Ameziani v Subramanyam
2020 NY Slip Op 31694(U)
April 29, 2020
Supreme Court, New York County
Docket Number: 805023/17
Judge: Joan A. Madden
Cases posted with a "30000" identifier, i.e., 2013 NY Slip Op 30001(U), are republished from various New York State and local government sources, including the New York State Unified Court System's eCourts Service.
This opinion is uncorrected and not selected for official publication.

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NEW YORK, IAS PART 11
-- X
LOURDES AMEZIANI,

INDEX NO. 805023/17

Plaintiff,

-against-

BALA SUBRAMANYAM, M.D.,LANA SELITSKY D.O. and DR BALA SUBRAMANYAM RADIOLOGY, P.C.,

Defendants.
--X
JOAN A. MADDEN, J.:

In this action for medical malpractice, defendants Bala Subramanyam, M.D. ("Dr. Subramanyam") and Dr. Bala Subramanyam Radiology, P.C. ("together the Subramanyam defendants") move for summary judgment dismissing the complaint against them (motion sequence no. 001). Defendant Lana Selitsky, D.O. ("Dr. Selitsky") separately moves for summary judgment dismissing that complaint against her (motion sequence no. 002).[1] Plaintiff opposes the motions.

Background

This action arises out of defendants' alleged failure to diagnose plaintiff Lourdes Ameziani ("Ms. Ameziani" or "plaintiff"), with an appendicitis. On August 7, 2014, at about 9:00 am, Ms. Ameziani presented as a walk-in patient with a positive home pregnancy test at a clinic where Dr. Selitsky is on staff as an obstetrician/gynecologist. Ms. Ameziani was seen by a medical assistant, who drew her blood to confirm the pregnancy. She was not seen by Dr.

[1]Motion sequence nos. 001 and 002 are consolidated for disposition.

Selitsky or another physician.[2] The blood test later confirmed her pregnancy. Plaintiff testified that she complained at the August 7 office visit of "very sharp abdominal pain" and that she was "very nauseous" (Ameziani EBT at 82).

According to plaintiff, on the afternoon of August 7, she called Dr. Selitsky's office reporting "sharp pains in my lower abdomen...[and] [n]ausea, constipation, sharp pains and vomiting." (Plaintiff's EBT at 97). Plaintiff did not speak to Dr. Selitsky. Dr. Selitsky testified that, upon learning of plaintiff's call reporting "early pregnancy and pelvic pain," she wrote a referral for Ms. Ameziani to the offices of Dr. Subramanyam, a radiologist, for a pelvic ultrasound to assist her in evaluating plaintiff's pain (Selitsky EBT at 36-38, 40, 42, 46, 49).[3]

Ms. Ameziani presented at Dr. Subramanyam's office for the ultrasound between 2:00 and 2:30 pm on August 7, and Dr. Subramanyan obtained her history, including a positive home pregnancy test and right lower quadrant pain since that morning (Subramanyan EBT at 26). Plaintiff testified that she told Dr. Subramanyan that she was nauseous (Plaintiff's EBT at 107), while Dr. Subramanyan denied that plaintiff told him of this symptom (Subramanyan EBT at 27, 28). Dr. Subramanyan testified that the purpose of the ultrasound was to rule out an ectopic pregnancy and to find the source of plaintiff's pain. (Id at 28-29). He also testified that he

---

[2]Plaintiff testified that she told the medical assistant that she did not think the pain was "normal" and asked to see Dr. Selitsky; however the medical assistant returned and told her that Dr. Selitsky said that she should take a Tylenol (Id at 89-90). Plaintiff's complaints of abdominal pain and nausea are not noted on the office chart and Dr. Selitsky testified that she was not informed that Ms. Ameziani complained of abdominal pain at the time of the August 7 visit, but that had she been told that a patient was complaining of pain she would have seen the patient (Selitsky EBT at 33, 34).

[3]Included in the record is part of the referral form that Dr. Selitsky faxed to Dr. Subramanyan's office at 1:41 pm on August 7, 2014, which states that the indication for the ultrasound is "early pregnancy and pelvic pain" (Dr. Subramanyan records, at 000004).

imaged plaintiff's right lower quadrant "because she had pain there," and this was the region where there is concern for an ectopic pregnancy, and that he considered that the source of the pain could be an appendicitis (Id at 32-33).

Dr Subramanyam testified that he performed the ultrasound study with a curved transducer and applied graded compression. (Id at 33, 34, 38, 39, 41). He also testified that he used a curved transducer probe during Ms. Ameziani's ultrasound because a linear transducer probe would not have captured the endo-vaginal images and would not have provided adequate depth penetration to allow him to visualize the abdominal structures that needed to be evaluated. (Id at 37-40). According to Dr. Subramanyam, during the ultrasound study he applied graded compression to facilitate his ability to visualize the abdominal structures, including the appendix, and to improve his perspective. (Id at 39,41, 43, 44). He testified that the patient's complaints of pain during the ultrasound procedure did not hold clinical significance for him as he is not a clinician and his focus was to use the information from the patient in his attempt to find abnormalities with the abdominal structures, which could provide an explanation for the patient's pain. (Id at 42-44).

With respect to the patient's appendix, Dr. Subramanyam testified that he "did not visualize the appendix," and denied reaching a conclusion that the appendix was normal or abnormal (Id at 47). He further testified that "the ultrasound has a modality. You cannot see every normal or abnormal appendix. I tried to see a normal appendix or an abnormal appendix, or any other cause for her pain. There were no findings in that area." (Id at 48). The ultrasound report found a left ovarian cyst, no evidence of torsion or abnormality in the right ovary and that the right lower quadrant and periumbilical region were scanned and "showed no abnormalities," and "no evidence of an ectopic pregnancy." (Dr. Subramanyam's records, at 000002). The report

did not mention the appendix.

While Ms. Ameziani was still in his office, Dr. Subramanyam telephoned Dr. Selitsky and told her he believed the pregnancy was in the uterus, and that he did not find the cause for plaintiff's pain, which he had explained to plaintiff (Id at 49, 50, 63). Plaintiff was then put on the call with Dr. Selitsky. According to plaintiff, Dr. Selitsky told her to get a copy of the ultrasound report "in the event" she "may want to go to the emergency room" (Plaintiff's EBT at 119). In contrast, Dr. Selitsky testified that she told plaintiff to "go to the nearest emergency room and bring the report with her so they wouldn't have to repeat the ultrasound again," and that she "emphasized the importance of ...going to the emergency room," as the ultrasound did not reveal the cause of her pain (Selitsky EBT at 69-71; 73-74). After she spoke to Dr. Selitsky, plaintiff returned home. Dr. Subramanyam testified that he did not give plaintiff any instructions regarding follow up or as to further treatment as it was not his role but that of the referring physician (Id at 50-54). Dr. Subramanyam testified that the ultrasound report which he faxed to Dr. Selitsky did not mention the appendix because "there [were] too many reasons for a patient to have pain, and I didn't have to specifically focus on the appendix" (Id at 59).

Dr. Selitsky testified that she called plaintiff the day after the ultrasound, (i.e. on August 8, 2014) "to see what happened in the emergency room," and plaintiff reported that she did not go to the emergency room but was feeling "a little better." (Selitsky EBT at 78). Dr. Selitsky further testified that she told plaintiff to take "pain precautions...meaning if the pain becomes severe go to the emergency room," with instructions to take fiber and have a follow up ultrasound in two weeks (Id at 79; Plaintiff's EBT at 132-135). Later that evening when she was experiencing pain, plaintiff again called Dr. Selitsky's office and explained her situation to the on-call covering physician who advised her to call 911 and go to the emergency room (Plaintiff's

EBT at 138).

Ms. Ameziani was transported by ambulance to the New York Presbyterian Hospital ("NYPH"), where she arrived at 11:32 pm. An ultrasound and MRI were taken. The ultrasound study did not indicate that the appendix was visualized, and no diagnosis of appendicitis was made, while the MRI revealed a acute appendicitis without perforation (NYPH Records at 280-281). A single incision laparoscopic appendectomy was performed at approximately 6:36 am on August 9, 2014. At the time of the procedure, an acutely inflamed, perforated and gangrenous appendix was noted and confirmed by the pathology report.

On August 11, plaintiff was diagnosed with a spontaneous abortion and miscarriage. On August 15, an abscess had developed and was confirmed by a CT-scan which was treated through ultrasound guided drainage; on August 20, another CT- scan showed a formation of new pockets of fluids and an additional drain was positioned. After 16 days of hospitilization, plaintiff was discharged, and on August 31, she returned to the hospital and her drains were removed.

In this action, plaintiff asserts claims against defendants for medical malpractice which resulted in her injuries, including a raptured appendix, remedial surgeries, and the loss of pregnancy.[4] With regard to the Subramanyam defendants, plaintiff alleges that Dr. Subramanyam departed from the standard of care in failing to identify the appendix; in failing to diagnose Ms. Ameziani's appendicitis; in failing to comment on the appendix in his report or in

[4]The original and amended complaint indicated that plaintiff intended to rely on the doctrine of res ipsa loquitor; however, as plaintiff does not argue in opposition to this motion that the doctrine applies, this theory of liability is deemed abandoned, and will not be considered by the court. In addition, while plaintiff's husband Slimane Ameziani was named as a plaintiff in this action, the claims by him were discontinued with prejudice by stipulation dated February 9, 2018.

his conversation with Dr. Selitsky, which left the misleading impression that the appendix was found to be normal; in using a curved transducer, instead of a linear one; and in failing to recommend a prompt, supplemental investigation of the cause of plaintiff's pain.

With respect to Dr. Selitsky, plaintiff alleges that she departed from the standard of care in her management of plaintiff's case by failing to unequivocally refer plaintiff to the emergency room once the ultrasound did not reveal that cause for her right abdominal pain, which departure was compounded by Dr. Selitsky's failure to have plaintiff go to the emergency room when she spoke to her the next day.[5]

As for causation, plaintiffs allege that defendants' respective departures from the standard of care, resulted in a delay in diagnosing the appendicitis, which significantly increased the risk of miscarriage, and caused the multiple post-operative abscesses and treatment.[6]

Following completion of discovery, the Subramanyam defendants and Dr. Selitsky separately moved for summary judgment, and plaintiff opposes the motions.

Subramanyam Defendants' Motion

The Subramanyam defendants move for summary judgment, arguing that they did not depart from the standard of care in connection with the ultrasound performed on plaintiff, and that plaintiff's asserted injuries are unrelated to any alleged acts or omissions of Dr. Subramanyam. They also argue that Dr. Subramanyam's choice of curved transducer was an exercise of medical judgment and is thus not a basis for liability, and that as a sonographer and

[5]While the Bill of Particulars includes allegations related to lack of informed consent and "reckless conduct" as well as additional departures, as these allegations and departures are not addressed by plaintiff's expert, they are deemed abandoned and will not be considered by the court.

[6]Plaintiff's experts do not address allegations that defendants' departures resulted in plaintiff's infertility, and the court therefore considers such allegations abandoned.

not a clinician, Dr. Subramanyam's duty was limited to diagnosing the source of plaintiff's pelvic pain to determine whether she had an ectopic pregnancy.

In support of their motion, the Subramanyam defendants submit the expert affirmation of Joseph M. Yee, M.D., a physician licensed to practice medicine in New York, who is board certified in diagnostic radiology. Dr. Yee opines, based on his review of the relevant medical records and images and the parties' depositions, that "in all respects Dr. Subramanyam's participation in the management of the patient met or exceeded the applicable standards of medical and radiologic practice at the time and place where treatment occurred." In this regard, he opines that "Dr. Subramanyam saw plaintiff not as a clinician but as a consultant in diagnostic ultrasound at the request of her primary care obstetrician, Dr. Selitsky [and that] [i]n his capacity as a sonographer who performed the study ordered by Dr. Selitsky on August 7, 2014, he exceeded the standard of care in a number of respects[7] and none of his conduct fell below the standard of care."

Dr. Yee opines:

> The evaluation of pelvic pain in early pregnancy is a complex issue for the clinician....The sonographer is not a clinician but serves an important supporting role to the obstetrician managing the pregnancy. Early pelvic pain in pregnancy can represent a tubal or ectopic pregnancy, which is appropriately evaluated by ultrasound examination. In this case, Dr. Subramanyam was able to determine that there was one gestational nidus within the uterus....[and] indicated that ectopic pregnancy was an unlikely cause for the patient's pain. Based upon the report of Dr. Subramanyam that still images from the sonographic study and his testimony regarding what he observed during the study, the patient had a normal ultrasound examination of the pelvis ... [and] [t]here was no evidence of an ectopic pregnancy....[t]his report was conveyed promptly both in writing and

[7]In support of his opinion that Dr. Subramanyam exceeded the standard of care, Dr. Yee notes that instead of having parts of the ultrasound study performed by technicians and other staff, Dr. Subramanyam was "personally involved" in, *inter alia*, gathering information from Ms. Ameziani, performing the diagnostic study, and choosing the mode of study.

orally by telephone, and this fully discharged Dr. Subramanyam's duty.

With respect to the allegations that Dr. Subramanyam was responsible for the delayed diagnosis of an appendicitis, Dr. Yee opines that:

> Even knowing that the patient was found to have appendicitis less than two days after the ultrasound examination of Dr. Subramanyam does not change the fact that his study showed a completely normal pelvic ultrasound. With knowledge of the subsequent diagnosis, there is no evidence of appendicitis on the retrospective review of the films of the August 7 pelvic ultrasound, and no reason for Dr. Subramanyam to have suggested further studies in his reporting to Dr. Selitsky. The images of the August 7 ultrasound do not show the appendix or any related anatomy, and all of the bowel shown on the films is normal in appearance. Even with the benefit of retrospect which Dr. Subramanyam did not have when he interpreted the films, there was no basis for him to have suspected appendicitis or evaluate the patient for that among the many other causes of pelvic pain in early pregnancy when he saw Ms. Ameziani for the single visit of August 7, 2014.

Dr. Yee also states that "the diagnosis of appendicitis was not made on the ultrasound study performed at [NYPH] in the early morning hours of August 9, 2014, either. This underscores the fact that pelvic ultrasound is not the study of choice for diagnosing disorders of the appendix. The MRI scan taken essentially contemporaneously with the NYPH ultrasound clearly showed the appendiceal pathology which would be expected." He thus opines "[t]here was no basis upon which the standards of accepted diagnostic ultrasound practice would have required that Dr. Subramanyam either anticipate an appendicitis was the cause of the earlier pelvic pain or required him to specifically suggest specific studies which might have revealed the presence of appendicitis at an earlier point."

With regard to the alleged departure related to Dr. Subramanyam's use of a curved transducer as oppose to a graded compression with a linear transducer, Dr. Yee opines that:

the choice of transducers and the use of graded compression are in the realm of judgments made by sonographers at the time they are performing studies, based upon the objectives of the study, the body habitus of the patient, and multiple other factors. The choice of either a linear or a curved transducer would both be within the standard of care, and the degree of use of graded compression is also based upon the judgment of the individual sonographer. Dr. Subramanyam had access to far more information in the course of the dynamic study than any subsequent radiologist who only has access to the few static images preserved from the essentially limitless number seen by Dr. Subramanyam. To suggest that the study would have been different with different technique is not supported by any evidence and is merely speculation that cannot be substantiated.

As for causation, Dr. Yee opines:

There is no evidence in this case that the patient's outcome, or the outcome of her pregnancy, was adversely affected by any act or omission on the part of Dr. Subramanyam. It is unfortunate that the patient contracted appendicitis during pregnancy, but she required surgery for appendicitis, and in that context a pregnant patient will frequently miscarry. There is no evidence that earlier diagnosis of the appendicitis would have resulted in treatment which was different from that which was rendered at New York Presbyterian Hospital, or that the outcome for the pregnancy or Ms. Ameziani would have been different from what it was [and]... that to a reasonable degree of medical certainty, Dr. Subramanyam's participation in the management of the patient was not a proximate cause, nor a substantial contributing factor, to any of the claimed injuries.

In opposition to the motion, plaintiffs submit the affirmation of Douglas C. Boxer, M.D. ("Dr. Boxer") who is licensed to practice medicine in New Jersey and is board certified in diagnostic radiology.[8] He states that his opinions, which are stated within a reasonable degree of medical certainty, are based on his review of the relevant medical records, including medical imaging studies and NYPH's CD imaging, the affirmation of Dr. Yee, and the parties'

depositions.

Upon review of Dr. Subramanyam's August 7, 2014 pelvic ultrasound examinations of Ms. Ameziani, Dr. Boxer states that "Doctor Subramanyam's report in this matter did not mention the unusual configuration of the uterus, did not comment on whether or not the appendix was identified, and made no recommendations for supplemental imaging investigation." He opines that "the appropriate sonographic technique for the investigation of suspected appendicitis, that of graded compression with a linear ultrasound transducer, was not incorporated; inexplicably, a curved transducer was utilized for Ms. Ameziani's 7 August 2014 ultrasound." (emphasis in the original).

Dr. Boxer also opines that:

> The presence of an early (four to five week) intrauterine gestation should not limit the ability of ultrasound for the detection of appendicitis as the uterus at such an early stage of pregnancy would not be large enough to obscure the region of the appendix. The fact that the right lower quadrant and periumbilical region were imaged on the 7 August 2014 ultrasound study is concordant with Doctor Subramanyam being aware that appendicitis was of clinical concern; this region of anatomy would not normally be included in a pelvic ultrasound study tailored to investigate a possible ectopic pregnancy. Doctor Subramanyam was aware of Ms. Ameziani's complaints typical for appendicitis, that of right-sided "sharp pains" in her lower abdomen and nausea, not the "pelvic pain" described in Doctor Yee's affirmation. Doctor Subramanyam confirmed this in the history he obtained on 7 August 2014, stating that the reason he imaged the right lower quadrant with ultrasound was "because she had pain there."

As for Dr. Subramanyam's decision to use a curved transducer as opposed to a linear transducer, Dr. Boxer opines:

> Simply because a variety of ultrasound transducers are available does not justify the use of equipment suboptimal for the task at hand. Doctor Subramanyam had access to a linear ultrasound transducer for Ms.

[8] In reply, plaintiff submits a certificate of conformity for Dr. Boxer.

> Ameziani's 7 August 2014 ultrasound, as the equipment was present in his office. I strongly disagree with Doctor Subramanyam's choice to not utilize a linear transducer for Ms. Ameziani's sonogram study and disagree with his argument, that a linear transducer would not have an adequate depth of field to visualize the appendix.... This directly contradicts decades of clinical experience with ultrasonography. A typical linear ultrasound transducer is readily capable of imaging to a depth of field of 4 cm. Ms. Ameziani's appendix was between 2.5 cm and 3.5 cm deep to the skin surface when visualized on her 9 August 2014 MRI study. It should be noted that Ms. Ameziani's MRI examination was performed without any compression; the use of compression as incorporated by Doctor Subramanyam during the evaluation of Ms. Ameziani's right lower quadrant with ultrasound would have brought the skin surface (and transducer) even closer to the appendix than it was during the MRI. Use of anterior graded compression sonography with adjuvant use of posterior manual compression, a technique that has been advocated in the medical literature for decades...[and] could have further aided in mitigating any possible depth of field issues with a linear transducer. Thus, had Doctor Subramanyam attempted to evaluate the right lower quadrant of the abdomen with a linear transducer it is logical to conclude with a reasonable degree of medical certainty, that the appendix would have been more likely to have been identified than by limiting the sonographic evaluation to the use of only a curved transducer....Doctor Subramanyam's use of a curved transducer for Ms. Ameziani's 7 August 2014 abdominal ultrasound study under the circumstances presented was not a matter of clinical judgment but rather a departure from the standards of radiological care.

As for Dr. Yee's statement that the ultrasound at NYPH on August 9, 2014 did not detect the appendicitis, Dr. Boxer opines that this statement "is misleading, as the [NYPH] ultrasound study...was limited to the *pelvis* (not the abdomen); the issue at hand is not the pelvic ultrasound study performed by Doctor Subramanyam, but rather his examination of the lower quadrant of the *abdomen*."(emphasis in original).

Dr. Boxer also opines that the "failure of ultrasound to demonstrate an acute appendicitis is not sufficient to exclude this diagnosis and does not preclude further prompt investigation [and

that]...the most common cause of acute abdominal pain in pregnancy is appendicitis, with a reported incidence of one in 766 pregnancies. Rapid and accurate diagnosis of acute appendicitis is especially critical in pregnancy as there is a higher rate of fetal mortality associated with perforated appendicitis relative to uncomplicated appendicitis promptly diagnosed and treated." He further opines that "[a]s Doctor Subramanyam was admittedly concerned about appendicitis, his failure to comment on the appendix in his report was inappropriate and misleading, leading to the impression that all was normal. Given the clinical context of concern for appendicitis, neglecting to comment at all on Ms. Ameziani's appendix, whether visualized or not, constituted a departure from standards of radiologic care."

Dr. Boxer further opines that "[g]iven the low negative predictive value of ultrasound in the evaluation of acute appendicitis and the clinical presentation (including nausea, right lower quadrant abdominal pain and failure of ultrasound to identify a gynecological/obstetrical etiology of Mr. Ameziani's symptoms), Doctor Subramanyam's conclusion (that he need not comment on the appendix) was not logical and did not meet the standard of radiological care [and that]...Dr. Subramanyam was obligated to opine on the appendix in his narrative describing the findings on the ...ultrasound study [and]...his failure to detail his inability to identify the appendix on ultrasound in his report and his conversation with Dr. Selitsky contributed to Dr. Selitsky's false impression that there was not appendicitis..."

As for causation, Dr. Boxer opines that Dr. Subramanyam's "[f]ailures to adhere to radiologic standards of care ... resulted in an unnecessary delay in the diagnosis of Ms. Ameziani's acute appendicitis. Ms. Ameziani's appendix had not perforated at the time of her presentation to Doctor Subramanyam (there were no sonographic findings to suggest perforated

appendicitis). Establishing the etiology of Ms. Ameziani's symptoms prior to her appendiceal perforation would have led to a better outcome, namely earlier surgical intervention, more likely than not before the appendix ruptured, thus greatly reducing Ms. Ameziani's likelihood of perioperative morbidity and preservation of her pregnancy (the incidence of fetal loss in uncomplicated appendicitis is less than 1.5% but it increases to 20-35% following appendiceal rupture)."

He further opines that "Ms. Ameziani gave her clinicians adequate time and clinical context to identify her appendicitis, a not uncommon entity. It was the failure of her clinicians to meet standards of care that led to a delay in her diagnosis of appendicitis with complications, subsequent morbidity and pregnancy loss."

The threshold issue on this summary judgment motion is the extent of the duty owed by Dr. Subramanyam to plaintiff. "[T]he duty of a physician may be limited to those medical functions undertaken by the physician and relied upon by the patient...the question is whether the physician owes a duty under the circumstances of a particular scenario." Burtman v.Brown, 97 AD3d 156, 161-162 (1st Dept 2012)(internal citations and quotations omitted). At the same time, it has been held that the duty of a radiologist is limited "to interpreting ... films and documenting their findings, ...[and] to communicate significant medical findings to a patient or her treating physician." Mosezhnik v Berenstein, 33 AD3d 895, 897 (2d Dept 2006)(citations omitted); Kindelan v. Society of New York Hospital, 277 AD2d 75, 76 (1st Dept 2000)(denying defendants' summary judgment motion where record raised triable issues of fact as to whether correct result of X-rays were ever communicated to emergency room attending physician treating plaintiff). In addition, while defendants' expert, Dr. Yee, opines that Dr. Subramanyam's duty

was limited to determining if plaintiff had an ectopic pregnancy, the court notes that "[w]hether a duty is owed in the first instance is a question for the court, and generally not an appropriate subject for expert opinion." Dallas- Stephenson v Waisman, 39 AD3d at 307 (internal citations omitted).

Applying these principles here, the court finds that Dr. Subramanyam, who not only interpreted the results of the ultrasound study but also performed the ultrasound and chose the type of equipment used to perform the study, owed plaintiff a duty to properly perform the ultrasound, including identifying parts of the body in issue and using the appropriate transducer, to accurately interpret the results of the study, and to properly communicate such results to plaintiff's treating physician, Dr. Selitsky. On the other hand, contrary to plaintiff's assertions, Dr. Subramanyam did not owe plaintiff a duty to recommend a further non radiological investigation of plaintiff's symptoms, and allegations that he departed by failing to make such recommendation is not a basis for the Subramanyam defendants' liability. See Dockery v. Sprecher, 68 AD3d 1043, 1046 (2d Dept 2009), lv denied 17 NY3d 704 (2011)(holding that defendant radiologist who was "not [plaintiff's] treating physician" and whose "role was to interpret MRI film and document his findings,...did not assume a general duty of care to independently diagnose the patient's medical condition")

With regard to whether Subramanyam defendants met their burden on this motion, the court notes that a defendant moving for summary judgment in a medical malpractice action must make a prima facie showing of entitlement to judgment as a matter of law by showing "that in treating the plaintiff there was no departure from good and accepted medical practice or that any departure was not the proximate cause of the injuries alleged." Roques v. Nobel, 73 AD3d 204,

206 (1st Dept 2010). To satisfy this burden, a defendant must present expert opinion testimony that is supported by the facts in the record and addresses the essential allegations in the bill of particulars. Id.

In claiming that the treatment did not depart from accepted standards, the movant must provide an expert opinion that is detailed, specific and factual in nature. See Joyner–Pack v. Sykes, 54 AD3d 727, 729 (2d Dept 2008). Expert opinion must be based on the facts in the record or those personally known to the expert. Defense expert opinion should specify "in what way" a patient's treatment was proper and "elucidate the standard of care." Ocasio–Gary v. Lawrence Hosp., 69 AD3d 403, 404 (1st Dept 2010). A defendant's expert opinion must also "explain what defendant did and why." Id. (quoting Wasserman v. Carella, 307 AD2d 225, 226 (1st Dept 2003).

Here, the Subramanyam defendants have met their burden based on Dr. Yee's opinion that Dr. Subramanyam did not depart from the accepted standards of care in the technique used to conduct the ultrasound study, including with regard to his choice of a curved transducer, which Dr. Yee opines was within his medical judgment; that his report of the results of the study were accurately and promptly communicated to Dr. Selitsky; and that there was no a basis in the films from the study to diagnose an appendicitis; and that the outcome of plaintiff's case was not adversely affected by any act or omission by Dr. Subramanyam.

As the Subramanyam defendants have made a prima facie showing, the burden shifts to plaintiff "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 v. Prospect Hosp., 68 NY2d 320, 324-325. Specifically, this requires that a plaintiff in a medical malpractice action "submit

evidentiary facts or materials to rebut the prima facie showing by the defendant physician that he was not negligent in treating plaintiff so as to demonstrate the existence of a triable issue of fact.... General allegations of medical malpractice, merely conclusory and unsupported by competent evidence tending to establish the essential elements of medical malpractice, are insufficient to defeat defendant['s]... summary judgment motion." Id. at 324–25. In addition, a plaintiff's expert's opinion "must demonstrate the requisite nexus between the malpractice allegedly committed and the harm suffered." Dallas-Stephenson v Waisman, 39 AD3d at 307 (internal citations and quotations omitted). If "the expert's ultimate assertions are speculative or unsupported by any evidentiary foundation . . . the opinion should be given no probative force and is insufficient to withstand summary judgment." Diaz v. Downtown Hospital, 99 NY2d 542, 544 (2002). On the other hand, summary judgment is not proper where "conflicting opinions of the parties' experts raise triable issues of fact." Boston v. Weissbart, 62 AD3d 517, 518 (1st Dept 2009).

Here, plaintiff has met this burden. As a preliminary matter, the Subramanyam defendants' argument that Dr. Subramanyam's decision to use a curved transducer to conduct the ultrasound is a based on his medical judgment and shields him from liability, is unavailing, as plaintiff has raised triable issues of fact based on Dr. Boxer's opinion that Dr. Subramanyam departed from the standard of care in choosing a curved transducer as opposed to a linear transducer to assess the source of plaintiff's pain in her lower right quadrant. See Lenzini v. Kessler, 48 AD3d 220, 221 (1st Dept 2008)(issue of fact for jury raised as to whether the defendant gynecologist "had been negligent in electing to wait and observe [plaintiff's] condition rather than undertaking immediate surgery").

Dr. Boxer's opinion is also sufficient to raise triable issues of fact as to whether Dr. Subramanyam departed from accepted medical practice in failing to identify the appendix in the study, including diagnosing an appendicitis and in failing to comment on the appendix in his report and in his communications with Dr. Selitsky, and as to whether these departures were a substantial factor in delaying the diagnosis of Ms. Ameziani's acute appendicitis, which caused her resulting injuries, including the loss of her pregnancy .

Accordingly, the Subramanyam defendants' summary judgment motion is denied except with respect to the departure alleging that Dr. Subramanyam failed to recommend a further non radiological investigation of plaintiff's symptoms, since the Subramanyam defendants did not owe a duty to make such a recommendation.

Dr. Selitsky's Motion

Dr. Selitsky moves for summary judgment, arguing that record is insufficient to raise triable issues of fact as to her liability. As noted above, the remaining departure asserted as against Dr. Selitsky concerns her alleged failure to unequivocally advise plaintiff to go to the emergency room on August 7 and August 8, once the ultrasound did not diagnose the cause of plaintiff's abdominal pain.

In support of her motion, Dr. Selitsky submits the affirmation of Iffath Abbasi Hoskins, M.D. ("Dr. Hoskins"), a physician licensed to practice medicine in New York, who is board certified in Obstetrics and Gynecology and Maternal-Fetal Medicine. Dr. Hoskins states that she has reviewed, *inter alia,* the bill of particulars, the medical records of Dr. Selitsky and Dr. Subramanyam, and has formed her opinions with a reasonable degree of medical certainty. Dr. Hoskins opines that Dr. Selitsky did not depart from the standard of care on either August 7 or

August 8, 2014, and that the treatment rendered by Dr. Selitsky comported with standard of medical practice.

With respect to the treatment of Ms. Ameziani on August 7, she opines that:

> Once that ultrasound ruled out ectopic pregnancy and found no explanation for her pain, including appendicitis, it was appropriate and within the standard of care to send the patient to the emergency room, which Dr Selitsky did. It would have been an inappropriate use of time to have the patient come to the office, as there was nothing more Dr. Selitsky could do in the office that had not already been done by Dr. Subramanyan when he performed the ultrasound. It was also appropriate for Dr. Selitsky to refer the patient to the emergency room for further evaluation and to bring a copy of the ultrasound so that the test would not be unnecessarily repeated. It would then be incumbent on the emergency room staff to perform further diagnostic studies which could not be performed in an Ob/Gyn clinic, and to obtain a surgical consult which would have been available through the emergency room if a concern for appendicitis presented.

As for the events of August 8, Dr. Hoskins opines that:

> After the ultrasound could not identify a cause of her symptoms, Dr. Selitsky's duty as a clinician was to follow up with the patient to determine if her symptoms had improved, or if she had followed the advice to go the emergency room. Dr. Selitsky did, in fact, call the patient on August 8, the following day, to see what happened in the emergency room. At that point,

> the plaintiff told Dr. Selitsky that she was feeling better and had not gone to the emergency room. Therefore, given that the patient was feeling better, there was no medical reason for Dr. Selitsky to examine her on that date, call her into the office for an exam, or order follow-up testing, and the standard of care did not require it. In addition, according to Dr, Selitsky's note in her chart on August 8, during that phone call the patient was instructed to follow up for a viability sonogram two weeks later, which was in accord with the standard of care for a pregnant patient with pregnancy-related symptoms, such as those of the plaintiff. The patient at that point was at five to six weeks gestation and no clear yolk sac was seen on the ultrasound on August 7. Instructing the patient to return for a viability sonogram was appropriate in order to determine if her pregnancy remained viable. The patient was also given instructions by Dr. Selitsky, as is documented in the chart, that if she had pain, she should go to the emergency department, which she did later that evening.

As for allegations that plaintiff lost the pregnancy as a result of Dr. Selitsky's alleged departures, which delayed the diagnosis of the appendicitis, Dr. Hoskins opines that:

> the miscarriage suffered by the patient in the days following the appendectomy, while unfortunate, is a risk associated with any intra-abdominal infectious process, surgical procedure performed on a pregnant patient and also may be related to the patient's bicornate uterus. Indeed, plaintiff lost two subsequent pregnancies, which in my opinion may have been attributable to the bicornate uterus (i.e. a slightly T-shaped uterus).... The administration, during early pregnancy, of anesthesia or manipulation during any surgery, or a combination of both, can result in spontaneous abortion. Surgery was necessary in 2014 to treat plaintiff's appendicitis and would have been necessary regardless of the timing of the diagnosis.

Dr. Selitsky also submits the affirmation of Michael B. Greico, M.D., who is licensed to practice medicine in New York and is board certified in general surgery and colon and rectal surgery, and who has treated cases of appendicitis in pregnant patients. Upon review of the bill of particulars, the medical records of Dr. Selitsky and Dr. Subramanyam, the surgical admission records at NYPH, and the deposition testimony of the parties, Dr. Greico opines to a reasonable

degree of medical certainty, as to the treating of appendicitis and the issue of proximate causation.

With respect to causation, Dr. Greico opines:

> no act and/or omission as alleged on the part of Dr. Selitsky was the proximate cause of the injuries claimed by the plaintiff. The course following the appendectomy, with perforation, can occur with any general appendectomy. The plaintiff would have required surgery to treat her appendicitis regardless of whether it was diagnosed on August 7 or 8. She always needed surgery and anesthesia. If plaintiff claims surgery and/or anesthesia caused the miscarriage, she always needed those things.... This has nothing to do with anything Dr, Selitsky did or failed to do. There is no question that Dr. Selitsky told the patient to go to the emergency room on August 7, and plaintiff acknowledged as much. The patient instead went home ...Had the patient taken Dr. Selitsky's advice and gone to the emergency room on August 7, she would nevertheless have been diagnosed with appendicitis and required surgery, which could still have resulted in a loss of pregnancy. This is assuming that the surgery and anesthesia caused the pregnancy loss, as opposed to any spontaneous loss of pregnancy in the first trimester or those pregnancies that result in loss due to a bicornate uterus. Furthermore, when she was initially hospitalized, radiology showed that the appendix was not ruptured. Thus, there can be no claim that Dr. Selitsky, through any action or inaction, caused or contributed to the rupture. She directed the patient to go to the emergency room on August 7, no rupture was seen on the MRI in the early morning hours of August 9, and a rupture was only found during the operation at 6:00 AM on that date.

With regard to the loss of the pregnancy, Dr. Greico opines that:

> the cause of the spontaneous abortion suffered by the plaintiff, while unfortunate, is unknown. It could have been a result of her bicornate uterus; because this six week embryo was not viable; because of a genetic or congenital anomaly; possibly due to surgery which the patient needed; possibly due to anesthesia which this patient needed. It had nothing to do with Dr. Selitsky, nor could it have been prevented by her.... The administration of anesthesia and trauma caused by any surgery, a combination of both, and even appendicitis itself, has its own risk for spontaneous abortion unrelated to the alleged delay in diagnosis. The

> patient required an emergent appendectomy on August 8, and would have needed the same surgery had she presented on August 7.

In opposition to Dr. Selitsky's motion, plaintiff submits the affirmation of Gregory Chen, M.D. ("Dr. Chen"), a physician who is licensed to practice law in Illinois and is board certified in Obstetrics and Gynecology. Dr. Chen states his opinion, which is stated within a reasonable degree of medical certainty, is based, *inter alia*, on his review various medical records, charts and reports pertaining to Ms. Ameziani leading up to and including her diagnosis of acute appendicitis at NYPH, the parties' deposition testimony, and the expert affirmations submitted by Dr. Selitsky.

Dr. Chen opines that "accepting [plaintiff's] testimony as true...Dr. Selitsky as an obstetrician and gynecologist, deviated from the standard of care in her management of [plaintiff]." Specifically, he opines that:

> While an ultrasound was appropriate for an initial evaluation of the patient's complaints, an unequivocal referral to an emergency room was required by the standard of care after the ultrasound results did not rule out appendicitis. Dr. Selitsky admits that she did not consider appendicitis as an etiology of the patient's pain. The foremost diagnoses for significant abdominal pain in the first trimester of pregnancy, especially in the right lower quadrant as noted, are the following (not in order of likelihood): right ovarian cyst or torsion, right ectopic pregnancy, appendicitis or degenerating myoma. After learning of the ultrasound results, Dr. Selitsky should have realized there was no right ovarian cyst or torsion, there was no uterine myoma and that it was significantly less likely that there was a right ectopic pregnancy. With all other diagnoses virtually eliminated, and the patient still complaining of significant abdominal pain, the index for suspicion of appendicitis should have been great enough to warrant an immediate and direct referral to an emergency department for further evaluation. Instead, according to the patient's testimony, Dr. Selitsky left the decision to the patient, and remarking that she get a copy of the ultrasound report before leaving the radiologist's office, in the event she might want to go to an emergency room.

With regard to Dr. Selitsky's telephone conversation with Ms. Ameziani the day after the ultrasound, he opines that when Dr. Selitsky learned that Ms. Ameziani "was feeling only 'a little better,' Dr. Selitsky should still have been concerned about ruling out an appendicitis [and][s]he should have broached the subject of the patient going to the emergency room for further evaluation [and][s]he should have questioned the patient as to why she did not go to the emergency if she had previously directed her to go."

Dr. Chen opines that "[c]ontent with the patient reporting that she was feeling 'a little better,' as opposed to better, much better or well, this doctor saw no reason to perform an examination or grow alarmed at the patient not seeking emergency room evaluation the day before... Instead, [Dr. Selitsky] was satisfied with prescribing fiber and having the patient schedule another ultrasound two weeks out. This compounds her departures from the standard of care if plaintiff's account of these interactions is true."

As for causation, Dr. Chen opines that:

> the delay in diagnosing [plaintiff's] appendicitis resulted in the development of a gangrenous infection with perforation. This causal connection between departure and delayed diagnosis significantly increased her risk of miscarriage and made for complications. It is not that administration of anesthesia or appendectomy generally cannot possibly cause a miscarriage. It is that studies have demonstrated that the fetal loss rate was far greater (35.7%) in patients with a perforated appendix versus 1.5% in patient's without a perforation. This patient suffered a spontaneous abortion two days after surgery [and]... she had a far better chance of holding onto the pregnancy had the appendectomy been done before the situation became acute [and]... the multiple post-operative intra-abdominal abscesses, with necessary treatment, were caused by the delayed diagnosis of appendicitis. Such abscesses are common after removal of a perforated appendix but rarely occur after a non-perforated appendix is removed. A prompt and firm referral by Dr. Selitsky to an emergency department would have resulted in a simpler, less complicated procedure and recovery. A typical hospital stay after a laporoscopic

> appendectomy is 1-2 days. Although the hospital MRI did not show a perforated appendix, the undiagnosed infection unnecessarily had many hours to worsen before [plaintiff] presented in the emergency room, leading directly to that perforation. Had Dr. Selitsky unequivocally directed this patient to an emergency room on August 7, or even during the afternoon of August 8, ... surgery would have been done at a time well before the appendix perforated, making for fewer complications like abscesses, a much shorter hospital stay and increasing the patient's chances of a better outcome, including preservation of the pregnancy.

As noted above, a defendant moving for summary judgment in a medical malpractice action must make a prima facie showing of entitlement to judgment as a matter of law by showing that "in treating the plaintiff there was no departure from good and accepted medical practice or that any departure was not the proximate cause of the injuries alleged," and that to satisfy this burden, a defendant must present expert opinion that is supported by the facts in the record and addresses the essential allegations in the Bill of Particulars. Roques v. Nobel, 73 AD3d at 206. In this case, Dr. Selitsky has met this burden based on the opinions of her experts that her treatment of plaintiff on August 7 and August 8, 2014, and specifically advising her to go to the emergency room on August 7, after the ultrasound did not reveal the source of her pain, and her advice to plaintiff on August 8, comported with the standard of care, and nothing Dr. Selitsky did or failed to do was a proximate cause of plaintiff's injuries, including the miscarriage and ruptured appendix.

As Dr. Selitsky has made a prima facie showing, the burden shifts to plaintiff to raise a triable issue of fact. Alvarez v. Prospect Hosp., 68 NY2d at 324-325. The court finds that plaintiff has controverted Dr. Selitsky's showing based on Dr. Chen's opinion that the standard of care required Dr. Selitsky to unequivocally direct plaintiff to the emergency room following the ultrasound, and to take more steps to assess plaintiff's condition on August 8, or to send her to the

emergency room, and that the delay in diagnosing the appendicitis resulted the development of a gangrenous infection with perforation, and significantly increased her risk of miscarriage. Moreover, while Dr. Selitsky testified that she instructed Ms. Ameziani to go the emergency room after the August 7 ultrasound did not reveal the source of Ms. Ameziani's abdominal pain, Ms. Ameziani's testimony raises an issue of fact in this regard. According, Dr. Selitsky's motion for summary judgment is denied.

Conclusion

In view of the above, it is

ORDERED that the motion for summary judgment by defendants Bala Subramanyam, M.D. and Dr. Bala Subramanyam Radiology, P.C. (motion sequence no. 001) is denied except with respect to the departure alleging that Dr. Subramanyam failed to recommend a further investigation of plaintiff's symptoms; and it is further

ORDERED that the motion for summary judgment by defendant Lana Selitsky, D.O. is denied; and it is further

ORDERED that the pre-trial conference previously scheduled for April 23, 2020, shall be held remotely on May 14, 2020 at 11 am and the parties shall contact the court at SFC-Part11@nycourts.gov to set up the conference call with the court; and it is further

ORDERED that pursuant to CPLR 2103(e) a copy of this order may be filed and served.

DATED: April 29 , 2020

Joan Madden
Digitally signed by Joan Madden
DN: C=US, OU=NY County Supreme Court, O=NYS Courts, CN=Joan Madden, E=jmadden@nycourts.gov
Reason: I am the author of this document
Location: New York, NY
Date: 2020-04-29 14:21:56
Foxit PhantomPDF Version: 9.7.0
J.S.C.