Plank v Choi
2016 NY Slip Op 30430(U)
March 14, 2016
Supreme Court, New York County
Docket Number: 805162/2013
Judge: Joan B. Lobis

SUPREME COURT OF THE STATE OF NEW YORK
NEW YORK COUNTY: IAS PART 6

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HELEN PLANK, As the Executrix of the Estate of EDWARD PLANK, deceased, and HELEN PLANK, Individually,

Plaintiffs,

-against-

BENJAMIN B. CHOI, M.D., and METROPOLITAN UROLOGY, PLLC,

Defendants.

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Index No. 805162/2013

Decision and Order

JOAN B. LOBIS, J.S.C.:

In this medical malpractice action, plaintiffs allege that defendants failed to diagnose Edward Plank's bladder cancer. After the commencement of this action, Mr. Plank died from a recurrence of the cancer and his widow, Helen Plank, was substituted as executrix of her husband's estate. She also sues on her own behalf. Defendant Benjamin B. Choi, M.D. is the urologist who first treated Mr. Plank in August 2010. Plaintiffs allege that defendant Metropolitan Urology, PLLC is vicariously liable for the malpractice of Dr. Choi. Discovery is complete and plaintiff filed the note of issue on July 28, 2015. Currently, defendants move for an order granting summary judgment under CPLR § 3212(b) and granting dismissal under CPLR § 3211(a)(7). For the reasons below, the Court denies the motion.

Mr. Plank treated with Dr. Choi between August 2010 and November 2011. When Mr. Plank first treated with Dr. Choi, the doctor specialized in transurethral laser prostate surgery, including photoselective vaporization of the prostate (PVP), to reduce urinary symptoms resulting from an enlarged prostate gland (benign prostatic hyperplasia). At the initial appointment, Dr. Choi

noted plaintiff's complaints of urinary frequency, urinary urgency, and other related problems. Dr. Choi attributed these problems to plaintiff's history of benign prostatic hyperplasia (BPH), for which plaintiff already took medications. Plaintiff underwent a pelvic sonogram, which revealed an abnormally high post void residual and median lobe growth, a condition which can cause increased obstruction. Urinalysis results were normal. Dr. Choi diagnosed Mr. Plank with BPH and detrusor dysfunction, or inability of the bladder to function properly, and planned testing and possible laser surgery.

Mr. Plank treated with Dr. Choi again one week later, with similar complaints about urinary flow and urge incontinence. Urodynamic tests shows bladder obstruction, decreased proprioception, or awareness of the bladder function, and increased bladder capacity. The doctor determined that a benign enlargement caused the construction and related problems and recommended PVP. At the next follow-up appointment, Dr. Choi found hematuria, or trace blood in the urine, but he attributed this to the urodynamic testing. Additional tests revealed bilateral hyperplasia of the prostate and significant medial lobe obstruction. Dr. Choi could not see the ureteral orifice in the bladder during the cystoscopy and he did not see a tumor. He concluded that the bilateral hyperplasia was benign. A cystoscopy the following day resulted in "vigorous" but controllable bleeding. Dr. Choi concluded that the surgery successfully provided Mr. Plank with a sufficient urinary channel. Although the lateral lobes were extremely large and there was limited ability to view the bladder. Dr. Choi did not take pathology tests, subsequently explaining that the tissue would not look normal so soon after the cystoscopy.

Mr. Plank continued to complain of difficulty voiding and other problems, and on October 25, 2010 he presented at an emergency room in New Jersey with difficulty voiding. The hospital performed a catheterization. At his December 13, 2010 appointment Dr. Choi did not undertake a urinalysis or find Mr. Plank's continued complaints abnormal in light of the catheterization. On January 7, 2011, Dr. Choi instructed Mr. Plank to increase his fluid intake and avoid heavy lifting to improve his condition.

Mr. Plank's condition worsened, and on April 13, 2011 he presented to Dr. Choi with pain during urination and intermittent hematuria. Tests revealed signs of possible prostate infection, according to Dr. Choi. The doctor ordered a prostate ultrasound that day, and ordered a urine culture test to rule out prostate infection. He additionally prescribed antibiotics and recommenced another medication. Subsequently, the urine culture results showed that Mr. Plank had prostatitis stemming from Klebsiella bacteria. Dr. Choi stated at deposition that he reasonably focused on the infection in light of Mr. Plank's recent surgeries and reasonably did not foresee or test for bladder cancer because of the intermittent nature of the patient's hematuria. He pointed out that his differential diagnosis included bladder cancer, but that he listed it as having a low probability. When Mr. Plank spoke to Dr. Choi a week later with ongoing bladder problems, Dr. Choi instructed him to continue the antibiotics.

Dr. Choi scheduled Mr. Plank's next appointment on June 1, so as to give the antibiotics a chance to work. Dr. Choi continued to focus on the infection and ordered a cystoscopy, which he described at deposition as the gold standard. He did not order a FISH (fluorescence in situ hybridisation) analysis for cancer, he further explained, because the FISH and

cytology tests are "adjunctive tests," which support or add to an understanding of the primary test results. Choi Dep. p 180. Moreover, he stated, if he had ordered the test it would not have altered his course of treatment. On June 20, 2011, Mr. Plank did not report blood in his urine. Mr. Plank's cystoscopy did not reveal bleeding or tumors but did show an ulceration. Concluding that the lesion did not appear to be cancerous and that a biopsy could result in more bleeding, Dr. Choi did not order a biopsy at this time. At this point, Dr. Choi stated at deposition, he had ruled out bladder cancer as a possibility.

Mr. Plank's next appointment with Dr. Choi took place on November 2, 2011. Mr. Plank had been experiencing hematuria for eight days at the time of this visit. Dr. Choi stated at deposition that Mr. Plank had not complained of any problems between the June and November visits and so he believed that this was a new occurrence. He further stated that his diagnosis "was more leaning toward his BPH being uncontrolled with significant bleeding." Id. p 198. He did not discuss the possibility of cancer with Mr. Plank and he still considered malignancy to be less likely than other possible prognoses. Dr. Choi did not perform another cystoscopy in light of the dangers of performing the procedure while Mr. Plank had a possible infection.

On November 15, 2011, Mr. Plank underwent a CT scan, which showed a large potential bladder mass. Non-party Dr. Neil Sherman performed a transurethral resection of the prostate biopsy and a cystoscopy. The November 22, 2011 biopsy results revealed that Mr. Plank had a high grade invasive carcinoma. He underwent surgery and chemotherapy in 2012, and the tumor was removed completely. At the time of the surgery, he was diagnosed with incidental

prostate cancer with a Gleason score of 6. As stated earlier, Mr. Plank suffered a recurrence of the bladder cancer in December 2012. He passed away in October 2013.

In support of their current motion for summary judgment, defendants submit the expert affirmation of Gary H. Weiss, M.D., Ph.D., a New York licensed physician who is board certified in urology. Dr. Weiss states that he has significant experience in the field and has performed thousands of transurethral cystoscopies, and that all of his opinions are set forth to a reasonable degree of medical certainty.

By way of background, Dr. Weiss explains that when men reach the age of forty, enlargement of the prostate begins. A patient such as Mr. Plank with severe BPH often has prostate tissue that protrudes into the bladder. Dr. Weiss sets forth the factual background relating to Dr. Choi's treatment of Mr. Plank and states that his decisions, including his original focus on infection, were reasonable in light of the actual existence of an infection. Further, he states that it was reasonable to believe that Mr. Plank's intermittent hematuria and infection were related to his biopsies and other medical procedures, not only because such relationship is normal, but because initially treatment with antibiotics seemed to alleviate his symptoms. He states that Mr. Plank's history of BPH and difficulty with urination, among other things, and the lack of signs of bladder cancer, made it reasonable not to conduct further tests at that time. He argues that defendants performed the "gold standard" test, a cystoscopy, on three occasions, twice in September 2010 and once in June 2011, and therefore there was no departure or failure to rule out bladder cancer.

Dr. Weiss opines that it was reasonable of Dr. Choi not to perform a urine cytology, a FISH analysis, or a cystoscopy in April 2011, and that his determination not to perform a PSA study was rational because Mr. Plank's infection would have rendered the results unreliable. He contends that nothing in the June 20 cystoscopy results conformed to typical bladder tumors, which generally appear as papillary, nodular, or broad-based. Dr. Weiss points out that the June 20, 2011 cystoscopy did not reveal any tumors.

Mr. Plank did not treat with Dr. Choi between his June 2011 and November 2011 appointments. Dr. Choi complied with the standard of care, the expert continues, by telling Mr. Plank to notify him if hematuria occurred. According to Dr. Weiss, it was reasonable for Dr. Choi to believe Mr. Plank did not experience gross hematuria until October 2011 because Mr. Plank did not contact Dr. Choi between the two appointments. He states it was rational to forego a cystoscopy on November 2, 2011, instead awaiting the results of the urine culture, because of the dangers inherent in performing this procedure when the patient possibly has an infection. As for other tests, such as a CT scan, Dr. Weiss states that this was within medical standards because the urine cytology in November revealed atypical rather than cancerous cells.

Moreover, Dr. Weiss states there is no proximate cause resulting from the alleged malpractice. He states that "[a] CT scan may have been indicated for upper urinary tract issues" in early June 2011, Weiss Aff. ¶ 33, but the doctor's failure to order these tests is not relevant because there were no malignancies in the upper tract. Dr. Weiss states that as there was nothing to biopsy on June 20 the failure to perform a biopsy was not a proximate cause of the patient's injury. He opines that the ulceration of the bladder neck observed on June 20, 2011 was not a cancer or

malignancy, stating that Mr. Plank's bladder cancer was located in a different area; and that the November urine cytology study showed atypical cells that were not compatible with plaintiff's high grade invasive carcinoma. Moreover, he states, even if the prostate cancer had been diagnosed in June, given that Mr. Plank was over eighty at the time it is probable that it would have been observed rather than actively treated – which might have led to a diagnoses of bladder cancer – and this further shows a lack of proximate cause. Finally, given the aggressive nature of the bladder cancer it likely would not have been evident in June had testing been performed.

In opposition, plaintiffs state that Mr. Plank smoked regularly between the ages of sixteen and forty-one, had a medical history which necessitated five prior biopsies and elevated post-void residual levels and PSA levels. These factors put him at high risk for bladder cancer, they contend, and there was no reason not to perform a biopsy, a CT scan, or at least a cytology of the urine, especially once Mr. Plank presented with hematuria. They support their position with the affidavit of a Rhode Island licensed physician, whose name and signature are redacted. The expert is board certified in urology and makes his statements to a reasonable degree of medical certainty. According to the expert, Dr. Choi deviated from the standard of care by failing to perform a bladder biopsy, a CT scan of the abdomen-pelvis, or a cytology in order to rule out bladder cancer. Moreover, he states that as a result of this failure Mr. Plank's diagnosis was delayed. The delay in diagnosis, he continues, proximately caused the bladder cancer to reach a more advanced stage and dramatically worsened his prognosis given the aggressive nature of his disease. He states that smokers are three times more likely to get bladder cancer than non-smokers, and that Mr. Plank's hematuria, irritation, pain during urination, and high PSA levels were all possible signs of bladder cancer. He states that Dr. Choi should have performed a bladder biopsy

on September 15, 2010 or September 16, 2010, on June 20, 2011, or at any point Mr. Plank presented with or complained of hematuria, and that the failure to do so constituted deviations from the standard of care. He points out that Mr. Plank treated with the doctor for over a year with ongoing complaints which did not subside altogether. He states within a reasonable degree of medical certainty that "had a bladder biopsy been done, it would have detected the cancer at an earlier stage and Mr. Plank's prognosis and 5 year survival rate would have been much better than what it was at stage IV." Expert Aff. ¶ 27.

In addition, the expert challenges Dr. Choi's conclusion that during this earlier period that there was no malignancy. He points to the doctor's notes from the time, which indicate that Dr. Choi had difficulty seeing Mr. Plank's bladder neck and his urethral orifices. Thus, the expert states, it was not possible for the doctor to reach a conclusion of any sort. He agrees that a cystoscopy is the "criterion" for diagnosing bladder cancer, but opines that Dr. Choi should have gone beyond this and performed a biopsy given Mr. Plank's history, risk factors, and ongoing complaints. He states that Dr. Choi's determination that subsequent inflammation was due to Mr. Plank's prior laser surgery constituted negligence, as the inflammation persisted past the normal three-to-six month healing period. He concludes that Dr. Choi should have considered the possibility of cancer, given the fact that the persistence of the inflammation which may have been due to the existence of damaged, cancerous tissue. He says that any concern over the bleeding that a biopsy might have caused was outweighed by the benefit of performing a biopsy. Moreover, he states, Dr. Choi stated that he was considering a further laser prostatectomy, and this would have caused even more bleeding than a biopsy. In light of the above, he states, Dr. Choi's reasoning was illogical and his decision constitutes malpractice.

The expert further opines that Dr. Choi should have performed a CT scan in April 2011 in response to Mr. Plank's Klebsiella. The standard of care, he indicates, required an upper tract imaging study to check for the existence of kidney stones. He opines that such a scan would have shown positive lymph nodes and hydronephrosis of the kidneys, indicating cancer. Given the aggressive nature of the cancer, the expert opines that a diagnosis seven months earlier would have resulted in a better prognosis than Mr. Plank ultimately had with stage IV cancer. He disputes defendants' argument that the cancer was located in the bladder trigone rather than the bladder neck where Dr. Choi noted inflammation. The trigone, he states, actually encompasses the neck.

In reply, defendants urge the Court to reject the expert affidavit because there was no certificate of conformity and the expert was not disclosed pursuant to its 2013 expert witness demand. They accuse plaintiffs of mischaracterizing the facts – for example, by suggesting that Mr. Plank's hematuria was nonstop between September 2010 and November 2011 when it actually was intermittent. They argue that plaintiffs' expert ignores the fact that there must be a stronger basis to perform a biopsy and point to deposition testimony indicating that Dr. Choi, despite the swelling, was able to see the bladder neck and ureteral orifices in September 2010 and it was not inflamed. They challenge the expert's presumption that Mr. Plank had cancer in April and June 2011, stating that this conflicts with their expert's contention that Mr. Plank's ulceration was inconsistent with cancer. They claim that Dr. Choi cannot be found liable merely because plaintiff's expert disagrees with the manner of treatment – in this case, the failure to perform a biopsy. They contend that plaintiff's expert's belief that the ulceration was malignant tissue is "conclusory and speculative." Reply Aff. ¶ 19. They state that the expert has failed to show how Dr. Choi's alleged failures proximately caused the injury, and that numerous other of his

conclusions were completely speculative. They state that if, as plaintiffs' expert states, the cancer was aggressive, a diagnosis in April or June of 2011 rather than in November of that year would not have changed his prognosis.

In considering a motion for summary judgment, this Court reviews the record in the light most favorable to the non-moving party. E.g., Dallas-Stephenson v. Waisman, 39 A.D.3d 303, 308 (1st Dep't 2007). The movant must support the motion by affidavit, a copy of the pleadings, and other available proof, including depositions and admissions. C.P.L.R. Rule 3212(b). The affidavit must recite all material facts and show, where defendant is the movant, that the cause of action has no merit. Id. Courts grants the motion if, upon all the papers and proof submitted, it is warranted as a matter of law in directing judgment. Id. It must be denied where facts are shown "sufficient to require a trial of any issue of fact." Id. This Court does not weigh disputed issues of material facts. See, e.g., Addo v. Melnick, 61 A.D.3d 453, 456 (1st Dep't 2009). Summary judgment proceedings are for issue spotting, not issue determination. See, e.g., Suffolk County Dep't of Soc. Servs. v. James M., 83 N.Y.2d 178, 182 (1994).

In a medical malpractice action, the movant must provide an expert opinion that is detailed, specific and factual in nature. E.g., Joyner-Pack v. Sykes, 54 A.D.3d 727, 729 (2d Dep't 2008). Expert opinion must be based on the facts in the record or those personally known to the expert. Rogues v. Noble, 73 AD.3d 204, 206 (1st Dep't 2010). The expert cannot make conclusions by assuming material facts not supported by record evidence. Id. Expert opinion should specify "in what way" a patient's treatment was improper and "elucidate the standard of care." Ocasio-Gary v. Lawrence Hosp., 69 A.D.3d 403, 404 (1st Dep't 2010). For a prima facie case, the

defendant must present expert opinion testimony that is supported by the record and addresses the plaintiff's essential allegations. Rogues v. Noble, 73 AD.3d at 206. Once a movant makes a prima facie showing, the burden then shifts to the non-moving party "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 N.Y.2d 320, 324 (1986). To meet that burden, a plaintiff must submit an expert affidavit stating the defendant departed from accepted practice and this proximately caused the injuries. See Rogues, 73 AD.3d at 207. Where opposing experts disagree on issues, those issues must be resolved by a fact finder, and summary judgment is precluded. Barnett v. Fashakin, 85 AD.3d 832, 835 (2d Dep't 2011); Frye v. Montefiore Med. Ctr., 70 AD.3d 15, 25 (1st Dep't 2009).

Initially, the Court rejects defendants' argument that plaintiffs' expert's affidavit should be disregarded. As for the certificate of conformity, the defect is not fatal and can be corrected nunc pro tunc. See Midfirst Bank v. Agho, 121 A.D.3d 343, 351 (2nd Dep't 2014)(dicta). In the context of a summary judgment motion, moreover, it is not only permissible but proper for a court to consider the expert affidavit notwithstanding this defect. See Bey v. Neuman, 100 A.D.3d 581, 582 (1st Dep't 2012)(medical malpractice case); Meikle v. Fremon Investment and Loan Corp., 125 A.D.3d 616, 617-18 (2nd Dep't 2015)(failure to consider affidavit in context of summary judgment motion was improper). As for plaintiff's failure to provide defendants with expert disclosure pursuant to defendants' June 2013 demand, the Court's August 18, 2015 pre-trial order requires plaintiff to provide such disclosure at least forty five days before trial. Moreover, it does not appear that defendants pursued their June 2013 discovery request after they made it as part of their initial discovery demand, and none of the discovery orders in this case provide for the

exchange of expert disclosure at an earlier date. Finally, the Court rejects defendants' argument that the expert is not qualified to opine about oncology, as the expert fully addresses his familiarity with bladder and prostate cancer in his affidavit. Any challenges as to his expertise, therefore, relate to credibility, which is a jury question.

In this motion, defendants' statements and documentation are sufficient to shift the burden to plaintiffs to show a triable issue of fact. In opposition, however, plaintiffs have satisfied this burden. They allege, with support, that Mr. Plank was at high risk of bladder cancer due to his medical history, including the symptoms he persistently presented, and that based on this Dr. Choi should not have dismissed the possibility of cancer. They also raise a triable issue as to proximate cause, based on the expert's discussion about the aggressive nature of the cancer and his opinion that, had the cancer been detected earlier it would have been at an earlier stage of progression and Mr. Plank's chance of survival would have increased accordingly. All of defendants' attacks on this opinion relate to issues of credibility, which are matters for the factfinder. The Court has considered all of defendants' arguments and they do not alter this conclusion.

Accordingly, it is

ORDERED that the motion is denied.

Dated: March 14, 2016

ENTER:

JOAN B. LOBIS, J.S.C.