Whalen v Sung Whang
2017 NY Slip Op 31064(U)
May 11, 2017
Supreme Court, Suffolk County
Docket Number: 12-34969
Judge: Jerry Garguilo

[* 1]

SHORT FORM ORDER

INDEX No. 12-34969
CAL. No. 16-01001MM

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

PRESENT:

Hon. JERRY GARGUILO
Justice of the Supreme Court

MOTION DATE 11-23-16
ADJ. DATE 1-18-17
Mot. Seq. # 003 - MG

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RICHARD WHALEN,

Plaintiff,

- against -

SUNG WHANG, BETH A. HAYES, MUHAMMAD H. NOOR, SANDHAYA M. SINGH, SCOTT R. CAPUSTIN, SCOTT R. CAPUSTIN, M.D., P.L.L.C., DAVID E. RIVADENEIRA AND ST. CATHERINE OF SIENNA MEDICAL CENTER,

Defendants.

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Upon the following papers numbered 1 to 124 read on this motion for summary judgment; Notice of Motion/ Order to Show Cause and supporting papers 1 - 17; Notice of Cross Motion and supporting papers ___; Answering Affidavits and supporting papers 18 - 22; Replying Affidavits and supporting papers 23 - 24; Other ___; (~~and after hearing counsel in support and opposed to the motion~~) it is,

ORDERED that the motion for summary judgment (1) dismissing the complaint as against defendants Muhammad H. Noor, M.D., Sandhaya M. Singh, M.D., and David E. Rivadeneira, M.D.,and (2) dismissing the second cause of action as against defendants St. Catherine of Siena Medical Center and Sung Whang, M.D., is granted.

Plaintiff Richard Whelan commenced this action to recover for personal injuries related to the alleged medical malpractice in a delayed diagnosis of appendicitis, lack of informed consent, improper and untimely

surgery, and the development of pressure sores. Issue has been joined, discovery is complete, and a note of issue has been filed. The action against Beth A. Hayes, M.D., Scott R. Capustin, and Scott R. Capustin, M.D., P.L.L.C., has been discontinued.

Defendants Muhammad H. Noor, M.D., David E. Rivadeneira, M.D., and Sandhaya M. Singh, M.D., now move for summary judgment dismissing the complaint and all cross claims asserted against them. Defendants Sung Whang, M.D., and St. Catherine of Siena Medical Center move for summary judgment in their favor on the second cause of action alleging lack of informed consent. In support of the motion, defendants submit, among other things, a copy of the pleadings; an expert affidavit of William Miller, D.O.; the deposition transcripts of plaintiff, Dr. Whang, Dr. Hayes, Dr. Noor, Dr. Singh, Dr. Capustin, Dr. Rivadeneira, and Crystal Piatnick; and plaintiff's medical records. Plaintiff offers no opposition to the application for summary judgment dismissing the first cause of action against Dr. Singh, and Dr. Rivadeneira, M.D., and withdraws his second cause of action alleging lack of informed consent. Plaintiff, however, opposes dismissal against Dr. Muhammad Noor on the first cause of action and submits, among other things, an expert physician's affidavit.

Plaintiff testified that he was experiencing "flu-like symptoms" and three or four people at his work had the flu. He testified he had pain on Friday that was approximately 4 inches to the right of his navel that lasted for half an hour and then went away. On Saturday he spent the day in bed. He testified that he felt nauseous but did not vomit, and did not recall experiencing abdominal pain. On Sunday night the pain got worse, and on Monday he was nauseous, fatigued, and felt pain radiating into his right shoulder. After drinking a glass of cold water, he felt a stabbing pain in his abdomen four inches to the right of his belly button. He testified the pain extended from his abdomen to his right shoulder to the right side of his neck, and that he had difficulty breathing. He testified he called his ex-wife, Crystal Piatnick, and told her he had pain traveling up his right shoulder and into his arm and neck. Ms. Piatnick testified she called the ambulance, which took plaintiff to the hospital.

Medical records reveal plaintiff was admitted to St. Catherine of Siena Medical Center from April 18, 2011 through May 9, 2011. On April 18, 2011, triage nurses documented plaintiff's chief complaint of abdominal pain for the past two days, radiating to his right shoulder with increased pain on inspiration and shortness of breath. The pain was noted to be 10 out of 10, sharp and constant. Plaintiff was seen by Dr. Beth Hayes at 8:15 p.m., in the emergency room, and her examination revealed tenderness in plaintiff's right upper quadrant, a positive Murphy sign, positive guarding, and no CVA tenderness. Dr. Hayes testified her diagnosis was gallbladder disease, cholelithiasis, cholecystitis, pneumonia, acute coronary syndrome, and gastritis. She ordered morphine for pain, Zofran for nausea, a chest x-ray, and an abdominal ultrasound to assess plaintiff's gallbladder, kidneys, liver and pancreas.

Dr. Sandhaya Singh, a St. Catherine of Siena Medical Center staff radiologist, interpreted the ultrasound performed by a technician. Dr. Singh testified that an abdominal ultrasound does not evaluate an appendix; and that an appendix is evaluated by performing a lower right quadrant ultrasound. She testified she was not given any information regarding the location of plaintiff's abdominal pain, the quality of the pain, or any other signs or symptoms. Dr. Singh testified plaintiff's gallbladder was unremarkable, as was his spleen and kidney, and that there was no evidence of gallstones, peri-cholecystic fluid, or gallbladder wall thickening. Dr. Singh had no other involvement with plaintiff.

Dr. Hayes testified she admitted plaintiff with a diagnosis of right lower lobe pneumonia. His cardiac enzymes were normal, but white blood count was elevated. Dr. Muhammad Noor, the hospitalist and a board certified internist, examined plaintiff and assigned him to the daytime hospitalist Dr. Sung Whalen. Dr. Noor testified that his findings from examining plaintiff's abdomen were benign. He testified that he advised Dr. Whalen to see plaintiff at 7:00 a.m. and that his examination did not find any signs or symptoms of appendicitis or tenderness or guarding. He ordered a pulmonary consultation, and morphine.

On April 19, 2011, plaintiff was examined by Dr. Capustin, a board certified pulmonary and critical care medicine attending physician. Dr. Capustin testified that plaintiff's chest x-ray revealed a right lower lobe atelectasis/infiltrate, and that plaintiff's abdomen was soft and nontender. He testified that plaintiff did not complain of abdominal pain, and that he ordered IV antibiotics, incentive spirometry, and CT angiogram of plaintiff's chest. On April 19, plaintiff was also seen by Dr. Malhotra, who recommended cardiac monitoring with serial cardiac enzymes. A echocardiogram noted no significant cardiac abnormalities.

Dr. Whalen examined plaintiff on April 19, 2011. He testified plaintiff was feeling better that day, but still complained of pain on the right side of his chest and abdominal area. A CAT scan showed no pulmonary embolism. Dr. Whalen assessed plaintiff with pneumonia, hypertension, and an abnormal EKG. He ordered follow-ups with pulmonology and cardiology. On April 20, 2011, Dr. Whalen noted that plaintiff had abdominal pain. He testified that plaintiff's pain was not significant and that there were no significant abdominal findings from the examination. On April 20, 2011, Dr. Capustin noted no pulmonary embolism per CAT scan, atelectasis/ inflitrate right middle and right lower lobe, chest pain less, lungs decreased breath sounds right base, afebrile. On April 21, Dr. Whang noted plaintiff complained of chills and abdominal pain. He testified plaintiff had positive bowel sounds with mild tenderness in the upper right quadrant and continued the assessment of pneumonia. Dr. Capustin ordered a CAT scan of plaintiff's abdomen and pelvis, IV and oral contrast. On April 21 at 5:45 p.m., the CAT scan was positive for appendicitis.

Thereafter, plaintiff was examined by Dr. Arumugam and surgical intervention was recommended. Hospital records indicate plaintiff needed more time to make a decision, and he was started on Primaxin for bowel coverage. Dr. David Rivadeneira, a board certified general, colon, and rectal surgeon, offered a second surgical opinion. After examining plaintiff, Dr. Rivadeneira agreed that plaintiff required surgery. Dr. Arumugam was to perform an appendectomy. Hospital notes indicate that on April 22, 2010, plaintiff requested Dr. Rivadeneira perform the surgery. A laparoscopic was planned, but converted to an open procedure due to significant adhesions, inflammatory process, and the presence of abscesses. The surgery revealed that plaintiff's appendix had ruptured and an infection had moved into the right upper quadrant. Dr. Rivadeneira used Seprafilm, an absorbable material that is used to reduce adhesions or scar tissue that develop after surgery.

Hospital records from April 23, 2011 indicate cardiology stopped following plaintiff, and he was instructed to follow-up in four to six weeks. Dr. Capustin, who examined plaintiff that same day, testified his diagnosis was peritonitis right lower lobe inflitrate with elevated right diaphragm secondary to subdiaphragmatic process, inhalation, and IV antibiotics to continue. Dr. Whang also testified that he examined plaintiff on April 23 and assessed appendicitis with microperforations and pneumonia. Dr. Genua

also examined plaintiff and her notes indicate, in part, that there was no flatus, that his pain was controlled, that the abdomen was soft, distended, and nontender, that the dressings were clean, dry and intact.

Hospital records from April 24, 2011, indicate that Dr. Genua noted plaintiff did not want to get out of bed, positive nausea, no reflux, temperature 100.4, pulse 102, blood pressure 139/93, abdomen soft, distended, nontender, no guarding. A nasogastic (NG) tube was placed and Dr. Whang requested an infectious disease consultation. Dr. Kohn examined plaintiff, discontinued rocephin and azithromycin, and ordered imipenem.

Dr. Rivadeneira testified he saw plaintiff on April 25 and 26, 2011, and plaintiff was afebrile and stable, but negative for bowl signs. Dr. Capustin noted no evidence of ongoing pneumonia. Hospital records indicate that on April 27, 2011 plaintiff developed a stage II ulcer, and a wound care nurse, Edna Rousseau, recommended a zone air mattress and a special seat cushion, which Dr. Whang ordered. On April 27, 2011, Dr. Rivadeneira notes positive flatus but a partial bowel obstruction. On April 28, Dr. Rivadeneira's examination of plaintiff showed positive bowel sounds, no fever, cough, chest pain, or shortness of breath, and no evidence of pneumonia. A clinical nutrition note indicates no food or water by mouth (NPO) and that plaintiff had a stage I or II ulcer in the sacral/buttock area. On April 29, the NG tube was removed and plaintiff tolerated clear liquids. On April 30, Dr. Rivadeneira's notes indicate plaintiff was doing well and pain medication was discontinued. However, on May 1 plaintiff was vomiting and Dr. Whang ordered NPO. A CAT scan revealed partial small bowel obstruction, and a conservative plan to allow it to resolve on its own was put in place. On May 2, a PICC line was placed and an endocrinology consult was preformed by Dr. Terrana. On May 3, plaintiff had positive bowl movement, no nausea, or vomiting. On May 4, a drainage procedure was scheduled, and on May 5, Dr. Shu-Ho Chang performed an abdominal wall abscess CT-guided drainage with an 8-French pigtail catheter yielding 30mL of slightly turbid serosanguinous fluid, which was negative for anaerobic or aerobic growth. On May 6, the NG tube was removed and on May 9 plaintiff was discharged from the hospital.

To make a prima facie showing of entitlement to summary judgment in an action to recover damages for medical malpractice, a defendant must establish through medical records and competent expert affidavits that it did not deviate or depart from accepted medical practice in the treatment of the plaintiff or that it was not the proximate cause of plaintiff's injuries (*see* ***Castro v New York City Health & Hosps. Corp.***, 74 AD3d 1005, 903 NYS2d 152 [2d Dept 2010]; ***Deutsch v Chaglassian***, 71 AD3d 718, 896 NYS2d 431 [2d Dept 2010]; ***Plato v Guneratne***, 54 AD3d 741, 863 NYS2d 726 [2d Dept 2008]; ***Jones v Ricciardelli***, 40 AD3d 935, 836 NYS2d 879 [2d Dept 2007]; ***Mendez v City of New York***, 295 AD2d 487, 744 NYS2d 847 [2d Dept 2002]). To satisfy this burden, the defendant must present expert opinion testimony that is supported by facts in the record and addresses the essential allegations in the bill of particulars (*see* ***Roques v Noble***, 73 AD3d 204, 899 NYS2d 193 [1st Dept 2010]; ***Ward v Engel***, 33 AD3d 790, 822 NYS2d 608 [2d Dept 2006]). Conclusory statements that do not address the allegations in the pleadings are insufficient to establish entitlement to summary judgment (*see* ***Garbowski v Hudson Val. Hosp. Ctr.***, 85 AD3d 724, 924 NYS2d [2d Dept 2011]). A physician owes a duty of reasonable care to his or her patients and will generally be insulated from liability where there is evidence that he or she conformed to the acceptable standard of care and practice (*see* ***Spensieri v Lasky***, 94 NY2d 231, 701 NYS2d 689 [1999]; ***Barrett v Hudson Valley Cardiovascular Assoc., P.C.***, 91 AD3d 691, 936 NYS2d 304 [2d Dept 2012]; ***Geffner v North Shore Univ. Hosp.***, 57 AD3d 839, 871 NYS2d 617 [2d Dept 2008]).

Failure to demonstrate a prima facie case requires denial of the summary judgment motion, regardless of the sufficiency of the opposing papers (*see* ***Alvarez v Prospect Hosp.***, 68 NY2d 320, 5088 NYS2d 923 [1986]). Once the defendant makes a prima facie showing, the burden shifts to the plaintiff to produce evidentiary proof in admissible form sufficient to establish the existence of triable issues of fact which require a trial of the action (*see* ***Alvarez v Prospect Hosp.***, *supra*; ***Kelley v Kingsbrook Jewish Med. Ctr.***, 100 AD3d 600, 953 NYS2d 276 [2d Dept 2012]; ***Fiorentino v TEC Holdings, LLC***, 78 AD3d 911 NYS2d 146 [2d Dept 2010]). In a medical malpractice action, a plaintiff opposing a motion for summary judgment need only raise a triable issue of fact with respect to the element of the cause of action or theory of nonliability that is the subject of the moving party's prima facie showing (*see* ***Bhim v Dourmashkin***, 123 AD3d 862, 999 NYS2d 471 [2d Dept 2014]; ***Hayden v Gordon***, 91 AD3d 819, 937 NYS2d 299 [2d Dept 2012]; ***Stukas v Streiter***, 83 AD3d 18, 918 NYS2d 176 [2d Dept 2011]; ***Schichman v Yasmer***, 74 AD3d 1316, 904 NYS2d 218 [2d Dept 2010]).

As to the first cause of action, defendants Dr. Noor, Dr. Rivadeneira, and Dr. Singh have established their prima facie entitlement to summary judgment dismissing the claim of medical malpractice and any cross claims against them. Dr. William Miller, their expert, avers that Dr. Noor, Dr. Rivadeneira, and Dr. Singh did not deviate from the accepted standard of care in the field of medicine in the care and treatment rendered to plaintiff. He further opines that the care and treatment rendered by Dr. Noor, Dr. Rivadeneira, and Dr. Singh was not the proximate cause of plaintiff's injuries. Dr. Miller avers that Dr. Noor, as the night hospitalist, admitted plaintiff to Dr. Whang's service after Dr. Hayes emergency room examination of plaintiff. Dr. Noor testified his examination revealed plaintiff's abdomen was "benign," soft, nontender with positive bowel sounds. After the diagnosis of pneumonia with a plan to rule out acute coronary syndrome, Dr. Noor was not involved in plaintiff's care and treatment. Dr. Miller avers that Dr. Noor's examination of plaintiff revealed "no sign or symptoms of appendicitis, tenderness, guarding or rebound pain," and that "the allegation that Dr. Noor failed to properly and timely palpitate [plaintiff's] abdominal region is without merit." Dr. Miller avers that Dr. Singh's sole involvement in the care and treatment of plaintiff was to interpret the abdominal ultrasound preformed on April 18, 2011, and that an abdominal ultrasound does not visualize the appendix. He opines her interpretation and impression of that test was correct. Dr. Miller also avers that Dr. Rivadeneira was requested to provide a second opinion after a CAT scan was positice for appendicitis. Dr. Miller opines the urgency of the surgery was properly explained and the conversion from laparoscopic appendectomy to an open procedure was appropriate. He opines that the use of Seprafilm to prevent the formation of further adhesions was not contraindicated and was appropriate.

Defendants Dr. Whang, Dr. Singh, Dr. Noor, Dr. Rivadeneira, and St. Catherine of Siena Medical Center have also established their prima facie entitlement to summary judgment dismissing the second cause of action alleging lack of informed consent. Dr. Miller avers plaintiff was gave informed consent for the surgery performed by Dr. Rivadeneira, the PICC line placed May 2, 2011, and the May 5 CT-guided drainage. He opines that these procedures did not cause any injury to plaintiff. Accordingly, the second cause of action is dismissed as to Dr. Whang, Dr. Singh, Dr. Noor, Dr. Rivadeneira, and St . Catherine of Siena Medical Center.

In opposition, plaintiff has failed to raise a triable issue of fact. Plaintiff's expert avers that plaintiff made no complaints of abdominal pain at the time of Dr. Noor's first examination of plaintiff at approximately 10:00 p.m. on April 18, 2011. The expert opines it was negligent and a departure from good

and accepted standards of medical practice in failing to re-examine and re-assess plaintiff's complaint of severe right-sided abdominal pain in the early morning hours of April 19, 2011. He opines that Dr. Noor should have re-examined plaintiff and performed a Psoas test and checked for the obdurator sign in order "to account for his patient's now additional complaint of severe right-sided abdominal pain requiring narcotic pain management." This opinion is speculative and is unsupport by the record and, therefore, is insufficient to withstand summary judgment (***Diaz v New York Downtown Hospital***, 99 NY2d 542, 754 NYS2d 195 [2002]). Plaintiff, by discontinuing his claim against Dr. Hayes, the emergency room physician, admits that Dr. Hayes was not negligent and did not commit malpractice. It is undisputed that Dr. Hayes did not palpate for the obdurator sign or conduct a Psoas test, and that Dr. Noor agreed with her assessment of plaintiff's condition. Moreover, plaintiff's expert does not allege negligence or malpractice when Dr. Noor first examined and assessed plaintiff at approximately 10:00 p.m. on April 18, 2011, at which time plaintiff's pain was not escalating. Rather, the evidence in the record shows that , while plaintiff complained of pain of 10 on a scale of 10 at 8:13 p.m., 6 mg. of morphine was administered. At 10:30 p.m., 1 mg. of morphine was ordered every three hours. At 11:30 p.m., plaintiff reported pain of 8 on a scale of 10 and 1mg. of morphine was administered. At 11:50 p.m., plaintiff reported pain of 4 on a scale of 10. On April 19, 2011, at 1:30 a.m., plaintiff's reported pain of 6 on a scale of 10 and Dr. Noor ordered 2 mg. of morphine every 4 hours. At 2:00 a.m., plaintiff's pain was 3 on a scale of 10 and at 5:20 a.m., plaintiff reported pain of 7 on a scale of 10, and 2 mg. of morphine was administered. The medical records reveal plaintiff's pain was not increasing, but the pain was reduced by less milligrams of morphine than was initially administered (6 mg. v 2 mg.). Plaintiff's expert's opinion, therefore, is not supported by the record and fails to raise a triable issue of fact. Accordingly the first cause of action and the cross claims asserted against Dr. Noor, Dr. Rivadeneira, and Dr. Singh are dismissed.

Dated: 5-11-17

HON. JERRY GARGUILO, J.S.C.

___ FINAL DISPOSITION __X___ NON-FINAL DISPOSITION