Rosenstack v wong

2011 NY Slip Op 33204(U)

December 6, 2011

Supreme Court, Nassau County

Docket Number: 1340/10

Judge: Ute W. Lally

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SCAN

SHORT FORM ORDER

SUPREME COURT - STATE OF NEW YORK
COUNTY OF NASSAU - PART 3

Present: HON. UTE WOLFF LALLY
Justice

MG

SELMA ROSENSTACK, Individually and as Executrix of the Estate of PAUL ROSENSTACK,

Plaintiffs,

-against-

TIMOTHY WONG, M.D., KLEIN, GEIER, LLP, M.D., L.L.P. and WINTHROP UNIVERSITY HOSPITAL,

Defendants.

Motion Sequence #2
Submitted September 27, 2011

INDEX NO: 1340/10

The following papers were read on the motion for summary judgment:

Notice of Motion and Affs.....1-4
Affs in Opposition.....5-7

Upon the foregoing, it is ordered that this motion by defendant Winthrop University Hospital ("Winthrop") for an order pursuant to CPLR 3212 granting summary judgment in its favor dismissing the plaintiff's complaint as against it is granted.

Plaintiff commenced this action to recover money damages for medical malpractice allegedly committed on the decedent Paul Rosenstack from July 24, 2008 through July 28, 2008.

In the Bill of Particulars, plaintiff alleges that the defendants failed to heed the findings of a flexible sigmoidoscopy performed at Winthrop University Hospital on July 24,

2008 and failed to wait a sufficient period of time following the discontinuance of anti-coagulation medication before performing a colonoscopy. It is further alleged that defendant Winthrop University Hospital failed to administer sufficient amounts of fresh frozen plasma in a timely manner and failed to assess the effect of the same to insure that Paul Rosenstack's INR levels and ability to coagulate were acceptable for the performance of a colonoscopy. Plaintiff further claims defendant hospital failed to perform STAT coagulation profiles before the performance of Paul Rosenstack's colonoscopy. Thereafter, it is alleged that defendants perforated the patient's ascending colon during the procedure by negligently advancing the scope beyond the 80 cm mark and to the cecum after observing there was no further bleeding in the colon. Additionally, plaintiff claims that defendants instilled an excessive amount of fluid and air during the colonoscopy and failed to identify and treat serosal tears in the ascending colon. There is also a claim for lack of informed consent. As a result thereof, Paul Rosenstack allegedly suffered multi-organ failure, secondary to a lower gastrointestional hemorrhage from bleeding colonic diverticula and death.

The facts of this action are recited in Teri Ann Quinlan's Affirmation and consist of the following:

On July 24, 2008, plaintiff-decedent, Mr. Rosenstack presented to the office of co-defendant Klein, Geier, Lipp, M.D., LLP where he was treated by co-defendant gastroenterologist Dr. Wong. The then 71 year old patient complained of two days of acute bloody diarrhea on the average of four to five times a day. It was reported that Mr. Rosenstack had a positive stress two weeks prior and was told he would need a cardiac cathetrization and stenting in the future. Dr. Wong performed a flexible sigmoidoscopy in

his office and observed blood up to 25 cm. The private attending physician referred Mr. Rosenstack to Winthrop for an evaluation and prep in advance of a colonoscopy on July 25, 2008.

Mr. Rosenstack presented to Winthrop at some time prior to 1:55 p.m. on July 24th. A CBA with PT/PTT and Fibrinogen testing was ordered. It was reported that Mr. Rosenstack had an elevated PT of 43.3 (9.2-12.8) and an elevated INR of 3.41 (0.87-1.11).

The record from Winthrop reveals that Dr. Wong initially saw Mr. Rosenstack at the hospital some time prior to 6:18 p.m. Dr. Wong documented Mr. Rosenstack's medical history as including a prior coronary bypass procedure, mechanical aortic valve replacement, thoracic aortic aneurysm repair, hypertension, and hypercholesterolemia. The patient denied nausea, vomiting, constipation, abdominal pain, fever, chills, dizziness, chest pain, or shortness of breath. Mr. Rosenstack was taking Coumadin at the time with reference to the above elevated INR value. Upon his physical examination, Dr. Wong noted that Mr. Rosenstack's chest was clear to auscultation, with normal cardiac rhythm and rate. Mr. Rosenstack's abdomen was soft, non-tender and non-distended, with positive bowel sounds. The co-defendant documented that the patient had a slightly elevated white blood cell count of 13.8 (3.9-11.0), with normal hematocrit (42.9), hemoglobin (14.1), and platelet counts (298). As part of his differential diagnosis for Mr. Rosenstack's rectal bleed, Dr. Wong contemplated the possibility of a diverticular bleed, infections, ischemia (presumably ischemic colitis), and cancer. He admitted Mr. Rosenstack for an immediate bowel prep and full colonoscopy the following day.

The record from Winthrop further reveals that Dr. Wong spoke with cardiologist Dr. Phillip Ragno "due to the urgency and acute nature." Dr. Ragno advised Dr. Wong that he could hold Coumadin for a few days. Dr. Wong documented that the benefit of evaluating the source of Mr. Rosenstack's rectal bleed with sedated colonoscopy outweighed the risk of a cardiac event during anesthesia. Dr. Wong further acknowledged that it was his decision to go forward with the colonoscopy. Dr. Wong further noted that the patient would need to be evaluated for the source of the bleed prior to percutaneous coronary intervention in view of the need for chronic anti-platelet theory with stent placement. Dr. Wong held Mr. Rosenstack's Coumadin and aspirin and indicated that he could continue to take his cardiac medications: Enalapril, Atenolol and Caduet. He further ordered IV fluids, Golytely (bowel prep)/Dulcolax, and the cessation of oral intake after midnight. The record reflects that Dr. Wong spoke with Mr. Rosenstack's family regarding the risks, benefits, and alternatives of performing a colonoscopy in an urgent setting.

Mr. Rosenstack was admitted to Winthrop on July 24, 2008 at 6:30 p.m. Mr. Rosenstack continued to have bloody diarrhea with no apparent stool present. A bowel prep was started at 6:45 p.m. and overnight it was reported that the patient continued to pass blood per his rectum.

Dr. Wong saw Mr. Rosenstack again on the morning of July 25, 2008. He documented that the patient completed a gallon of Golytely and had bloody bowel movements throughout the night. Dr. Wong performed a physical examination with normal results. The patient's lab values were noted: WBC 10.5, a slightly decreased hemoglobin of 11.8 (12.7-18.0), decreased hematocrit of 34.7% (38-52), and normal platelet count of

254. Dr. Wong's impression was diverticulosis versus ischemic colitis versus cancer and indicated that he spoke with cardiology. Dr. Wong further reported that he was going to attempt a sedated colonoscopy that day.

On July 25, Dr. Nicolas Raio saw Mr. Rosenstack in cardiology consultation. He noted from the EKG that Mr. Rosenstack had a normal sinus rhythm with no ST changes. Importantly, Dr. Raio documented that the procedural risk for a colonoscopy was low despite Mr. Rosenstack's medical history and recent positive stress test. He reiterated that it was appropriate to hold Coumadin for now and recommended the administration of a beta blocker and post-procedure telemetry.

The record reveals that on July 25 at 9:55 a.m., Dr. Wong ordered the transfusion of one unit of fresh frozen plasma. At 1:55 p.m., Mr. Rosenstack was infused with fresh frozen plasma. Mr. Rosenstack arrived in the Endoscopy Unit in advance of his colonoscopy on July 25 at 3:05 p.m. Nurse Teich documented the patient's pre-procedure vital signs as including a blood pressure of 152/93, heart rate of 103, respiration rate of 18, and 02 sats of 98% on room air. In addition to fresh frozen plasma, Mr. Rosenstack was also given an IV push of Lopressor just prior to the colonoscopy.

Mr. Rosenstack's colonoscopy started at 3:30 p.m. on July 25. It was reported that the benefits, risks and alternatives to the procedure were discussed and that informed consent was obtained. Propofol was administered to Mr.Rosenstack as a deep sedative. Dr. Wong noted that the endoscope was passed with ease under direct visualization and advanced to the terminal ileum. The scope was withdrawn and the mucosa was carefully examined. There was blood-filled mucosa from the rectum to 80 cm in the traverse colon,

with a clear demarcation from normal mucosa to blood at 80 cm. The right colon and cecum contained no blood, a small sessile polyp was observed in the ascending colon, and the terminal ileum was clear. Dr. Wong further documented an extensive amount of diverticulosis on the colon and blood throughout the distal transverse, left colon and rectum. He identified multiple diverticula that had mild oozing as potential sources for the bleed. Two diverticula were injected with a total of 8 ccs of 1:10,000 epinephrine at the mouth of the diverticula. Dr. Wong additionally placed three endoclips at the mouth of the diverticula. Other potential sources of the bleeding were identified in the sigmoid and descending colon. The report also reflects that Dr. Wong found large external and internal hemorrhoids. The procedure ended at 4:29 p.m.

Dr. Wong reported that the multiple large diverticula found in the colon were the source of the patient's acute rectal bleeding. He noted that these diverticula could potentially continue to bleed. He recommended that the patient return to the floor with a hold on Coumadin and anti-platelet gents. Dr. Wong further recommended a CBC check, blood transfusion to maintain a hemoglobin level greater than 10, and a surgery consult.

Mr. Rosenstack arrived in the recovery area at approximately 4:50 p.m. Nurse Amanda Noble performed an initial assessment of the patient and noted a Post Anesthesia Recovery Score as follows: Activity – 2 (able to move all extremities); Respiration – 1 (limited respiratory effort); Circulation – 1 (systolic pressure 50 plus or minus of the preanesthetic level); Consciousness – 0 (not responding), and Color – 1 (pale, dusky, mottled, other). The patient had a documented blood pressure of 122/47, heart rate of 95, respiration rate of 16, and 02 sat of 96% on three liters of oxygen. The patient was deeply

sedated at this time and Nurse Noble assigned the patient a pain rating of 0 on the objective pain scale. She examined Mr. Rosenstack and noted that his abdomen was hard and he was perspiring.

At 5:00 p.m., Nurse Noble documented that Mr. Rosenstack had a blood pressure of 123/63, a pulse of 110, increased respiration rate of 26, and 02 sat of 94% on five liters of oxygen. He was still deeply sedated and, upon physical examination, Nurse Noble noted that the patient's abdomen remained hard. At 5:10 p.m., Nurse Noble documented that Mr. Rosenstack's blood pressure was 111/67, he had an elevated heart rate of 114, an increased respiration rate of 30, 02 sat of 97% on five liters of oxygen. At 5:20 p.m., it was reported that Mr. Rosenstack's oxygen saturation level fell to 72% on 10L of oxygen.

At approximately 5:23 p.m., the Rapid Response Team was called for an emergent intubation and responded to Mr. Rosenstack's bedside at 5:30 p.m. Mr. Rosenstack was successfully intubated and an abdominal x-ray was ordered to rule out perforation. The study was completed at 5:36 p.m. and a suspicious triangular-shaped lucency was observed overlying the liver. Intra-abdominal free air could not be excluded and a general surgeon, Dr. David Shin, was contacted. The Winthrop record reveals that Dr. Wong spoke with the patient's family members regarding his condition and the need for emergent surgery. The patient developed acute ST elevations on EKG and a cardiologist was informed of the patient's condition.

At approximately 6:30 p.m., Mr. Rosenstack was transported to the O.R. suite for a life-saving exploratory laparotomy performed by Dr. Shin. Dr. Wong testified that he cared for Mr. Rosenstack in the GI recovery room up until the point he suspected a

perforation, at which time he transferred Mr. Rosenstack's care to Dr. Shin.

The exploratory laparotomy commenced at 6:28 p.m. and ended at 7:43 p.m. Upon entering the abdomen, an extensive amount of intra-abdominal free air was observed. The large bowel was followed from the rectosigmoid junction proximally and there was no evidence of any perforation or damage found. Upon inspection of the ascending colon, Dr. Shin found several serosal tears, the largest of which measured approximately 4 cm across. Due to the patient's prior history of left colonic diverticulosis, the evidence of a colonic injury on the right, and in light of the massive myocardial infarction interpreted on EKG prior to the procedure, Dr. Shin performed a subtotal colectomy with ilestomy. The specimen was removed and an ileostomy was created. The patient was left intubated and transported to surgical ICU ("SICU") in a stable condition with a guarded prognosis.

Mr. Rosenstack was admitted to the SICU on pressors and vent care. Dr. Shin noted that his abdomen was distended with oozing from the incision site. On July 26, 2008, Dr. Shin performed a decompression of the abdomen for abdominal compartment syndrome. Mr. Rosenstack continued to bleed from his abdomen and later on July 26 was brought back to the O.R. for an exploratory procedure. Three liters of old blood were evacuated and the patient's abdomen was packed with multiple lap bands. Following the procedure, Mr. Rosenstack was brought back to the ICU in critical condition. On July 27, 2008 given Mr. Rosenstack's increasing azotemia, persistent acidosis, and onset of hypokalemia, he began continuous renal replacement therapy (CRRTT)/continuous venovenous hemodiafiltration (CVVH). A right femoral Quinton catheter was placed and CVVH was initiated. At approximately 7:00 p.m. on July 27, Mr. Rosenstack had an

episode of ventricular tachycardia and was shocked into a bradycardic rhythm. He subsequently became asytolic and was successfully resuscitated. After several additional episodes of asystole, the patient's family decided to execute a DNR with no chest compressions and no defibrillator. Mr. Rosenstack expired at 8:52 a.m. on July 28, 2008.

Winthrop moves for summary judgment on the grounds that it cannot be held vicariously liable for the alleged malpractice of private attending physicians. In July 2008, Dr. Wong was employed by Klein, Geier, Lipp, M.D., LLP and was not an employee of Winthrop. Dr. Wong managed Mr. Rosenstack's care in his private office and then directed Mr. Rosenstack to Winthrop for further evaluation of the patient's rectal bleed and preparation in advance of a colonoscopy.

Winthrop also asserts that the treatment rendered by Winthrop comported with good and accepted standards of medical practice and did not permanently cause any injuries to Mr. Rosenstack. (*Garbowski v Hudson Val. Hosp. Ctr.*, 85 AD3d 724). In support thereof, Winthrop submits the expert affirmation of Dr. Ira Goldman.

In his expert affirmation, Dr. Goldman states, in pertinent part, as follows:

> "It is my opinion, within a reasonable degree of medical certainty that at all times, the medical care and treatment provided to plaintiff by the staff at Winthrop University Hospital comported with good and accepted medical practice. It is further my opinion, within a reasonable degree of medical certainty, that the medical care and treatment provided by the staff of Winthrop University Hospital was not, and could not be, a proximate cause of the plaintiff's alleged injuries and ultimate demise.
>
> It is my opinion, within a reasonable degree of medical certainty that at all times prior to Mr. Rosenstack's colonoscopy that the staff at Winthrop University Hospital carefully and appropriately monitored, documented and reported Mr. Rosenstack's condition. It is further my opinion within a reasonable degree of medical certainty that at all times prior to Mr. Rosenstack's colonoscopy, the staff of Winthrop University Hospital properly

carried out Dr. Wong's orders for CBCs, bowel prep, a plasma transfusion and the administration of Lopressor. Additionally, Mr. Rosenstack appropriately received FFP in an effort to reverse the effects of anticoagulation prior to the procedure. It is my opinion within a reasonable degree of medical certainty that FFP was timely administered to the patient.

It is further my opinion, within a reasonable degree of medical certainty, that as the patient's private attending gastroenterologist, it was Dr. Wong's responsibility to manage, supervise, direct, and control the care and treatment rendered to Mr. Rosenstack prior to his colonoscopy. This would include ordering of blood products, medication, and laboratory studies. Specifically, it would be Dr. Wong's responsibility to order repeat laboratory studies prior to the patient's colonoscopy. It would not be the responsibility of the hospital staff to order repeat lab studies.

It is my opinion, within a reasonable degree of medical certainty that the treatment rendered to Mr. Rosenstack in the recovery of the Endoscopic Unit from 4:50 p.m. to 6:10 p.m. on July 25, 2008 was entirely within the standard of care for post-operative treatment of a patient who underwent an endoscopic procedure. During the colonoscopic recovery period, if a patient has received sedation for a colonoscopy, it is appropriate for the hospital staff to check the patient's vital signs every ten minutes until the patient wakes up. When patients come out of colonoscopies their abdomens are often times distended and firm. After a colonoscopy patients are frequently diaphoretic. It is my opinion, within a reasonable degree of medical certainty, that the signs and symptoms Mr. Rosenstack experienced in the endoscopic recovery room, including a distended abdomen, diaphoresis, and increased respiratory rate were all consistent with frequently observed physiological responses that a patient may experience to anesthesia and secondary to a colonoscopy. Further, it is my opinion, within a reasonable degree of medical certainty, that there were not definitive signs or symptoms suggesting that the patient's colon may have been perforated and/or the patient was experiencing post-colonoscopy complications up until the point that Nurse Noble contacted the Rapid Response Team. Accordingly, it is my opinion within a reasonable degree of medical certainty, that the staff at Winthrop timely and appropriately monitored the patient following the colonoscopy, undertook all appropriate measures to improve the patient's oxygenation, timely recognized the signs and symptoms of a bowel perforation, and timely and appropriately communicated all relevant findings to the attending physician, Dr. Wong.

It is my opinion, within a reasonable degree of medical certainty that it is the responsibility of the patient's private attending physician to obtain informed consent. It is further my opinion, within a reasonable degree of medical

certainty that it is not the responsibility of the staff at Winthrop to obtain informed consent when they neither ordered nor performed a surgery. The colonoscopy performed by Dr. Wong carries with it unavoidable risks of possible complications, specifically including bleeding perforation and infection. These risks, as well as the benefits and alternatives to the procedure were explained and discussed with Mr. Rosenstack. This is evidenced by Dr. Wong's deposition testimony and the informed consent form signed by Mr. Rosenstack.

Accordingly, it is my opinion within a reasonable degree of medical certainty that the care rendered by the hospital staff comported with good and acceptable practice at all times. It is further my opinion within a reasonable degree of medical certainty that the care and treatment rendered to this patient did not and could not proximately cause any of the injuries claimed by the plaintiff."

In opposition to the motion, plaintiffs submit the expert affirmation of Dr. Gerald Salen. In his affidavit, Dr. Salen opines, in pertinent part, as follows:

"I. Winthrop owed a duty to the decedent to have in place to enforce policies and procedures regarding the performance of endoscopies, including those performed on patients who were anticoagulated and its failure to have same was a breach of that duty.

II. Winthrop's physicians deviated from accepted standards of care in not insuring that a sufficient volume of fresh frozen plasma was given before the colonoscopy and a pre-procedure INR was performed which was within a safe and acceptable range for the performance of the decedent's colonoscopy.

III. Winthrop's employees, including nurse Amanda Noble, deviated from accepted standards of care in the post-procedure monitoring of the decedent and as a result this caused a delay in the diagnosis and treatment of the decedent's perforation.

IV. Winthrop had a duty, in addition to Dr. Wong, to provide informed consent to the decedent.

V. The aforesaid deviations were a component, even if not the sole, producing cause of the decedent's injuries and subsequent demise from said injuries."

> "On a motion for summary judgment dismissing the complaint in a medical malpractice action, a defendant must make a *prima facie* showing that there was no departure from good and accepted medical practice, or that the plaintiff was not injured by any such departure (*see Salvia v St. Catherine of Sienna Med. Ctr.*, 84 AD3d 1053; *Ahmed v New York City Health & Hosps. Corp.*, 84 AD3d 709, 710; *Stukas v Streiter*, 83 AD3d 18, 24-26). Once a defendant physician has made such a showing, the burden shifts to the plaintiff to 'submit evidentiary facts or materials to rebut the *prima facie* showing by the defendant . . . so as to demonstrate the existence of a triable issue of fact' (*Alverez v Prospect Hosp.*, 68 NY2d 320, 324; *see Stukas v Streiter,* 83 AD3d at 24). General allegations that are conclusory and unsupported by competent evidence tending to establish the essential elements of medical malpractice are insufficient to defeat a defendant's motion for summary judgment (*see Salvia v St. Catherine of Sienna Med. Ctr.,* 84 AD3d at 1054; *Ahmed v New York City Health & Hosps. Corp.,* 84 AD3d at 711[*Upshur v Staten Island Medical Group*, 930 NYS2d 649, 2011 N.Y. Slip Op. 07213])".

Winthrop met its *prima facie* burden of establishing the absence of any departure from good and accepted medical practice (*Arkin v Resnick*, 68 AD3d 692, 694). In opposition, the plaintiffs failed to raise a triable issue of fact (see *Stukas v Streiter, supra*). The Winthrop staff did not exercise independent judgment over the decedent's care (*Hill v St. Clare's Hosp.*, 67 NY2d 72, 79; *Cham v St. Mary's Hops. of Brooklyn*, 72 AD3d 1003, 1004; *Cerny v Williams*, 32 AD3d 881, 883), and the orders of the attending physicians were not so clearly contraindicated by normal practice that ordinary prudence would require inquiry into the correctness of the orders (*Toth v Community Hosp. at Glen Cove*, 22 NY2d 255, 265; *Georgetti v United Hosp. Med. Ctr.*, 204 AD2d 271, 272).

Ordinarily, a hospital may not be held liable for the malpractice of a physician who is not an employee of the hospital (*Ventura v Beth Israel Medical Center*, 297 AD2d 801, *lv to app den.* 99 NY2d 510; *Cook v Reisner*, 295 AD2d 466; *Ryan v New York City Health & Hospitals Corp.*, 220 AD2d 734; *Sledziewski v Cioffi*, 137 AD2d 186, 188-189). However,

a hospital may be held vicariously liable for the acts of independent physicians if the patient enters the hospital through the emergency room and seeks treatment from the hospital, not from a particular physician (*Mduba v Benedictine Hospital*, 52 AD2d 450, 453; *see also Noble v Porter*, 188 AD2d 1066; *Agustin v Beth Israel Hosp.*, 185 AD2d 203, 205-206; *Soltis v State of New York*, 172 AD2d 919).

As the court observed in *Rivera v Bronx-Lebanon Hospital Center* (70 AD2d 794, 796), there may be circumstances under which liability may be imposed for independent contractors, and such answer lies in the degree of control exercised by the hospital. Here, the decedent did not present himself to the emergency room at Winthrop.

As noted above, the co-defendant physicians in this case were private attending physicians independently retained by the plaintiff to treat him. While the surgery in question was performed at Winthrop, the record is devoid of any proof that any individually and specifically identified hospital employee was involved in the decision to perform the surgeries in question nor its execution. All those actions were performed by private attending physicians, not hospital employees. Moreover, the record is devoid of any proof that the hospital controlled the manner in which the surgery was performed or committed any act for which it would otherwise be vicariously liable for the acts of private attending physicians.

Dismissal of the informed consent claim is also warranted here.

A hospital is ordinarily not answerable to a plaintiff in breach of informed consent claims (*Fiorentino v Wenger,* 19 NY2d 407; *Nagengast v Samaritan Hosp.,* 211 AD2d 878). A hospital is under no duty to obtain a patient's informed consent if there is no reason to

suspect malpractice would occur (*Fiorentino, supra; Nagengast, supra*). The record is devoid of any proof that the hospital should have interceded in the physician-patient relationship (*Fiorentino, supra*).

In view of the foregoing, the motion is granted and the complaint is dismissed as against Winthrop.

The action shall continue as against the remaining defendants.

Dated: DEC 06 2011

UTE WOLFF LALLY, J.S.C.

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