Cameron-Scott v Levie
2024 NY Slip Op 35302(U)
March 5, 2024
Supreme Court, Bronx County
Docket Number: Index No. 301177/2012E
Judge: Michael A. Frishman
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NEW YORK SUPREME COURT – COUNTY OF BRONX

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF BRONX: PART 34

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PAULINE CAMERON-SCOTT,

Plaintiff,

- against -

MARK D. LEVIE, M.D., MARK D. LEVIE, M.D., P.C., SARAH BELLEMARE, M.D., SARAH BELLEMARE, M.D., P.C., MONTEFIORE MEDICAL CENTER, THE UNIVERSITY HOSPITAL FOR THE ALBERT EINSTEIN COLLEGE OF MEDICINE, HENRY AND LUCY MOSES DIVISION, JACK D. WEILER DIVISION, MONTEFIORE MEDICAL CENTER, HENRY AND LUCY MOSES DIVISION, AND THE JACK D. WEILER HOSPITAL OF THE ALBERT EINSTEIN COLLEGE OF MEDICINE,

Defendants.

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Index №. 301177/2012E

Hon. MICHAEL A. FRISHMAN,
Justice of the Supreme Court

The following papers numbered 9-31, 36-42, and 44 were read on this Motion for Summary Judgment **(Seq. No. 003)**:

Sequence No. 003	NYSCEF Doc. Nos.
Notice of Motion, Affirmation in Support, Statement of Material Facts – Exhibits and Affirmations Annexed	**9-31**
Affirmation in Opposition, Response to Statement of Material Facts, Statement of Material Facts – Exhibits and Affirmation Annexed	36-42
Reply Affirmation	44

In this action for medical malpractice and lack of informed consent, defendants, MARK D. LEVIE, MD, SARAH BELLEMARE, MD and MONTEFIORE MEDICAL CENTER, s/h/a MONTEFIORE MEDICAL CENTER, THE UNIVERSITY HOSPITAL FOR THE ALBERT EINSTEIN COLLEGE OF MEDICINE, HENRY AND LUCY MOSES DIVISION, JACK D. WEILER DIVISION, MONTEFIORE MEDICAL CENTER, HENRY AND LUCY MOSES DIVISION, AND THE JACK D. WEILER HOSPITAL OF THE ALBERT EINSTEIN COLLEGE OF MEDICINE (hereinafter individually as "Dr. Levie," "Dr. Bellemare," and "MMC" or collectively as "defendants"), move by Notice of Motion for an Order granting them summary judgment dismissing the Complaint of plaintiff Pauline Cameron-Scott ("plaintiff"). Plaintiff opposes the motion. For the reasons discussed infra, defendants' motion is granted.

Plaintiff filed this medical malpractice action alleging an extensive number of injuries and alternative theories including allegations of bowel trauma and/or perforation having occurred during plaintiff's August 5, 2009 hysterectomy performed by Dr. Levie that ultimately caused the need for surgery to resolve plaintiff's bowel obstruction on September 15, 2009 and a follow-up surgery for an infection on September 18, 2009. Plaintiff's allegations include negligence in her post-operative care following her supracervical hysterectomy and failure to appreciate and treat plaintiff's bowel injuries. Generally, plaintiff alleges that defendants were negligent in their post-operative care and treatment causing delays that necessitated two additional surgeries resulting in avoidable bowel resection and subsequent infection. The allegations also include defendants' failure to diagnose plaintiff's surgical belly and/or ileus and/or abdominal complaints including failure to address her continued symptoms and complaints with requisite surgical evaluation and/or exploration and/or surgical treatment. Plaintiff further asserts that plaintiff's 2012 and 2014 hospitalizations were necessitated to address injuries caused by defendants' 2009 negligence.[1]

A defendant in a medical malpractice action establishes *prima facie* entitlement to summary judgment by showing that in treating the plaintiff, he or she did not depart from good and accepted medical practice, or that any such departure was not a proximate cause of the plaintiff's alleged injuries (*Anyie B. v Bronx Lebanon Hosp.*, 128 AD3d 1, 2 [1st Dept 2015]). If a defendant in a medical malpractice action demonstrates *prima facie* entitlement to summary judgment by a showing either that he or she did not depart from good and accepted medical practice or that any departure did not proximately cause the plaintiff's injuries, plaintiff is required to rebut defendant's *prima facie* showing "via medical evidence attesting that the defendant departed from accepted medical practice and that such departure was a proximate cause of the injuries alleged" (*Ducasse v New York City Health & Hosps. Corp.*, 148 AD3d 434, 435 [1st Dept 2017], *citing Anyie B.* at 3). "The plaintiff must rebut defendant's prima facie showing without '[g]eneral allegations of medical malpractice, merely conclusory and unsupported by competent evidence'" (*Henry v Duncan*, 2018 NY Slip Op 30219[U] at *2 [Sup Ct, New York County 2018] [*citing Alvarez v Prospect Hosp.*, 68 NY2d 320, 325 [1986])]; *affd* 169 AD3d 421 [1st Dept 2019]).

"A plaintiff's expert opinion must demonstrate 'the requisite nexus between the malpractice allegedly committed' and the harm suffered" (*Dallas-Stephenson v Waisman*, 39 AD3d 303, 307 [1st Dept 2007] [internal citation omitted]). "With respect to opinion evidence, it is well settled that expert testimony must be based on facts in the record or personally known to the witness, and that an expert cannot reach a conclusion by assuming facts not supported by record evidence" (*Henry*, 2018 NY Slip Op 30219[U] at *2, *affd* 169 AD3d 421 [1st Dept 2019] ["[t]he injury itself cannot be the only basis to conclude that a departure occurred" [internal citations 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 New York Downtown Hosp.*, 99 NY2d 542, 544 [2002]; *Giampa v Marvin L. Shelton, M.D., P.C.*, 67 AD3d 439 [1st Dept 2009]). Further, the plaintiff's expert must address the specific assertions of the defendant's expert with respect to negligence and causation (*see Foster-Sturrup v Long*, 95 AD3d 726, 728-729 [1st Dept 2012]).

[1] The pleadings specify that plaintiff was confined to non-party White Plains Hospital in June 2014 for approximately six days and for one day in 2012.

At the outset, it appears undisputed that plaintiff, at the time of her treatment at issue, was a fifty-year-old woman with a history of recurrent uterine fibroids and that the supracervical hysterectomy performed by Dr. Levie on August 5, 2009 was not contraindicated.[2] It also appears undisputed that there is no evidence of bowel perforation occurring during plaintiff's hysterectomy. The records also support that during plaintiff's hysterectomy, her bowel was packed back with no active bleeding noted and there was a decision to close the abdomen upon completion of the procedure. It is further undisputed, and the records support, that plaintiff developed a post-operative ileus[3] as confirmed by a postoperative abdominal x-ray ("KUB"), as well as a urinary tract infection ("UTI"), after which she was treated by placement of a nasogastric tube ("NGT") which resolved the ileus and plaintiff was discharged on August 12, 2009 with instruction for outpatient follow-up with Dr. Levie. It is also undisputed that plaintiff appeared for a follow-up with Dr. Levie on August 25, 2009, who testified that he noted her complaints were now resolved.

It is further undisputed, and the record supports, that plaintiff presented to the emergency department on August 29, 2009 with complaints of multiple days of vomiting and cramping as well as constipation since surgery but that after her CT scan was negative and plaintiff had a bowel movement, was tolerating oral intake with her pain resolved and abdomen benign, plaintiff was discharged with instructions to follow up with Dr. Levie. It is also undisputed and supported by the record, that plaintiff returned to the emergency department on September 1, 2009 with similar complaints and was admitted through September 7, 2009 after another CT scan revealed increasing pelvic ascites[4] with thick walled loops of small bowel that appear to be somewhat adhered down into the pelvis developing at least a partial small bowel obstruction ("SBO"). This same CT report specifically stated that "[t]his is very significantly different than on the previous examination."

Despite the extensive pleadings, after a review of these papers, the central issues in this case stem from allegations of negligence from the September 1, 2009 admission onwards as it is also undisputed that plaintiff was re-admitted to MMC on September 13, 2009 with continued similar recurrence of complaints during which she underwent two additional surgeries and was thereafter discharged on October 9, 2009. However, as the pleadings contain allegations of negligent performance of plaintiff's hysterectomy on August 5, 2009, such will be addressed first.

In support of their motion, defendants submit the affirmations of Michael L. Namaroff, M.D., who is Board Certified in Obstetrics and Gynecology, and Dan Seth Reiner, M.D., who is Board Certified in General Surgery and Surgical Critical Care.

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[2] To the extent that plaintiff's lengthy and extensive pleadings contain any allegations that this initial surgery was contraindicated, such assertion was neither contained in plaintiff's opposition nor opined to by plaintiff's expert board-certified gynecologist.

[3] Postoperative ileus is a prolonged absence of bowel function after surgical procedures, usually abdominal surgery. It is a common postoperative complication with unclear etiology and pathophysiology. It is a benign condition that usually resolves with minimal intervention. Management of postoperative ileus relies on supportive care after excluding more serious and reversible surgical conditions such as mechanical obstruction (National Library of Medicine, postoperative ileus [https://www.ncbi.nlm.nih.gov/bools/NBK560780/] free online version, 7/31/23).

[4] Ascites is a condition in which fluid collects in spaces within your abdomen (Johns Hopkins Medicine, ascites [https://www.hopkinsmedicine.org/health/conditions-and-diseases/ascites] free online version).

In opposition, plaintiff submits the redacted affirmation of a physician Board Certified in Obstetrics and Gynecology who asserts that he/she is familiar with the standards of care for the performance of hysterectomy surgery, including but not limited to abdominal supracervical hysterectomy, as was performed on plaintiff.

Defendants' experts generally opine that there were no deviations or departures by defendants in the care and treatment provided to plaintiff and that no departures or omissions in care caused or contributed to the injuries alleged by plaintiff. Dr. Reiner opines that although, generally, injury to the bowel is considered a recognized risk of abdominal hysterectomy given the proximity of bowel to the operative field, there was no intraoperative or postoperative evidence of bowel injury to plaintiff. Specifically, Dr. Reiner states that every postoperative study, including the KUB and CTs, as well as the intraoperative findings on September 15, 2009 and 18, 2009 ruled out any injury to the small bowel, including perforation or trauma flowing from her August 5, 2009 surgery. Dr. Namaroff similarly states that plaintiff's postoperative imaging, including the KUB during her initial hysterectomy admission, her August 2009 CT scan, and CTs during both of her September 2009 admissions are all inconsistent with any resulting perforation or injury to the small bowel.

While defendants' surgical expert, Dr. Reiner, acknowledges that plaintiff suffered an ileus following her supracervical hysterectomy, he opines that this is a common postoperative condition after such a surgery. Dr. Reiner further opines that plaintiff's ileus was appropriately treated in accordance with the standard of care with placement of an NGT resulting in resolution of the ileus and plaintiff's complaints, including tolerating solid food and, she was therefore appropriately discharged on August 12, 2009. Dr. Reiner also opines that upon her initial post-hysterectomy discharge, there was no evidence of any other postoperative infection, other than her UTI, which can occur after any surgery, and which was unrelated to any claimed injury to the bowel. Additionally, Dr. Reiner opines, and the records support, that Dr. Bellemare's intraoperative observations during plaintiff's September 15 and September 18, 2009 surgeries also evidence the absence of any perforation or trauma of plaintiff's small bowel that occurred during the hysterectomy surgery. Thus, defendants' experts' have established their *prima facie* showing of entitlement to dismissal of any medical malpractice claims pertaining to Dr. Levie's negligent performance of plaintiff's supracervical hysterectomy.

In opposition, plaintiff's undisclosed Board Certified Obstetrics and Gynecology expert neither discussed any allegations of negligent performance of plaintiff's supracervical hysterectomy nor refuted defendants' experts' *prima facie* showing of entitlement to dismissal of any medical malpractice claims pertaining to Dr. Levie's negligent performance thereof. Moreover, plaintiff's expert fails to address or refute defendants' experts' opinions regarding a lack of objective medical evidence of any perforation or injury to plaintiff's small bowel during her hysterectomy (*see e.g. Foster-Sturrup v Long*, 95 AD3d 726 [1st Dept 2012]). Consequently, all claims relating to Dr. Levie's negligent performance of plaintiff's supracervical hysterectomy on August 5, 2009 must be dismissed.

Turning to plaintiff's allegations that it was a departure from accepted practices for defendants' failing to perform surgery on plaintiff during her September 1, 2009 through

September 7, 2009 admission after plaintiff's continued abdominal complaints including nausea, vomiting and constipation following her discharge from MMC on August 12, 2009.[5]

With respect to these allegations, Dr. Reiner opines that after plaintiff presented to MMC on September 1, 2009 with a partial small bowel obstruction,[6] defendants treated plaintiff within the standard of care with conservative management by placement of an NGT, resulting in improvement of her condition and appropriate discharge home as there was no indication of any injury that developed as a consequence of the patient's management for postoperative small bowel obstruction. He further points out that even after her discharge in October 2009, plaintiff experienced another episode of partial SBO, which resolved without surgery.[7] Dr. Reiner acknowledges that although there was postoperative free fluid in the pelvis, this was consistent with plaintiff's postoperative status and such fluid often develops as a result of inflammation from surgery in the pelvis. Dr. Reiner further opines that postoperative small bowel obstruction is a known complication after any surgery that is performed in the pelvis and that when a partial bowel obstruction results, the standard of care is to attempt to manage and treat with conservative measures such as placement of an NGT, as was done in this case, which resulted in the alleviation of plaintiff's symptoms and the partial bowel obstruction during her September 1, 2009 admission. However, he also opines that it was the findings of inflammation consistent with volvulus on surgical pathology which resulted in plaintiff's recurrent episode of small bowel obstruction and her ultimate need for resection of a small piece of bowel.

In summary, Dr. Reiner opines that not only does plaintiff's small bowel obstruction and volvulus fail to reflect development as a result of trauma, injury, or defendants' departures from standard of care, defendants properly treated plaintiff with conservative management by placement of an NGT after her presentation to MMC on September 1, 2009 and through her appropriate discharge on September 7, 2009 as her condition improved. Additionally, he opines, plaintiff was appropriately and timely taken to the operating room by Dr. Bellemare on September 15, 2009 after symptoms of bowel obstruction failed to resolve following placement of an NGT upon her September 13, 2009 re-admission. Furthermore, plaintiff's ultimate need for surgery and resection were neither a consequence of any postoperative mismanagement by defendants nor the cause of her subsequent episodes of small bowel obstruction years later.

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[5] The balance of the Court's discussion will hereafter concentrate on the opinion of defendants' surgery expert, Dr. Reiner, since the balance of plaintiff's allegations surround plaintiff's failure to timely receive surgical intervention to resolve her continued abdominal complaints following her August 12, 20009 discharge.

[6] As seen in plaintiff's CT of abdomen and pelvis with oral and IV contrast, the report of which is dated 9/2/2009 and attached as an exhibit, states, inter alia, the presence of increasing pelvic ascites with thick walled loops of small bowel that appear to be somewhat adhered down into the pelvis developing at least a partial small bowel obstructive pattern; [t]he exact etiology of this is unclear; ...with air fluid level being formed upstream with loops of small bowel dilated..; [t]he oral contrast has...moved...which is evidence that at least low-grade small bowel obstruction is not complete; [t]he other fluid and fat stranding of most of the loops of small bowel in the low pelvis are of uncertain etiology. Additionally, the record supports that this CT was compared with plaintiff's similar exam of August 30, 2009 and the 9/2/2009 CT impression "is very significantly different than on the previous examination."

[7] Plaintiff's attached medical records show a six-day admission in May of 2014 where CT scan showed mildly distended loops of proximal jejunum consistent with either early complete or partial SBO; that she was made NPO, hydrated, had NGT for decompression and that she responded to nonoperative management and regained bowel function.

Based upon defendants' surgical expert's affirmation and attached medical records, defendants make a *prima facie* showing of their entitlement to summary judgment on the balance of plaintiff's medical malpractice claims. Consequently, the burden has shifted to plaintiff to raise issues of fact.

As previously stated, in opposition, plaintiff submits the redacted affirmation of a physician Board Certified in Obstetrics and Gynecology who asserts that he/she is familiar with the standards of care for the performance of hysterectomy surgery, including but not limited to abdominal supracervical hysterectomy, as was performed on plaintiff. Plaintiff's expert further asserts that he/she is also familiar with the follow-up of patients who have undergone hysterectomy surgery and developed a postoperative ileus and/or small bowel obstruction, partial or otherwise, following such a procedure and, additionally, has participated in the follow-up of patients who have experienced ileus and partial bowel obstruction following hysterectomy procedures.

"A physician need not be a specialist in a particular field if he nevertheless possesses the requisite knowledge necessary to make a determination on the issues presented. Once the expert professes such knowledge, the issue of the expert's qualifications to render such an opinion must be left to trial" (*Almeyda v Concourse Rehabilitation & Nursing Ctr., Inc.*, 195 AD3d 437, 437 [1st Dept 2021] [internal citation omitted]).

Plaintiff's expert generally opines with a reasonable degree of medical and gynecologic certainty that there was a departure from accepted practices in failing to perform surgery on plaintiff upon re-admission to MMC on September 1, 2009.[8]

Plaintiff's obstetrics and gynecology expert further opines that plaintiff's continued abdominal complaints over the course of one month postoperatively were compatible with the development of an ileus and/or partial bowel obstruction that was due to development of adhesions and contributing to bowel inflammation without any reference to anything in the record to support this assertion. Additionally, plaintiff's expert does not assert familiarity with the standards of care surrounding surgical management of bowel obstruction including the conservative course of treatment during the September 1, 2009 admission. To this point, plaintiff's expert neither addresses Dr. Reiner's opinion that conservative treatment is the standard of care nor discusses placement of the NGT during this admission or that the records show that plaintiff's complaints resolved. Rather, plaintiff's expert states, in conclusory fashion, that it was likely that inter abdominal adhesions were causing inflammation to her small bowel and that surgical management was necessary as it was foreseeable plaintiff would develop a small bowel obstruction which would contribute to injury to the bowel and increase the likelihood of bowel resection and other complications.[9] Furthermore, there is nothing in the record to support plaintiff's assertions that

[8] The Court recognizes defendants' argument that this assertion does not specifically include what surgery should have been performed during the September 1, 2009 admission. However, the Court exercises its discretion and interprets plaintiff's assertion as meaning the surgery addressing plaintiff's small bowel obstruction which was performed on September 15, 2009.

[9] Plaintiff's expert also states that Dr. Bellemare's failure to assess the significance of plaintiff's post-hysterectomy history and complaints was a departure but points to nothing in the record to support this assertion. Additionally, the record supports that plaintiff's consultation during her September 1, 2009 admission appreciated a history of nausea,

plaintiff's bowel resection and subsequent infection requiring surgical intervention would have been avoided had surgery been performed prior to September 15, 2009.

The Court finds that with respect to plaintiff's remaining allegations, to wit, her surgical management and care regarding her SBO, plaintiff's expert's affirmation is speculative, conclusory, and fails to address the standards of care as opined to by defendants' surgical expert. Furthermore, plaintiff's expert failed to establish that he/she possessed the appropriate qualifications to opine on the course of treatment for SBO and surgical management and intervention (*see e.g. Newell v City of New York*, 204 AD3d 574, 574-575. [1st Dept 2022] [internal citations omitted] [court's discretionary determination that internist expert did not demonstrate familiarity with surgery and was not qualified to render an opinion as to accepted standards of medical care in performing plaintiff's surgery and, in any event, was speculative, conclusory, and unsupported by the evidence and thereby granted the motion, affirmed]; [*see e.g. Diaz v New York City Health and Hosps. Corp.*, 2024 WL 187078, at *1 [NY AD 1st Dept 2024] *citing Park v Kovachevich*, 116 AD3d 182 [1st Dept 2014], *lv denied* 23 NY3d 906 [2014] [opinion evidence must be based on facts in the record]; *Kaplan v Karpfen*, 57 AD3d 409, 409-410 [1st Dept 2008] [plaintiff's conclusory and speculative expert opinions were insufficient to raise triable issue of fact].

Assuming, *arguendo*, that plaintiff's expert set forth sufficient qualifications to render opinions on the surgical care and management of small bowel obstruction, the expert's affirmation contains opinions unsupported by the record. Specifically, that had an earlier operation been undergone, a bowel resection on September 15, 2009 and development of a sub-fascial collection necessitating the additional procedure on September 18, 2009 would have been avoided, has no basis in the record. Additionally speculative is that plaintiff would have undergone a less extensive operative procedure had she been operated on for lysis of adhesions during her initial September 2009 admission and that the September 18, 2009 procedure would have been unnecessary had the adhesions been freed earlier which were causing or contributing to her continuing abdominal complaints. Furthermore, even if plaintiff's expert's affirmation were sufficient to opine as to an alleged deviation from the standard of care, there is nothing to support that any such deviation was a proximate cause of plaintiff's SBO and ultimate need for resection (*see Zhong v Matranga*, 208 AD2d 439, 443 [1st Dept 2022], *affd sub nom. Min Zhong v Matranga*, 39 NY3d 1053 [2023] [internal citations omitted] ["[a]n expert cannot speculate, guess, or reach their conclusion by assuming material facts not supported by the evidence;" "[i]t is essential that the facts upon which the opinion is based be established, or fairly inferable, from the evidence"]).

Similarly, plaintiff submitted no evidence that defendants failed to obtain informed consent for any of plaintiff's treatment. As such, any claims for lack of informed consent are heretofore dismissed.

The parties' remaining arguments have been considered and are found to be without merit.

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vomiting and abdominal discomfort. Moreover, it is undisputed that the September 2, 2009 CT scan showed a partial bowel obstruction.

Accordingly, it is hereby

ORDERED that defendant's motion seeking summary judgment is heretofore granted; And it is further

ORDERED that the Clerk of the Court is directed to enter judgment in favor of defendants herein, dismissing the Complaint; And it is further

ORDERED that counsel for defendant shall serve a copy of this Order with Notice of Entry on all parties within thirty (30) days of the entry of this Order.

This constitutes the Decision and Order of the Court.

Dated: March 5, 2024

HON. MICHAEL A. FRISHMAN, J.S.C.

1. CHECK ONE.....	X CASE DISPOSED IN ITS ENTIRETY	☐ CASE STILL ACTIVE
2. MOTION IS.....	X GRANTED ☐ DENIED	☐ GRANTED IN PART ☐ OTHER
3. CHECK IF APPROPRIATE.....	☐ SETTLE ORDER	☐ SUBMIT ORDER