visualization of the pelvic structures was noted. Several adhesions were noted and an omental adhesion was taken down using an EnSeal device. The ligaments were dissected and the bladder, which was adherent to the lower uterine segment and cervix was taken down using hydrodissection and Endoshear scissors. The uterine vessels were coagulated and transected to the level of the uterine artery, which was coagulated using the EnSeal device. The bladder was then retrograde filled with methylene blue to ensure that the bladder was completely dissected off. The vaginal hysterectomy was performed, clamping, transecting and ligating the relevant structures. The laparoscope was again used to determine no further bleeding and irrigation with sterile water was performed, following which, plaintiff was taken to the recovery room in stable condition.

A 4:00 p.m. post-operative note indicates that the plaintiff was tolerating sips of water and a Foley catheter was in place, draining clear yellow urine. Her abdomen was non-distended and she had no leg edema. The plan was to discharge her the following morning after a CBC was performed. A further note on October 16, 2015 at 6:00 a.m. indicates that Ms. Nuzzi complained of mild suprapubic pain, her abdomen was soft with mild distention and decreased bowel sounds. Discharge arrangements were made but at 2:00 p.m., the plaintiff was noted to be vomiting and was medicated for the same. At 3:00 p.m., plaintiff reported feeling dizzy and was noted to have decreased blood pressure. Blood tests were ordered and at 3:30 p.m., following discussion with Dr. Lieberman, a STAT abdominal CT scan was ordered to rule out a ureter injury. The scan was completed at 6:48 p.m. and indicated hyperdense fluid in the pelvis consistent with a hemorrhage. Injury to the left ureter could not be excluded. Dr. Lieberman was consulted and suggested holding a blood transfusion and administering IVP (intravenous pyelogram, a radiological procedure used to visualize the urinary system). A transfusion of red blood cells was ordered.

On October 17, 2015 at 4:08 a.m., a repeat CT scan with contrast demonstrated a transection of the distal left ureter with an abrupt cutoff and marked extravasation of contrast centered at this level with a large amount of retroperitoneal complex free fluid (likely representing a combination of contrast, urine and blood). Thereafter, an exploratory laparotomy was performed to reimplant the left ureter, which also required partial resection. Plaintiff was transfused twice prior to the procedure. The right uterine artery was found to be actively bleeding and was also clipped and cauterized. The bladder was found to be free of leaks.

Plaintiff was discharged home on October 20, 2015, with a Foley catheter in place. She

was given discharge instructions by Dr. Dinglas, directing her to follow-up with Dr. Lieberman and a urologist and was given a referral to VNS. Plaintiff presented to Dr. Lieberman on October 29, 2015, reporting pain in her back and painful urination. She was given a prescription for Cipro. Following additional complaints of pain, plaintiff reported to urologist Dr. Corcoran, who removed a stent from plaintiff's bladder. He suspected an accidental puncture and laceration of the genitourinary system. Plaintiff continued to complain of pain on urination through February 10, 2016.

Dr. Lind opines that performance of a laparoscopic hysterectomy, left salpingo-oophorectomy and right salpingectomy was clinically indicated, given plaintiff's medical history and clinical examination. In addition, Dr. Lind opines that the ureteral injury sustained by the plaintiff during the procedure is a known and accepted complication of laparoscopic hysterectomy which can occur in the absence of malpractice, having a statistical incidence of between 1 and 2%. According to Dr. Lind, the risk is increased in a patient such as the plaintiff who had two prior surgeries. He further opines that appropriate protective measures were taken by Dr. Lieberman during the procedure to reduce the risk of injury to the ureters, including dissection of the broad ligament to permit visualization of the ureter and the use of methylene blue filling to verify integrity of the bladder. Dr. Lind also indicates that there is no specific requirement that ureteral stents be used during this procedure and that such prophylactic use is controversial. Further, Dr. Lind finds that the postoperative management of the plaintiff was consistent with good standards of medical care and practice and that her injury was diagnosed and treated in a timely fashion. He indicates that calling in a surgical consult and performance of an exploratory laparotomy within 24 hours of abnormal symptoms was well within the standard of care.

Finally, Dr. Lind opines that the records show that Dr. Lieberman obtain full informed consent of the plaintiff and that the particular nature of their discussions were memorialized.

In opposition, plaintiff submits the redacted affirmation of a physician board-certified in obstetrics and gynecology, who indicates that he/she has performed countless surgeries, including hysterectomies and the requirements thereof. He/she has reviewed the pertinent records as well and Dr. Lind's expert affirmation. Plaintiff's expert opines that Dr. Lieberman departed from the standard of care in performing a laparoscopic-assisted vaginal hysterectomy, left salpingo-oophorectomy and right salpingectomy, rather than a supracervical hysterectomy. Further, plaintiff's expert opines that the procedure should have been performed via laparotomy rather than laparoscopically in light of the plaintiff's prior caesarean sections because of the likelihood of adhesions. He/she indicates that the procedure that was performed was actually counterindicated in this patient as her cervix was normal and did not need to be removed.

Additionally, according to plaintiff's expert, upon encountering adhesions, Dr. Lieberman should have converted to an open procedure to provide greater ability to identify and protect the ureter. Plaintiff's expert further indicates that the defendant failed to identify and protect plaintiff's left ureter and permitted dissection too close to this structure, also failing to recognize

and address the injury in a timely fashion. Plaintiff's expert explains that because the uterine artery crosses the ureter anteriorly, the ureter must be clearly identified prior to ligating the uterine artery in order to safeguard it. Further, plaintiff's expert states that the record does not indicate that Dr. Lieberman checked the ureter for damage or peristalsis. Upon review by pathology, it was determined that a portion of the ureter was burned, likely as a result of contact with the EnSeal device.

Finally, plaintiff's expert opines that the Dr. Lieberman failed to obtain a proper informed consent from the plaintiff. In particular, plaintiff's expert notes plaintiff's deposition testimony to the effect that Dr. Lieberman did not discuss with her any of the risks related to hysterectomy performed either laparoscopically or by some other method and did not discuss a supracervical hysterectomy as an option. He/she indicates that ureteral injury is not an "accepted risk" of a hysterectomy but physicians must nevertheless advise patients of the possibility.

In light of the record evidence and conflicting medical affidavits presented, the court finds that there are issues of fact concerning whether the defendants departed from the standards of good and accepted medical practice in performing the laparoscopic-assisted hysterectomy and in failing to timely identify and address injury to plaintiff's left ureter during the procedure and whether such departures substantially contributed to the damages that plaintiff claims in this action. "Summary judgment is not appropriate in a medical malpractice action where the parties adduce conflicting medical expert opinions." (*Feinberg v Feit*, 23 AD3d 517, 519 [2d Dept 2005]). "Such conflicting expert opinions will raise credibility issues which can only be resolved by a jury [or trier of fact]." (*DiGeronimo v Fuchs*, 101 AD3d 933, 936 [2d Dept 2012]; *See also Hayden v. Gordon*, 91 Ad3d 819 [2d Dept 2012]). Moreover, plaintiff's own testimony together with the opinions offered by her expert physician are sufficient to raise a question of fact regarding whether adequate informed consent was provided to the plaintiff.

Moreover, contrary to defendant's contention, plaintiff's expert's opinion is neither conclusory nor speculative but rather contains sufficient detail of the departures from the applicable standards of care that, according to said expert, resulted in plaintiff's injuries. Nor does plaintiff's expert physician offer wholly new theories of liability, prejudicing defendant's case. Rather, plaintiff's expert directly addresses and disputes Dr. Lind's opinion that the chosen procedure was indicated in light of plaintiff's medical history. (*See Mackauer v. Parikh*, 148 AD3d 873 [2d Dept 2017]).

By their cross-motion, defendant's Dr. Dinglas and Winthrop University Hospital contend that the surgical procedure was conducted under the direction and supervision of Dr. Lieberman, who was a non-employee attending physician at the facility. Accordingly, these defendants contend that, as a matter of law, neither assisting physician Dr. Dinglas nor Winthrop University Hospital can be liable in this action. As noted above, plaintiff presents no opposition to this motion and acknowledges Dr. Lieberman's attested control of the procedure. Accordingly, on the cross-moving defendant's prima facie showing, summary judgment will be granted in their favor.

Finally, with respect to the claims of Vincent Nuzzi, the law is clear that a spouse's derivative claims stem from a relationship based on affection, companionship, society and solace. (*See Rakich v. Lawes*, 186 AD2d 932 [3d Dept 1992]; *see also Dooley v. Skodnek*, 138 AD2d 102 [2d Dept 1988] [derivative cause of action ceased at the time of marital separation]). Here, plaintiff testified at deposition that she was in the process of divorcing her spouse following some ten years of abuse. Additionally, plaintiff testified that issues with her marriage preceded her surgery and that she was solely responsible for household chores and childcare. There is no opposition to this aspect of defendants' motions. Accordingly, the derivative cause of action on behalf of Vincent Nuzzi must be **dismissed**.

For the foregoing reasons, it is hereby

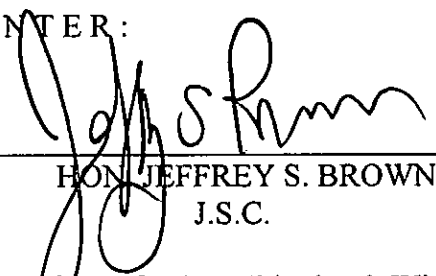
ORDERED, that the motion for summary judgment by Cara Lieberman, M.D. and Prohealth Care Associates is **denied** with respect to the first and second causes of action and **granted** with respect to the third cause of action; and it is further

ORDERED, that the motion for summary judgment by Cheryl Dinglas, D.O. and Winthrop University Hospital is **granted** in its entirety.

This constitutes the decision and order of this Court. All applications not specifically addressed herein are denied.

Dated: Mineola, New York
September 4, 2019

ENTER:


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J.S.C.

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ENTERED

SEP 05 2019

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