Cole v Rosensweig
2013 NY Slip Op 32266(U)
September 13, 2013
Supreme Court, New York County
Docket Number: 150819/09
Judge: Joan B. Lobis

SUPREME COURT OF THE STATE OF NEW YORK — NEW YORK COUNTY

PRESENT: JOAN B. LOBIS Justice PART 6

Bentona Cole

- v -

Morton A. Rosenowitz

INDEX NO. 150219/09
MOTION DATE 8-20-13
MOTION SEQ. NO. 003
MOTION CAL. NO.

The following papers, numbered 1 to _____ were read on this motion to (for) summary judgment

	PAPERS NUMBERED
Notice of Motion/ Order to Show Cause — Affidavits — Exhibits ...	E-Filed: 20-24
Answering Affidavits — Exhibits	26-34
Replying Affidavits	35-37

Cross-Motion: ☐ Yes ☐ No

Upon the foregoing papers, it is ordered that this motion

THIS MOTION IS DECIDED IN ACCORDANCE WITH THE ACCOMPANYING MEMORANDUM DECISION, ORDER + JUDGMENT

MOTION/CASE IS RESPECTFULLY REFERRED TO JUSTICE FOR THE FOLLOWING REASON(S):

Dated: 9/17/13

JOAN B. LOBIS J.S.C.

Check one: ☐ FINAL DISPOSITION ☑ NON-FINAL DISPOSITION

Check if appropriate: ☐ DO NOT POST ☐ REFERENCE

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

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BARBARA COLE,

Plaintiff,

Index No. 150219/09

-against-

Decision, Order, and Judgment

NORTON S. ROSENSWEIG, M.D.,

Defendant.

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

In motion sequence 002, Norton S. Rosensweig, M.D., moves pursuant to Rule 3212 of the Civil Practice Law and Rules for summary judgment. Plaintiff Barbara Cole opposes the motion. For the following reasons, the motion is granted in part and denied in part.

This medical malpractice case arises out of the treatment rendered to Barbara Cole by Dr. Norton Rosensweig from 2003 through 2007. Ms. Cole has a complex medical history. She is prone to excessive bleeding due to hemophilia. She was diagnosed with endometriosis. In 1990, she began treatment for Hashimoto's thyroiditis, a disease where the immune system attacks the thyroid gland, resulting in an underactive thyroid gland. She was stable until December 2002, when she developed an upper respiratory infection and took antibiotics, which led to abdominal pain and bloody diarrhea.

Ms. Cole began treating with Dr. Rosensweig, an internist and gastroenterologist, on January 20, 2003, upon a referral from her ear, nose, and throat doctor. During Ms. Cole's first visit, Dr. Rosensweig recorded her complaints of complications from the antibiotics, diarrhea, nausea,

dysphagia, weight loss, and a sensation of food being stuck in her throat. Dr. Rosensweig documented Ms. Cole's medical history and noted that Ms. Cole experienced sensitivity to various foods.

Dr. Rosensweig treated Ms. Cole approximately 40 times between 2003 and 2007, during which she continued to experience abdominal pain, dysphagia, constipation, and bloody diarrhea. In addressed Ms. Cole's complaints, Dr. Rosensweig's primary impression was that Ms. Cole suffered from gastroesophageal reflux disease (GERD) and irritable bowel syndrom (IBS). He administered various tests and prescribed medications, which had varying degrees of success in relieving Ms. Cole's symptoms. Additionally, Dr. Rosensweig testified that he placed Ms. Cole on a carbohydrate-free diet, although this is not documented in the medical records.

Ms. Cole testified that she adopted a gluten-free diet in June 2007, after having spoken with other doctors and friends who believed that she had celiac disease. She states that she approached Dr. Rosensweig about considering celiac disease as a possible diagnosis, but he dismissed it as a " fad disease." Ms. Cole contends that her gluten-free diet relieved her abdominal pain.

Out of concern that she may be suffering from celiac disease, Ms. Cole began treating with Dr. Moshe Rubin, a gastroenterologist, in July 2007. Dr. Rubin ordered genetic and serological tests for celiac disease. No serological markers for celiac disease were detected. The genetic testing, however, indicated that Ms. Cole had half of the DQ2 heterodimer associated with celiac disease,

the Human Leukocyte Antigen (HLA) DQA1*05. Approximately 95% of celiac patients have the DQ2 heterodimer, and the remaining 5% have the DQ8 heterodimer. Dr. Rubin believed that Ms. Cole was gluten sensitive and had celiac disease.

Ms. Cole also started treating with Dr. Peter Green at the Celiac Disease Center at Columbia University in October 2007. Dr. Green noted that Ms. Cole's gluten-free diet had helped alleviated her symptoms of abdominal pain and fatigue. He ordered serological testing for celiac disease, which revealed an absence of the heightened autoimmune response usually present in patients with celiac disease. Dr. Green also performed an endoscopy and took biopsies from Ms. Cole's stomach, duodenum, and lower esophagus. The pathology reports returned without any abnormalities. Despite these results, Dr. Green believed that Ms. Cole had celiac disease due to Ms. Cole's "marked response to gluten withdrawal in the context of an appropriate HLA . . . type for Celiac disease (HLA DQ2 heterodimer)."

Ms. Cole commenced this action on November 20, 2009, alleging that Dr. Rosensweig misdiagnosed her as having IBS and failed to diagnose and treat her for celiac disease. As a result, Ms. Cole alleges that she suffered extreme pain, hair loss, muscle weakness, loss of mobility, and gastrointestinal bleeding. She further contends that she is unable to work and engage in daily activities. Ms. Cole also has a cause of action for lack of informed consent.

Dr. Rosensweig seeks summary judgment to dismiss both causes of action on the grounds he did not depart from the standard of care in treating Ms. Cole. The defendant also seeks

sanctions against the plaintiff. The defendant contends that he performed various tests, all of which effectively ruled out celiac disease. He notes that he performed an endoscopy on January 22, 2003, during which he examined the patient's esophagus, stomach, and duodenum, and found no evidence of celiac disease. He states that he performed another endoscopy on January 23, 2006, during which he took four biopsies from the patient's duodenum. The biopsies revealed no evidence of celiac disease. The defendant contends that the plaintiff does not suffer from celiac disease, since all the tests conducted, including those by her subsequent treaters, showed no evidence of the condition.

In support of his motion, the defendant submits an affirmation from James Henry Grendell, M.D., a physician licensed in New York and board certified in gastroenterology, internal medicine, and nutrition. After reviewing the plaintiff's medical records and the deposition transcripts in this case, Dr. Grendell opines to a reasonable degree of medical certainty that the care rendered by Dr. Rosensweig was in accordance with the accepted standards of care. He explains that celiac disease is a very specific and rare autoimmune disease in the digestive system triggered by the consumption of gluten found in foods containing rye, wheat, or barley. Patients with celiac disease who consume gluten can suffer an autoimmune response that causes damage in the small intestine, including the duodenum, and can experience problems absorbing nutrients. There is no cure for celiac disease aside from adopting a gluten-free diet.

Dr. Grendell states that genetic tests, serological tests, and biopsies are the three primary ways of testing for celiac disease. Genetic tests analyze for the genetic marker for the celiac disease, DQ2 and DQ8 heterodimers. He asserts that patients who lack DQ2 and DQ8 heterodimers

lack the genetic basis to develop celiac disease. Serological tests search for a series of antibodies that reflect the heightened autoimmune response to the consumption of gluten in celiac patients, including Anti-Gliadins IgG and IgA levels, Tissue Transglutaminase IgA and IgG levels, and Anti-Endomysial IgA levels. A biopsy of the small intestine or duodenum evaluates the damage to the gastrointestinal system caused by the autoimmune response in celiac patients.

Dr. Grendell concludes that because Dr. Rosensweig found no evidence of erosion in the plaintiff's duodenum or a heightened autoimmune response during the endoscopy performed on January 22, 2003, Dr. Rosensweig did not need to take a biopsy at that time. He further adds that the biopsy taken on January 23, 2006 revealed that the intestinal villi were preserved and normal. Dr. Grendell indicates that patients with celiac disease would have shortened or blunted intestinal villi, which causes difficulties absorbing nutrients. Because the patient's villi were preserved, Dr. Rosensweig appropriately ruled out celiac disease. Defendant's expert notes that the patient's subsequent treaters found no evidence of celiac disease after performing a serological test, genetic test, and biopsy. He states that the half of the DQ2 heterodimer present in the patient's genes is insufficient to support a diagnosis of celiac disease. He concludes that, based on the tests performed by Drs. Rosensweig, Rubin, and Green, Ms. Cole does not suffer from celiac disease. He believes that Ms. Cole's clinical history was consistent with GERD and IBS, and that Dr. Rosensweig appropriately placed Ms. Cole on a restricted diet.

In opposition, Ms. Cole argues that summary judgment should be denied due to outstanding issues of fact. She argues that she suffers from celiac disease, which condition has been

repeatedly diagnosed by Drs. Green and Rubin. The plaintiff submits an affirmation from William Bisordi, M.D., F.A.C.P., who indicates that he is a physician licensed in New York and is board certified in Internal Medicine and Gastroenterology. After reviewing the medical records and deposition transcripts, he opines to a reasonable degree of medical certainty that Dr. Rosensweig departed from the standard of care while treating Ms. Cole. He states that Ms. Cole's complaints and medical history on January 20, 2003, was indicative of a clinical diagnosis of celiac disease. He argues that Dr. Rosensweig should have included celiac disease in his differential diagnosis and should have ordered blood work to specifically test for celiac disease. The expert explains that the symptoms for IBS can overlap with those for celiac disease, and opines that IBS should have been ruled out once Ms. Cole began experiencing iron deficiency anemia and gastrointestinal hemorrhaging. He opines that the standard of care is to consider celiac disease in any patient suspected of having IBS. The patient should have been placed on a trial of a gluten-free diet, and he opines that Dr. Rosensweig's recommendation that the patient be placed on a low carbohydrate diet is not synonymous with a gluten-free diet.

Dr. Bisordi further notes that Ms. Cole experienced a dramatic remission in her abdominal complaints and fatigue after starting a gluten-free diet. The expert opines that serological tests and biopsies are unreliable tests if a patient is already on a gluten-free diet, because the intestinal damage begins to heal within weeks of gluten being removed from the diet and antibody levels decline over months. Dr. Bisordi states that the endoscopy and biopsy reports performed after 2007 represent false negatives, since Ms. Cole had adopted a gluten-free diet by that time.

The expert believes that given the plaintiff's response to her gluten-free diet and her HLA genotype for celiac disease, Human Leukocyte Antigen (HLA) DQ2 heterodimer, Ms. Cole was suffering from celiac disease while under the care of Dr. Rosensweig between 2003 and 2007. He advances that the defendant deprived the plaintiff of a substantial possibility of early and effective treatment, thereby increasing her pain, suffering, and disability.

The plaintiff also submits the affirmation of Dr. Peter Green, who states that he is licensed in New York and is a Professor of Clinical Medicine and the Director of the Celiac Disease center at Columbia University Medical Center. He first saw Ms. Cole on October 9, 2007, when she presented with complaints of abdominal pain, bloating, diarrhea, and anemia. She also had a history of Hashimoto's thyroiditis, endometriosis, and clotting factor deficiency. He notes that Ms. Cole's gluten-free diet resulted in a remission of her abdominal pain. Dr. Green diagnosed Ms. Cole with celiac disease due to her positive response to her gluten free diet and her genetic results.

In reply, the defendant asserts that the plaintiff's expert affirmation is conclusory. The defendant reiterates that the January 22, 2003, endoscopy indicated no signs of celiac disease and precluded the need to take a biopsy at that time. The defendant further states that, contrary to plaintiff's expert's conclusions, Dr. Rosensweig placed the plaintiff on a carbohydrate-free diet, which is inclusive of a gluten-free diet. Dr. Rosensweig further states that the biopsy and endoscopy results from January 23, 2006, which showed no evidence of celiac disease, further supports his position that either the patient did not have celiac disease or the condition was alleviated by the carbohydrate-free diet that he prescribed.

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). A 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 a defendant is the movant, that the cause of action has no merit. Id. This Court may grant the motion if, upon all the papers and proof submitted, it is established that the Court 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.

In a medical malpractice case, to establish entitlement to summary judgment, a physician must demonstrate that he did not depart from accepted standards of practice or that, even if he did, he did not proximately cause injury to the patient. Roques v. Noble, 73 A.D.3d 204, 206 (1st Dep't 2010). In claiming treatment did not depart from accepted standards, 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. Roques, 73 A.D.3d at 206. The expert cannot make conclusions by assuming material facts not supported by record evidence. Id. Defense expert opinion should specify "in what way" a patient's treatment was proper and "elucidate the standard of care." Ocasio-Gary v. Lawrence Hosp., 69 A.D.3d 403, 404 (1st Dep't 2010). A defendant's expert opinion must "explain 'what defendant did and why.'" Id. (quoting Wasserman v. Carella, 307 A.D.2d 225, 226 (1st Dep't 2003)). Conclusory medical affirmations or expert opinions that fail to address a plaintiff's essential factual allegations are insufficient to establish prima facie

entitlement to summary judgment. 73 A.D.3d at 206. Once a defendant establishes a prima facie case, a plaintiff must then rebut that showing by submitting an affidavit from a medical doctor attesting that the defendant departed from accepted medical practice and that the departure proximately caused the alleged injuries. Id. at 207.

In this case, the defendant met his prima facie burden by submitting competent expert evidence by Dr. Grendell, who opines that Dr. Rosensweig performed the appropriate diagnostic testing, including an endoscopy, which showed no evidence of celiac disease. Plaintiff's expert, however rebuts this showing by opining that a patient with Ms. Cole's symptoms should have been diagnosed with celiac disease. Plaintiff's expert states that the symptoms for IBS often overlap with those for celiac disease, and genetic tests and serological tests should have accompanied the defendant's evaluation of Ms. Cole. Furthermore, plaintiff's and defendant's experts disagree as to the significance of the HLA heterodimer encountered in Ms. Cole's genotype. The parties also disagree as to the nature of the plaintiff's diet between 2003 and 2007. Due to these unresolved issues of fact and conflicting expert statements, summary judgment on the medical malpractice cause of action must be denied.

In light of the above, the defendant's request for sanctions and cost is denied, as it was conditioned upon the dismissal of the case. The portion of the defendant's motion seeking to dismiss the plaintiff's lack of informed consent cause of action, however, is granted. The plaintiff does not oppose dismissing this cause of action. Accordingly, it is

ADJUDGED that the portion of the motion seeking to dismiss the plaintiff's claim for lack of informed consent is granted, and that cause of action is dismissed; it is further

ORDERED that the remainder of the motion is denied; and it is further

ORDERED that the parties shall appear for a pre-trial conference on Tuesday, October 15, 2013, at 10:00 a.m.

Dated: Sept. 17, 2013

ENTER:

JOAN B. LOBIS, J.S.C.