Williams v Mormando
2012 NY Slip Op 32784(U)
November 2, 2012
Supreme Court, Suffolk County
Docket Number: 06-11980
Judge: Jerry Garguilo
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SHORT FORM ORDER

INDEX No. 06-11980
CAL No. 12-00942MM

SUPREME COURT - STATE OF NEW YORK
I.A.S. PART 47 - SUFFOLK COUNTY

PRESENT:

Hon. JERRY GARGUILO
Justice of the Supreme Court

MOTION DATE 9-28-12 (#005)
MOTION DATE 9-24-12 (#006)
ADJ. DATE (005) & (006) 10-3-12
Mot. Seq. # 005 - MG
006 - MG

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MARIA H. WILLIAMS, as Administrator of the Estate of GARY LEE WILLIAMS, and MARIA H. WILLIAMS, individually,

Plaintiffs,

- against -

ROBERT MORMANDO, M.D., ALAN JACOBSON, M.D., BRADLEY SPANGHER, M.D. and JOHN T. MATHER MEMORIAL HOSPITAL OF PORT JEFFERSON, NEW YORK, INC.,

Defendants.

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Upon the following papers numbered 1 to 25 read on these motions for summary judgment ; Notice of Motion/ Order to Show Cause and supporting papers (005) 1-15; (006)16-25 ; Notice of Cross Motion and supporting papers ____; Answering Affidavits and supporting papers _____; Replying Affidavits and supporting papers ____; Other ___; (~~and after hearing counsel in support and opposed to the motion~~) it is,

ORDERED that the unopposed motion (005) by the defendant Alan Jacobson, M.D., pursuant to CPLR 3212 for summary judgment dismissing the complaint as asserted against him is granted; and it is further

ORDERED that the unopposed motion (006) by the defendant Bradley Spangher, M.D. and Mather Memorial Hospital Medical Center of Port Jefferson, New York, pursuant to CPLR 3212 for summary judgment dismissing the complaint as asserted against them is granted.

In this action, Maria H. Williams, as administrator of the estate of the decedent, Gary Lee Williams, seeks damages premised upon alleged medical malpractice, lack of informed consent, and wrongful death of the decedent, and further asserts a derivative claim. The plaintiff's decedent was under the care and treatment of the defendants for, among other things, Lupus, right scapula pain, shortness of breath, distended abdomen, and some swelling of his lower extremities. He had a recent history of pneumonia. On September 29, 2004, the plaintiff's decedent collapsed at home. He never regained consciousness and died at Mather Memorial Hospital due to cardiac arrest.

The proponent of a summary judgment motion must make a prima facie showing of entitlement to judgment as a matter of law, tendering sufficient evidence to eliminate any material issues of fact from the case. To grant summary judgment it must clearly appear that no material and triable issue of fact is presented (***Friends of Animals v Associated Fur Mfrs.,*** 46 NY2d 1065, 416 NYS2d 790 [1979]***; Sillman v Twentieth Century-Fox Film Corporation***, 3 NY2d 395, 165 NYS2d 498 [1957]). The movant has the initial burden of proving entitlement to summary judgment (***Winegrad v N.Y.U. Medical Center***, 64 NY2d 851, 487 NYS2d 316 [1985]). Failure to make such a showing requires denial of the motion, regardless of the sufficiency of the opposing papers (***Winegrad v N.Y.U. Medical Center***, *supra*). Once such proof has been offered, the burden then shifts to the opposing party, who, in order to defeat the motion for summary judgment, must assemble, lay bare and reveal his proof in order to establish that the matters set forth in his pleadings are real and capable of being established (***Castro v Liberty Bus Co.,*** 79 AD2d 1014, 435 NYS2d 340 [2d Dept 1981]).

The requisite elements of proof in a medical malpractice action are (1) a deviation or departure from accepted practice, and (2) evidence that such departure was a proximate cause of injury or damage (***Holton v Sprain Brook Manor Nursing Home***, 253 AD2d 852, 678 NYS2d 503[2d Dept 1998], *app denied* 92 NY2d 818, 685 NYS2d 420). To prove a prima facie case of medical malpractice, a plaintiff must establish that defendant's negligence was a substantial factor in producing the alleged injury (*see,* ***Derdiarian v Felix Contracting Corp.***, 51 NY2d 308, 434 NYS2d 166 [1980]; ***Prete v Rafla-Demetrious,*** 221 AD2d 674, 638 NYS2d 700 [2d Dept 1996]). Except as to matters within the ordinary experience and knowledge of laymen, expert medical opinion is necessary to prove a deviation or departure from accepted standards of medical care and that such departure was a proximate cause of the plaintiff's injury (*see,* ***Fiore v Galang***, 64 NY2d 999, 489 NYS2d 47 [1985]; ***Lyons v McCauley,*** 252 AD2d 516, 517, 675 NYS2d 375 [2d Dept 1998], *app denied* 92 NY2d 814, 681 NYS2d 475; ***Bloom v City of New York,*** 202 AD2d 465, 465, 609 NYS2d 45 [2d Dept 1994]).

To rebut a prima facie showing of entitlement to an order granting summary judgment by the defendant, the plaintiff must demonstrate the existence of a triable issue of fact by submitting an expert's affidavit of merit attesting to a deviation or departure from accepted practice, and containing an opinion that the defendant's acts or omissions were a competent-producing cause of the injuries of the plaintiff (*see*, ***Lifshitz v Beth Israel Med. Ctr-Kings Highway Div.***, 7 AD3d 759, 776 NYS2d 907 [2d Dept 2004]; ***Domaradzki v Glen Cove OB/GYN Assocs.***, 242 AD2d 282, 660 NYS2d 739 [2d Dept 1997]). "Summary judgment is not appropriate in a medical malpractice action where the parties adduce conflicting medical expert opinions. Such credibility issues can only be resolved by a jury" (***Bengston v Wang,*** 41 AD3d 625, 839 NYS2d 159 [2d Dept 2007]).

In motion (005), Alan Jacobson, M.D. seeks summary judgment dismissing the complaint on the basis that the care and treatment he provided to the decedent comported with the standard of care; that he ordered the decedent to undergo various tests, but the decedent failed to have those diagnostic tests performed, and thus he was unable to further assess the decedent's symptoms. In addition, he asserts that the etiology of the cardiac arrest cannot be determined in that there was no autopsy performed as the decedent's spouse refused to consent to an autopsy. In support of motion (005), defendant Alan Jacobson, M.D. has submitted, inter alia, an

attorney's affidavit; the affidavit of Alan Jacobson, M.D.; copies of the summons and complaint, Jacbson's answer, and the plaintiff's verified bill of particulars; the unsigned but certified transcript of the examination before trial of Maria G. Williams dated June 30, 2009; the signed and certified transcript of the examination before trial of Alan Jacobson, M..D. dated April 22, 2010; certified copy of the Mather Memorial Hospital record; a copy of the medical records maintained by defendant Jacobson; and the Mather Hospital emergency department record.

Maria Williams testified to the extent that in July 2004, she was working in New York and her husband drove to North Carolina to check on their house there and to stay in North Carolina for the summer. During the drive there, he became sick with a temperature of 103.8 and was subsequently treated at Pender Memorial Hospital in North Carolina. The plan was to admit him to the hospital, but the decedent refused. He was then admitted a day later for a week and was advised that his heart had enlarged. The plaintiff testified that she did not remember the diagnosis, but stated he was treated for pneumonia. After his discharge from the hospital, he complained that his breathing wasn't as it should be. He followed up with a pulmonologist and a cardiologist, and Dr. Singh who prescribed a nebulizer and advised him that after pneumonia it would take six months to get back to feeling better.

Ms. Williams testified that her husband returned to New York in August, 2004, and several days after his return, went to Mather Hospital as he had shortness of breath. She stated that he was to be admitted but then was discharged home. Thereafter, she stated, her husband followed up with Dr. Jacobson, who referred him to Dr. Mormando, whom he saw on September 13, 2004. He did not seem improved, but remained active. On the weekend prior to his death, he went to the NAACP, voter registration, and a Nassau Coliseum event. On the day before his death, he spoke to the Legislature about a new prison to be built in Suffolk County. On the morning of her husband's death, she was at home when he advised her that he did not feel well. When he went to another other room, she heard him fall. She found him unconscious, and called 911. Her husband was pronounced dead at Mather Hospital after unsuccessful resuscitation.

Alan Jacobson, M.D. avers that he was a physician licensed to practice medicine in New York in 2004, but has permitted his New York licensure to lapse, and is now licensed only in Illinois since 2004. He is board certified in internal medicine and rheumatology. Dr. Jacobson averred that Gary Williams had been referred to him by Dr. Arbeit to evaluate the decedent for Lupus and gout. He first began treating Gary Williams in November 2001. The decedent had a history of pulmonary embolism in the 1980s and gout. There was a lapse in treatment from June 10, 2002, when the plaintiff's decedent moved to North Carolina. Treatment was resumed again on August 24, 2004, when the decedent returned to New York and advised him that he had a recent hospitalization in North Carolina due to pneumonia for which he was treated with antibiotics. He also provided a recent history of having pulled his right scapula region while lifting, and was treated at Mather Memorial Hospital where pulmonary embolism was ruled out. The decedent further advised him that he had forgotten to take one of his blood pressure medications that day, as he was noted to have an elevated blood pressure of 150/110.

Dr. Jacobson continued that upon examination, his assessment was that of SLE (Lupus) with gout, and right scapula muscle sprain. The decedent had crackles in his lung bases, and an echocardiogram was ordered based upon the decedent's shortness of breath, as Lupus patients can develop pericardial effusion (fluid around the heart). A chest x-ray was ordered, after which a CT of the chest was planned. Blood work was ordered. At that visit, he also referred the decedent to an internist, Robert Mormando, M.D., for his general medical care. The decedent missed his next appointment scheduled for September 23, 2004. On September 27, 2004, he received a telephone message from Mrs. Williams advising that her husband had a Lupus flare-up and was

unable to breathe, but had no shortness of breath. Dr. Jacobson stated that when he saw the decedent on September 27, 2004, he had already been seen by Dr. Mormando's associate who prescribed steroids and antibiotics for the shortness of breath for his worsening condition. Dr. Jacobson advised the decedent to go to the emergency room if his symptoms worsened, but he refused. Although the decedent had his blood work drawn, he had not yet had his echocardiogram. Dr. Jacobson stated that he had not been provided with any of the decedent's previous medical records from North Carolina or Mather Hospital, and that his assessment of the etiology of the decedent's shortness of breath and symptoms was unclear. He could not rule out cardiac, bronchitis, pneumonia, or pleural effusion.

Dr. Jacobson stated that on September 29, 2004, he received a telephone call from Mrs. Williams advising him that her husband been taken by ambulance to Mather Hospital emergency room where he was pronounced dead on arrival. She also advised him that she had a large funeral planned and did not want an autopsy performed. He continued that Mrs. Williams asked him to sign the death certificate, and after he spoke with the Medical Examiner, he did sign it, noting the cause of death as cardiac arrest based upon that conversation. He stated that Mrs. Williams advised him that her husband also refused her requests for him to go the emergency room prior to his death, and that he had forgotten to get his echocardiogram as he was very busy with speaking engagements at schools, and the NAACP involving a lawsuit against Suffolk County, among other things.

Dr. Jacobson opined that his care and treatment provided at both office visits prior to decedent's death was appropriate and conformed with the standard of care, with no deviations or departures from acceptable medical standards in the assessments and tests ordered. He continued that he was further unable to assess the decedent's symptoms without the necessary tests ordered on August 24, 2004, which the decedent never had performed. He concluded that the etiology of the cardiac arrest could be determined in the absence of test results or an autopsy, and had the decedent gone to the emergency room on September 27, 2004, or prior to his collapse at home on September 29, 2004, it is not known whether it would have altered the outcome, given that it is known that he had a cardiac arrest.

Based upon consideration of the evidentiary submissions and the adduced testimonies, it is determined that the Alan Jacobson, M.D. has established prima facie entitlement to summary judgment dismissing the complaint as asserted against him on the bases that he did not depart from good and accepted standards of medical care and treatment, that he ordered the decedent to undergo various tests, but the decedent failed to submit to all those diagnostic tests, namely the echocardiogram, and thus he was unable to further assess the decedent's symptoms. The etiology of the cardiac arrest cannot be determined in that there was no autopsy performed as the decedent's spouse refused to consent to the autopsy. Accordingly, proximate cause cannot be demonstrated by the plaintiff.

Here, the plaintiff has not opposed the motion, and has failed to raise a factual issue to preclude summary judgment from being granted to the defendant Alan Jacobson, M.D.

In view of the foregoing, motion (005) is granted and the complaint as asserted against Alan Jacobson, M.D. is dismissed with prejudice.

In motion (006), Bradley Spangher, M.D. and John T. Mather Memorial Hospital of Port Jefferson seek summary judgment dismissing the complaint as asserted against them on the bases that the only treatment provided to the decedent was on August 18, 2004, during an emergency room visit, and the decedent was discharged home; that during the five and a half weeks thereafter, the decedent was seen at various times at the

separate offices of Dr. Mormando and Dr. Jacobson before collapsing at home and dying on September 29, 2004 at Mather Memorial Hospital; that they complied with the applicable standard of care; that the decedent was seen by Dr. Joseph on consultation who determined that the decedent did not require admission to the hospital; and that any care and treatment rendered by them did not proximately cause any injury to the decedent. In support of this application, the moving defendants have submitted, inter alia, an attorney's affirmation; the expert affirmation of Anthony Mustalish, M.D.; copies of the summons and complaint, defendants' answers and plaintiff's verified bill of particulars; a certified copy of the Mather Memorial Hospital emergency department record; an uncertified copy of the decedent's death certificate and uncertified copies of the records of defendant Jacobson and defendant Mormando, which are not in admissible form to be considered on a motion for summary judgment; and a signed transcript of the examination before trial of Bradley Spangher, M.D. dated June 22, 2011.

Bradley Spangher, M.D. testified to the extent that he is a physician licensed to practice in New York, is board certified in emergency medicine, and is currently employed by Mather Memorial Hospital as an emergency medicine physician in the emergency department. During the course of his employment on August 18, 2004, he saw the decedent, Gary Williams, who presented to the emergency room at 9:05 a.m. with complaints of neck pain radiating to his right scapula, and a cough for three days. He was aware of the decedent's recent history of pneumonia treated with antibiotics, as well as his prior history of Lupus, hypertension and pulmonary embolism.

Upon examination, Dr. Spangher stated that he elicited pain with apparent muscle spasm, worse to the right side of the decedent's upper back, and a tender left trapezoid (shown as right on his diagram). He noted a few rales at the base of his lungs. He ordered x-rays of his chest and neck, an EKG, blood work, blood culture, cardiac enzymes, triponan and CPK, D-dimer and BNP. The decedent's lungs were clear on x-ray; the EKG showed a left bundle branch block with non-specific ST changes, but he could not tell if the change was acute, old, or chronic; the BUN and creatinine, CPK enzyme, D-dimer, and the BNP were elevated. The elevation of the BNP, he stated, could correlate with congestive heart failure. A V-Q scqan was ordered to evaluate for pulmonary emboli due to the elevated D-dimer. Dr. Spangher continued that he had concerns that the decedent might have had the recurrence of a blood clot to the lung, or might be in congestive heart failure, so he called Dr. Joseph to see the decedent on consultation. Thereafter, he had no further involvement in the decedent's care and treatment. Dr. Joseph discharged the decedent after the consultation was completed.

Anthony Mustalish, M.D., defendants' expert, testified that he is a physician licensed to practice medicine in New York and is board certified in preventive medicine and emergency medicine. He described his educational training and experience, including thirty years engagement in the practice of emergency medicine. It is Dr. Mustalish's opinion within a reasonable degree of medical certainty that Bradley Spangher, M.D. and John t. Mather Memorial Hospital of Port Jefferson did not depart from good and accepted medical practice in the treatment of the decedent, and that the actions of those defendants were not the proximate cause of the decedent's alleged injuries. He continued that when the fifty-nine year old decedent was seen at defendant Mather Hospital on August 18, 2004, a series of blood work and tests were obtained by Dr. Spangher. The decedent was discharged home by the defendant Harold Joseph, M.D. who saw him on consultation.

Dr. Mustalish set forth the findings in the EKG and various cardiac enzymes, which were not indicative of acute cardiac damage or an acute ischemic process. The BNP (B-natriuretic peptide) value was elevated at 794 and such elevation can be seen in the presence of congestive heart failure. The elevated D-dimer level raised the possibility that the decedent had developed a blood clot somewhere in the body. However, he stated, these tests must be correlated with the patient's specific clinical picture. Dr. Mustalish opined that Dr. Spangher

clearly appreciated the decedent's history, physical findings and test results which raised a degree of concern for which he determined that the decedent should be seen by a family practice specialist to determine whether the decedent would be admitted to the hospital or could be safely discharged to receive further medical follow up as an outpatient.

Dr. Mustalish set forth that the "thorough" note by Dr. Joseph supports Dr. Joseph's impression to have the decedent follow up with a physician upon discharge. It is Dr. Mustalish's opinion that Dr. Spangher appropriately evaluated the decedent and that his care and treatment of the decedent in the emergency room at Mather Hospital was consistent with the accepted standards of emergency room care. He continued that it is not the responsibility of the emergency room physician to arrive at a final diagnosis and to provide definitive care, rather, it is the emergency room physician's responsibility to perform an appropriate initial evaluation, provide appropriate initial therapy, stabilize the patient, and make arrangements for a consultant to evaluate the patient and provide definitive in-patient care, if necessary, or to determine that the patient's further care can be managed as an outpatient, which is what occurred in this case. Dr. Mustalish continued that the plaintiff was seen on four or five different occasions over the next five and one-half weeks before he unfortunately suddenly arrested and died. He concluded that not only did Dr. Spangher and the hospital staff follow accepted standards of emergency room practice, but also Dr. Spangher fully discharged his obligation towards the patient by cautiously determining that the decedent should be seen on consultation by the appropriate medical specialist; and there was nothing which would have caused Dr. Spangher or the staff at Mather Memorial Hospital to override the determinations by Dr. Joseph.

Based upon consideration of the evidentiary proof, it is determined that the record establishes that Dr. Spangher and Mather Memorial Hospital of Port Jefferson demonstrated prima facie entitlement to summary judgment dismissing the complaint. The plaintiff has not opposed this motion, and thus, has failed to raise a triable factual issue to preclude summary judgment to the moving defendants.

Accordingly, motion (006) is granted and the complaint is dismissed as asserted against defendant Bradley Spangher, M.D. and Mather Memorial Hospital Medical Center of Port Jefferson.

Dated: 11/2/12

J.S.C.

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

HON. JERRY GARGUILO