[* 1]

COPY

SHORT FORM ORDER

INDEX No. 06-24468
CAL No. 12-00969MM

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

PRESENT:

Hon. JERRY GARGUILO
Justice of the Supreme Court

MOTION DATE 9-26-12
ADJ. DATE 2-13-13
Mot. Seq. # 002 - MG; CASEDISP

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

Plaintiffs,

- against -

HAROLD JOSEPH, M.D.,

Defendant.

FREDERICK K. BREWINGTON, ESQ.
Attorney for Plaintiffs
556 Peninsula Boulevard
Hempstead, New York 11550

FUREY, FUREY, LEVERAGE, MANZIONE, WILLIAMS & DARLINGTON, P.C.
Attorney for Defendant
600 Front Street, P.O. Box 750
Hempstead, New York 11550

Upon the following papers numbered 1 to 36 read on this motion for summary judgment; Notice of Motion/ Order to Show Cause and supporting papers (002)1 - 17; Notice of Cross Motion and supporting papers ___; Answering Affidavits and supporting papers 18 - 23; Replying Affidavits and supporting papers 34 - 36; Other ___; (~~and after hearing counsel in support and opposed to the motion~~) it is,

ORDERED that motion (002) by the defendant Harold Joseph, M.D., pursuant to CPLR 3212 for summary judgment dismissing the complaint as asserted against him 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. There is a consolidated action pending under Index No. 06-11980 by the plaintiff against defendants Robert Mormando, M.D., Alan Jacobson, M.D., Bradley Spangher, M.D., and John T. Mather Memorial Hospital of Port Jefferson, New York, Inc. In the unopposed motions (005) and (006) in that action, summary judgment was granted to defendants Alan Jacobson, M.D., Bradley Spangher, M.D., and Mather Memorial Hospital of Port Jefferson.

The plaintiff's decedent was receiving care and treatment 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. No autopsy was authorized by the plaintiff, and the etiology of the cardiac arrest was undetermined.

JH

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 (002), Harold Joseph, M.D. seeks summary judgment dismissing the complaint on the basis that the care and treatment he provided to the decedent on August 18, 2004, when the decedent presented to the emergency room at John T. Mather Memorial Hospital, comported with the standard of care; and that any act or omission by him did not proximately cause any of the plaintiff's decedent's injuries. While the plaintiff's bill of particulars alleges that the alleged departures by Dr. Joseph occurred on September 13, 17, and 23, 2004, the decedent was seen by Dr. Joseph only on August 18, 2004. Defendant Joseph contends that he ordered the decedent to undergo various tests upon discharge from the emergency department and to follow up with a private medical doctor, but the decedent failed to have those diagnostic tests performed. Dr. Joseph contends that he did not see the plaintiff's decedent at any time after August 18, 2004. 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 (002), the defendant has submitted, inter alia, an attorney's affidavit; the affidavit of James M. Mumford, M.D.; copies of the summons and complaints in both actions, Joseph's answer and demands, and the answers served by defendants Jacobson, M.D., Spangher, M.D., and John T. Mather Memorial Hospital, and the plaintiff's verified bill of particulars; the transcripts of the examinations before trial of Maria G. Williams dated June 30, 2009 and continued June 6, 2010, Robert Mormando, M.D., Alan Jacobson, M.D. dated April 22, 2010, Bradley Spangher, M.D. dated June 22, 2011, and Harold Joseph, M.D. dated December 8, 2011, all in admissible form; certified copy of the Mather Memorial Hospital emergency department record; and a copy of the letter signed by Alan Jacobson, M.D. with a medical record; and a certified copy of the plaintiff's death certificate.

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, as well as 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 into another 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. averred that he was a physician licensed to practice medicine in New York in 2004, but has permitted his New York license 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 at 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 not be determined in the absence of test results or an autopsy. He continued that had the decedent gone to the emergency room on September 27, 2004, or prior to his collapse at home on September 29, 2004, he did not know whether it would have altered the outcome, given that it is known that he had a cardiac arrest.

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 scan 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. He stated that Dr. Joseph discharged the decedent after the consultation was completed.

Harold Joseph, M.D. testified to the extent that he is a physician licensed in New York State since 1964. He was not board certified in any area of medicine. In 2004, he was employed at John T. Mather Memorial Hospital as an attending in family practice. He had no independent recollection of the decedent. In reviewing the emergency room record from Mather Memorial, he noted that he saw the decedent on August 18, 2004 as he was on call for the emergency room family practice internal medicine schedule. He was requested by Dr. Spangher to see the plaintiff's decedent to determine whether or not he should be admitted to the hospital. He noted that the plaintiff's decedent was a fifty-eight year old male who was seen and evaluated in the emergency room for neck pain radiating to his right shoulder, and cough for three days. He then evaluated him, the lab records, and x-ray findings. He felt the BNP, BUN, creatinine, CPK, and the D-dimer studies were abnormal. When the BNP is over 100, he suspects some cardiac involvement, and the decedent's level was 794. The D-dimer was 783 which is significant for blood clots. The radiology VQ scan revealed no pulmonary emboli. Cardiac enzymes were normal. The EKG showed a sinus arrhythmia, which he felt was nonspecific. He felt the decedent was in no distress at the time. The decedent's blood pressure was elevated to 153/103. Dr. Spangher had ordered Lasix 40 mg IV at 12:10 p.m. as he heard bibasilar rales. Dr. Joseph stated that when he examined the decedent, there was no swelling of the extremities, and his chest and lungs were clear with no rales or wheezing. Dr. Joseph felt the plaintiff's decedent had no clinical evidence of CHF (congestive heart failure) or pneumonia, and that the neck and shoulder pain was due most likely to muscle strain.

Dr. Joseph continued that his differential diagnosis included congestive heart failure, pneumonia, pulmonary embolism, and muscle strain. He ruled out congestive heart failure on the basis of the physical examination, the lab work, cardiogram, and chest x-ray which showed no acute process. He stated that the decedent presented with no acute symptomology warranting hospitalization. He conveyed to the decedent what further examinations were necessary and could be done on an outpatient basis. He referred him to follow up with Dr. Wesley-Bethune, an internist, and to continue his medication. After discharging the decedent, he did not speak to him or his family, and had no further contact with him.

James M. Mumford, M.D., Dr. Joseph's expert, averred that he was a physician licensed to practice medicine in New York and is board certified in family medicine. He set forth his education and training, and professional experience, as well as the materials and records he reviewed. Dr. Mumford addressed the care and treatment provided to the plaintiff's decedent on August 18, 2004, which was the only date of treatment by Dr. Joseph, and not September 13, 17, and 23, 2004, as set forth in the bill of particulars. Dr. Mumford set forth his opinions within a reasonable degree of medical certainty that the medical evidence establishes that Dr. Joseph's care and treatment of the plaintiff's decedent, Gary Lee Williams, was in accordance with good and accepted standards of medical practice, and that there is nothing that he did or failed to do which can reasonably be said to have been a proximate cause of the injuries claimed in plaintiff's bill of particulars.

Dr. Mumford continued that Dr. Joseph became involved with the care and treatment of the decedent during his emergency presentation to Mather Hospital on August 18, 2004. He stated that Mr. Williams was a fifty-eight year old male who presented at 8:30 a.m. with neck pain radiating to his right scapula, and coughing for three days. No history of heart failure was relayed, however a history of recent pneumonia, lupus, hypertension, and pulmonary embolism twenty years ago was provided. His medications were noted. Dr. Mumford set forth Dr. Spangher's examination which revealed muscle spasm on the right side in the neck and tenderness in the right trapezoid, and a few rales at the bases of the lungs. Examination of the heart was normal with a regular rate and rhythm and normal heart sounds. Lasix was ordered, as well as a series of tests, as set forth. Dr. Joseph then saw the plaintiff's decedent. Dr. Mumford opined that Dr. Joseph appropriately examined the patient and appropriately evaluated the results of the labs and tests in accordance with good and accepted standards of medical practice. Based upon the decedent's clinical picture, symptoms, and test results, there was no indication for a clinical diagnosis of acute heart failure on August 18, 2004. This, he continued was so, even in the presence of an elevated BNP value which may be suggestive of heart failure. He continued that heart failure is a clinical diagnosis based on symptoms and physical findings in combination with other lab results and must be correlated with the clinical symptoms of the patient.

Dr. Mumford discussed the various findings relative to laboratory testing and other studies which were done, and set forth their indications. He stated that while the total CPK level requires determination of whether damage is to the heart or other muscles, and in light of the decedent's complaints of neck pain, it was a reasonable determination that the elevated total CPK was attributable to skeletal muscle. The nonspecific abnormal EKG findings were appropriately recognized as was that the decedent was asymptomatic. The decedent's blood pressure had lowered to 150/80, pulse was 90, and respirations were 16. He was in no distress, had normal breathing, and was not short of breath. The rales had dissipated. The chest x-ray revealed no acute process. Thus, it was reasonable and appropriate for the decedent to be discharged home and referred to a primary medical doctor for follow up care and treatment and further diagnostic testing.

Dr. Mumford set forth Dr. Joseph's differential diagnoses of congestive heart failure and pneumonia, which he appropriately ruled out based upon lack of clinical evidence. His discharge diagnoses included chronic renal insufficiency, muscle strain, history of lupus erythema, thrombocytopenia, and hypertension. Flexural 10 mg. for muscle strain was appropriately ordered, and the decedent was instructed to remain on his current medication regime, including blood pressure medications. The decedent was appropriately advised to call his primary medical doctor the following day for coordination of his care and further testing, and that further examination on an outpatient basis could be done, including an echocardiogram, which could not be done from the emergency department. Upon discharge from the emergency room at Mather Hospital, on August 18, 2004, the plaintiff's decedent then obtained care and treatment with Dr. Jacobson, his rheumatologist, and Dr. Mormando, his new primary medical doctor. On September 29, 2004, Mr. Williams suffered from a sudden cardiac arrest and died. It is Dr. Mumford's opinion within a reasonable degree of medical certainty that the care and treatment rendered by Dr. Joseph on August 18, 2004, did not cause or contribute to his death almost six weeks later.

Based upon the foregoing, it is determined that Dr. Joseph has established prima facie entitlement to summary judgment dismissing the complaint on the bases that he did not depart from good and accepted standards of care of the plaintiff's decedent, and that there was nothing which he did or failed to do which was the proximate cause of the injuries claimed by the plaintiff.

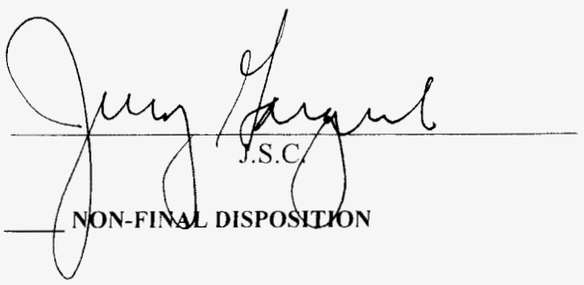
The plaintiff has submitted the affirmation of her expert, a physician licensed to practice medicine in New York who is board certified in internal medicine. He set forth his education and training along with his work experience, and stated the records and materials which he reviewed. It is plaintiff's expert's opinion within a reasonable degree of medical certainty that Dr. Joseph departed from good and accepted medical practice in his care and treatment of the plaintiff's decedent, in that he failed to obtain a cardiology consult and echocardiogram examination on August 18, 2004, failed to follow the decedent for congestive heart failure and further evaluate him to rule out coronary heart disease, which departures were substantial factors in causing the decedent's death on September 27, 2004.

The plaintiff's expert set forth the decedent's presentation to the emergency department on August 18, 2004, including various testing and results. Dr. Joseph then saw the decedent as the on-call family practice physician to further evaluate and possibly admit the decedent. He set forth the care and treatment by Dr. Joseph, including his evaluation of the various laboratory studies and other diagnostic tests which were performed by Dr. Joseph. The plaintiff's expert opined that Dr. Joseph failed to consider the diagnosis of congestive heart failure given the decedent's multiple risk factors, including hypertension. He continued that Dr. Joseph should have determined whether it was a new or old left bundle branch block, and did not appreciate Dr. Spangher's finding of rales at both lung bases. He added that an echocardiogram and cardiac consultation should have been ordered, and the decedent should have been admitted. Thus, concludes the plaintiff's expert, the failure to diagnose the decedent's congest heart failure was a substantial factor in causing the decedent's death on September 27, 2004.

It is determined that the plaintiff's expert has failed to demonstrate that any of the alleged departures by Dr. Joseph were the proximate cause of the plaintiff's death more than five weeks after Dr. Joseph saw the plaintiff's decedent in the emergency department at Mather Memorial on August 18, 2004. Plaintiff's expert has not set forth the standard of care or commented upon the fact that the plaintiff's decedent was referred to an internist for additional care and treatment, further diagnostic testing, and evaluation of his conditions, and was no longer under the care of Dr. Joseph upon discharge from the emergency room. Instead, the plaintiff's decedent was to follow up with his private medical doctor and undergo various testing, which he failed to do. Plaintiff's expert's opinion is conclusory and unsupported by evidentiary proof as he does not address the passage of time between the August 18, 2004 treatment by Dr. Joseph and the decedent's death on September 27, 2004, including the decedent's failure to obtain his echocardiogram after he was discharged on August 18, 2004 from Mather Hospital. Without establishing proximate cause, the plaintiff cannot establish that the injuries claimed in the bill of particulars were the result of any alleged departures.

Accordingly, motion (002) is granted and the complaint of this action is dismissed as asserted against defendant Harold Joseph, M.D.

Dated: 5/30/13



J.S.C.

X FINAL DISPOSITION **NON-FINAL DISPOSITION**