Paniagua v New York City Health & Hosp. Corp.
2016 NY Slip Op 30693(U)
March 17, 2016
Supreme Court, Bronx County
Docket Number: 309247/2011
Judge: Douglas E. McKeon
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SUPREME COURT OF THE STATE OF NEW YORK

COUNTY OF BRONX - PART IA-19A

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ESTATE OF DAISY PANIAGUA, by JOSE NUNEZ, Administrator,

Plaintiff(s),

- against -

INDEX NO:309247/2011

NEW YORK CITY HEALTH & HOSPITAL CORPORATION, EVELYN IRIZARRY, M.D., GUIRY MEHU, M.D., SOULA PRIOVOLOS, M.D., and LISA CHARGUALAF, M.D.,

DECISION/ORDER

Defendant(s).

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HON. DOUGLAS E. MCKEON

Defendant's motion for summary judgment is decided as follows.

This is a medical practice action wherein plaintiff alleges that defendants negligently treated decedent during her admission to Lincoln Hospital from September 29, 2010 to October 1, 2010. Specifically, plaintiff alleges that defendants delayed a diagnosis of abdominal perforation. Movants argue that all defendants acted in accordance with good and accepted standards of medical practice and that any action or inaction by them is not the proximate cause of decedent's death.

Movants argue that on September 29th, when decedent walked into the emergency room at Lincoln with complaints of lower abdominal pain, she was

stable. Triage notes indicate that she was well nourished and oriented, and in no acute distress. She was initially diagnosed with diverticulitis.

At 11:30 a.m. Physician's Assistant, Crystal Owens, noted guarding with no tenderness and patient denied experiencing fever, chills, diarrhea, chest pain, dizziness or blood. It was noted she had sharp abdominal pain since 2:00 a.m. Emergency room physician, Dr. Mehu, examined patient and agreed with the history of diverticulitis with onset of abdominal pain. Because she had a history of diverticulitis, Dr. Mehu wished to rule out diverticulitis and abscess. The treatment plan included blood work, hydration, pain medication, a CT of the abdomen, pelvis and reevaluation.

At 11:45 a.m. PA Owens placed a stat order for a CT scan of the abdomen. At 12:12 p.m. her vital signs remained stable and intravenous hydration was commenced. The contrast material necessary for the CT scan was ordered and patient started taking the contrast material at 2:00 p.m. Her vital signs remained normal. At 2:40 she complained of pain and was given morphine. At 4:07 p.m. the patient was taken for the CT scan which revealed the presence of a perforation. There was scattered diverticula in the pelvis and lower abdomen. The patient was admitted and at 5:45 p.m. colorectal surgeon Irizzary examined her. It was noted for the first time that patient appeared sick with a distended abdomen and apparent dehydration. Dr. Irizarry ordered the patient to be admitted to the surgical Intensive Care Unit for increased hydration in

contemplation of an exploratory laparotomy.

At 9:21 p.m. when the patient was deemed stable to undergo surgery she was taken to the operating room. Dr. Irizarry performed a surgical exploration of the abdomen commencing at 10:00 p.m. She noted the presence of peritonitis as well as a large necrotic hole in the colon. The abdomen was washed out and a 12 centimeter section of the colon removed. A decision was made not to mature the ostomy due to the patient's fragile status with hypotension and she was intubated and returned to the Surgical Intensive Care Unit. She remained in critical condition due to septic shock secondary to four quadrants peritonitis.

On September 30th she suffered respiratory failure. On October 1, 2010 she remained in critical condition and deteriorating. Dr. Irizarry brought her back to the operating room for an attempt at life-saving surgery but her prognosis was noted to be extremely poor. During draping, the patient developed cardiac arrest. The surgeon noted ischemia with global bowel ischemia and gangrene. Further resuscitation was aborted because the situation was deemed futile and she was pronounced dead at 10:19 a.m.

Movant argues that there are two distinct periods of time involved in this matter, treatment prior to the CT scan and treatment subsequent to the CT scan prior to surgery. They argue that the patient was always treated pursuant to appropriate standards of care. Movants have provided the Court with expert testimony indicating that the patient did not present to the emergency room with

signs or symptoms of acute surgical abdomen, sepsis or peritonitis. Her sole complaint was abdominal pain for several hours which she described to her nephew as not serious. During the entire time prior to the CT scan results, the patient remained stable without any signs of infection or that she needed immediate surgery. Her white blood cell count remained normal and her presentation remained consistent with diverticulitis. A CT scan was ordered after which the perforation was seen and the effects of sepsis began to take hold. It would have been contraindicated to have brought the patient for surgery immediately because of the high likelihood that induction of anesthesia in a patient who had rapidly become dehydrated from sepsis would have caused her blood pressure to plummet and result in shock. Furthermore, in retrospect it is known that the decedent was septic prior to ever having been seen by surgery as results of a blood test taken at 4:42 p.m. on September 29th showed bacteria in her blood, the presence of which carries an exceptionally high mortality rate. The patient's severe sepsis and numerous co-morbidities rendered it highly unlikely that her death could have been prevented.

Emergency Medicine expert, Joseph LaManti, M.D., opines that an accurate medical history was obtained and the patient's vital signs were within normal limits and that she did not exhibit any signs or symptoms of sepsis. Therefore, there was never an indication to call for a surgery consultation prior to the CT scan. When the patient was triaged in the emergency room she was

appropriately categorized as urgent because she was not coding nor hypotensive and her vital signs and white blood cell counts where within normal limits. Dr. Mehu's plan was appropriate and proper testing was timely implemented. Colorectal Surgery expert Bruce Gingold, M.D., opines that the patient never presented with any signs or symptoms of perforation while in the emergency room. Given the patient's complaints at the time, Dr. Mehu and the ER staff reasonably formulated a diagnosis of diverticulitis. Regardless of the differential diagnosis of diverticulitis, the proper test reported as the usual way to diagnose a perforation is by a CT scan with oral contrast which was done here in a timely manner. The experts opine that given the stability of the patient in the emergency room and the necessity for the oral contrast to reach the end of the gastrointestinal tract, the amount of time that passed from when the CT scan was ordered to when it was preformed was appropriate. Furthermore, the patient promptly received a surgical consultation and evaluation after reporting of the CT scan results. Second year resident, defendant Lisa Chargualaf, M.D., could not render any final decision as to the patient's surgical treatment. She properly deferred to the Chief Surgery resident who contacted the surgeon Dr. Irizarry who arrived within a half hour of Dr. Chargualaf's consultation.

Plaintiff's attorney waived Dr. Chargualaf's deposition and none of the allegations in the Bills of Particulars pertain to her. As she had no authority to devise any treatment plan or conduct any medical procedure the case should be

dismissed against her.

The experts opine that Dr. Irizarry's treatment was proper as the patient required immediate fluid prior to surgery and had she not gotten it, could have suffered significant complications or death. Dr. Irizarry properly obtained informed consent and therefore the patient's allegations of informed consent are without merit. The patient's medical chart contains a signed consent form to the attempted laparotomy. The experts also opine that following the procedure, Dr. Priovolos and Dr. Irizarry properly treated decedent. General Surgeon Priovolos was the attending physician in the SICU and according to expert Gingold there was never any indication for this doctor to take the patient back into the operating room because she would not have survived. On September 30th, when she was the attending physician, the patient was in septic shock and unable to maintain stable vital signs and surgery would cause her death. Regarding Dr. Irizarry, there was nothing she could have done to treat the necrotic bowel or save the patient's life at the time of the October 1, 2010 surgery.

Dr. Farber, an expert in the treatment of sepsis, explains that earlier surgery could not have reversed the patient's sepsis or prevent her death. Dr. Farber opines that the ischemic bowel occurred because of her perforation and not the timing of surgery. Due to the perforation, the patient sustained four quadrant peritonitis which sent her into septic shock which cannot always be reversed and could not have been reversed in this patient. From the onset of the

manifestation of sepsis, this patient experienced a rapid development of multi-organ system disease. The defendants did all they could to stabilize the patient with fluid antibiotics, and source control but the sepsis was irreversible. Based on the multi-organ system failure decedent's mortality rate was over 90% and would not have been altered by earlier surgery. This was a function of the perforation and not the medical care received. Dr. Farber opines that once the perforation occurred, which likely happened before she arrived at the hospital (as she timed the onset of pain hours before her arrival), sepsis, which caused her death, was inevitable. Dr. Gingold also opines that the purpose of this surgery is to clean out the area and prevent damage and inflammation, but that the surgery does not and cannot do anything to treat sepsis.

The Court notes that plaintiffs do not oppose that portion of the motion to dismiss the claims against defendants doctors Mehu, Priovolos or Chargualaf. As such, the motion is granted as to them. Concerning NYCHHC and Dr. Irizarry, plaintiff argues that NYCHHC is vicariously liable for Dr. Irizarry's actions herein.

Plaintiff has offered an expert affirmation by a physician, who is a Board Certified Surgeon, whose name has been redacted. This doctor opines that failing to perform surgery when the perforation was diagnosed was a departure from proper standards of medical care and that the delay of over 5 hours to hydrate decedent deprived her of a substantial possibility of undergoing surgical repair while she was strong enough to survive. He argues that the medical

records do not support Dr. Irizarry's conclusion that plaintiff was dehydrated so that surgery should be delayed. Even if it could be argued that decedent was dehydrated, the defendants departed from proper practice by failing to properly commence rapid hydration. The placement of the central line was delayed until 8:05 p.m. which was 3 ½ hours after the perforation was diagnosed. The longer the delay in performing the surgery, the greater the amount of fecal matter entering the abdomen and exacerbating the condition. Movants' expert, Dr. Farber states that decedent's condition led to a grave prognosis with a mortality rate of 75 to 90%. However, this expert turns indicates that earlier surgical intervention would, therefore, have given her a survival rate of 10 to 25%. This expert also opines that although a perforation is the most serious risk factor when considering complicated diverticulitis, studies have reported mortality rates between 22 and 39% for free perforation and peritonitis. This expert opines that it was a departure not to take her to the operating room for a prompt surgical repair and that delaying surgery to aggressively hydrate decedent deprived her of a substantial possibility of recovering. Instead the departures delayed prompt diagnosis and surgery and caused decedent's death.

The Court finds that although movants have established a *prima facia* case of entitlement to summary judgment, plaintiff's expert affirmation is sufficient to defeat it. The expert affirmation and opposition has addressed movants experts with sufficient particularity to raise questions of facts as to whether the surgery

should have been performed sooner. As such, the motion is denied as to Dr. Irizarry and NYCHHC.

So ordered.

Dated: 3/17/16

Douglas E. McKeon, J.S.C.