Bouganim v Katz

2020 NY Slip Op 31738(U)

June 2, 2020

Supreme Court, New York County

Docket Number: 805626/2015

Judge: Eileen A. Rakower

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

PRESENT: Hon. EILEEN A. RAKOWER **PART 6**
Justice

JACOB BOUGANIM and SHARON J. BOUGANIM, **INDEX NO. 805626/2015**

Plaintiffs, **MOTION DATE**

- v - **MOTION SEQ. NO. 3, 4**

LESTER BRIAN KATZ, M.D., and BLAIR S. LEWIS, M.D., **MOTION CAL. NO.**

Defendants.

The following papers, numbered 1 to _____ were read on this motion for/to

PAPERS NUMBERED

Notice of Motion/ Order to Show Cause — Affidavits — Exhibits ...

Answer — Affidavits — Exhibits ___________________________________

Replying Affidavits

Cross-Motion: X Yes No

Under Motion Sequence 3, Defendant Lester Brian Katz, M.D. ("Dr. Katz") moves for summary judgment pursuant to CPLR § 3212 on the grounds that Dr. Katz did not depart from accepted standards of medical care and treatment with respect to the medical care rendered to Plaintiff Jacob Bouganim ("Plaintiff") and there is a lack of causation between the medical care and the alleged injuries. Plaintiff opposes Dr. Katz's motion for summary judgment.

Under Motion Sequence 4, Defendant Blair S. Lewis, M.D. ("Dr. Lewis") moves for summary judgment pursuant to CPLR § 3212 and for the dismissal of the claims asserted against Dr. Lewis. Plaintiff does not oppose Dr. Lewis' motion for summary judgment (See NYSCEF DOC. NO. 138).

Factual Background

This action involves Defendants' treatment of Plaintiff's recurrent diverticulitis.

In 2008, Plaintiff was diagnosed with recurrent diverticulitis. Between 2008 and 2013, Plaintiff treated with Dr. Arthur Talansky to manage his symptoms, which included chronic abdominal pain.

In June 2013, surgery was recommended to Plaintiff to treat his acute sigmoid diverticulitis. Plaintiff consulted with several physicians and chose Dr. Katz to perform the surgery. Dr. Katz's medical records from Plaintiff's July 30, 2013 visit describe Plaintiff as being a "55 year old man with at least 10 episodes of diverticulitis in the past year as well as multiple hospital admissions." The medical records state that the "[l]ast episode was 3 weeks ago where he had fever and severe abdominal pain" and Plaintiff "has become progressively more constipated." The medical records state that "[l]aparoscopic sigmoid resection and complications were discussed in detail." (Dr. Katz - 083). Plaintiff signed a consent to surgery form on August 6, 2013, prior to the procedure by Dr. Katz, indicating that Plaintiff had been advised of the risks, alternatives, and benefits of surgery. (Dr. Katz - 063)

On August 22, 2013, Dr. Katz performed a laparoscopic sigmoid resection on Plaintiff at Mount Sinai Hospital. Dr. Katz surgically removed a section of the sigmoid colon and created an anastomosis connecting the remaining portions of the colon. Dr. Katz's operative notes documented that "the anastomosis was checked with Betadine and air and found to be intact" and "[t]here was no tension of the anastomosis." (Dr. Katz- 020). On August 25, 2013, Plaintiff was discharged from Mount Sinai.

On September 10, 2013, Plaintiff saw Dr. Katz for a postoperative follow-up. Dr. Katz's medical notes state that Plaintiff complained "of more abdominal pain and possible fever," and "[n]o bowel movement." Dr. Katz noted, "Examination he (sic) looks well." Dr. Katz further noted that Plaintiff was "[v]ery anxious," "does not feel warm," and that

his "[a]bdomen is soft with mild Right lower quadrant tenderness." (Dr. Katz - 084).

On that same day, Dr. Katz obtained an abdominal CT scan. The findings of the CT scan were as follows: "[t]he small bowel is normal in caliber;" "[t]here is no obstruction;" "[t]he anastomosis is identified and is unremarkable;" "a few scattered diverticulum in the main sigmoid colon;" "[s]light thickening of the remaining sigmoid colon is likely exaggerated secondary to under-distention;" and "no abnormality identified." (Dr. Katz – 059).

Plaintiff continued to complain of abdominal pain. On October 22, 2013, Dr. Katz texted Plaintiff to contact Dr. Lewis "[t]o stretch anterior resection anastomosis."

Plaintiff presented to Dr. Lewis' office on October 24, 2013 for a consultation. Dr. Lewis noted that based on her initial evaluation of Plaintiff, it was "[u]nclear if he [Plaintiff] has narrowing at anastomosis" and was "[c]learly not truly obstructed since he moves his bowel." Dr. Lewis recommended a "colonoscopy with possible dilation." (Dr. Lewis - 05-07)

On October 30, 2013, Dr. Lewis performed a "total colonoscopy" and "a stricture of the anastomosis was identified and dilated and a colon polyp was removed." Plaintiff was discharged and advised to "return to previous diet" and "[c]ontinue present medications." (Dr. Lewis 13-16).

After continued complaints from Plaintiff, on December 30, 2013, Dr. Lewis performed a flexible sigmoidoscopy. In a letter to Plaintiff, Dr. Lewis wrote that the "anastomosis was dilated to 18 mm, but it was unlikely that his symptoms were a result of the narrowing of the anastomosis." Plaintiff was told to take Metamucil daily and to drink 1.5 liters of water daily. (Dr. Lewis - 20).

Plaintiff returned to Dr. Lewis on April 15, 2014 with complaints of abdominal pain and bloating. Dr. Lewis reviewed Plaintiff's March 30, 2014 CT scan and assessed Plaintiff's symptoms as "likely

secondary to constipation and are not from diverticulitis nor stricture." (Dr. Lewis -02; Dr. Lewis -26)

On November 10, 2014, Plaintiff presented to non-party colorectal surgeon Dr. Jeffrey Milsom. Dr. Milsom's medical records show that Plaintiff's "[c]hief complaint" was for "abdominal pain." (Dr. Milsom-01). On November 25, 2014, Dr. Milsom performed a colonoscopy on Plaintiff. During the procedure, Dr. Milsom located a colorectal anastomosis "at about 20 cm from the anal verge." Dr. Milson noted that "[d]istal to this was bowel that was in spasm and it had 2 right-angled turns to it." Dr. Milsom further noted that "[t]here were several diverticula noted above the anastomosis." Dr. Milsom noted, "Significant was that this exam was going to be used for the deliberation of the proper course of action in the future. I did feel that on seeing this anastomosis, that it was likely the cause of his symptoms and that he was having difficulty evacuating owing to this." (Dr. Milsom 06-07)

On April 7, 2015, Dr. Milsom performed a "[l]aparoscopic assisted colorectal resection around the anastomosis with takedown of the splenic flexure and colorectal anastomosis with intraoperative flexible sigmoidoscopy." During the procedure, Dr. Milsom made the following findings:

> "1. There was a colocolonic anastomosis located in the left side of the pelvis, which was densely adherent to the pelvic sidewall on the left side with no obvious process related to this, although there was clearly angulation of the colon at the site of the anastomosis. 2. The rest of the intra-abdominal contents appeared to be normal. There were minimal adhesions. There was no abscess and no other obvious process in the abdomen except in the left colon."

(Dr. Milsom-16).

The pathology report from Dr. Milsom's April 7, 2015 surgery describes two pieces of tissue. Specimen "A" is "labeled 'proximal resected margin colon' and consists of a 3 x 1.5 x 1 cm segment of colon." The diagnosis of Specimen "A" is described as "diverticulitis coli." Specimen "B" is "labeled 'colon and rectal anastomosis' and consists of a 6 cm long x 6 cm in circumference segment of colon." Specimen "B" is described as being "opened to reveal an intact anastomosis at 3 cm from one end." The diagnosis of Specimen "B" is "colo-colonic anastomosis with post-surgical changes and adhesions." (Dr. Milsom -19-21).

Plaintiff continued to follow-up with Dr. Milsom's office through November 17, 2015 with complaints of abdominal pain. On November 17, 2015, Dr. Milsom performed a flexible sigmoidoscopy and balloon dilation. Dr. Milsom noted in his findings that Plaintiff "has minor diaphragmatic narrowing of the anastomosis," and "[l]ots of spasms." Dr. Milsom prescribed Levsin and recommended an IBS diet. (Dr. Milsom 21-25).

In March 2016, Plaintiff was prescribed another IBS medication, Librax. By October 2016, Plaintiff reported that his bowel discomfort had resolved and his bowel movements were normal.

Summary Judgment Standard

CPLR § 3212 provides in relevant part, that a motion for summary judgment,

> shall show that there is no defense to the cause of action or that the cause of action or defense has no merit. The motion shall be granted if, upon all the papers and proof submitted, the cause of action or defense shall be established sufficiently to warrant the court as a matter of law in directing judgment in favor of any party… [t]he motion shall be denied if any party shall show facts sufficient to require a trial of any issue of fact.

A defendant moving for summary judgment in a medical malpractice case has the burden of making a prima facie showing of entitlement to judgment as a matter of law by showing that "there was no departure from good and accepted medical practice or that any departure was not the proximate cause of the injuries alleged" by introducing expert testimony that is supported by the facts in the record. *Rogues v. Nobel*, 73 A.D.3d 204, 206 [1st Dept. 2010].

Once the defendant has made this showing, the burden shifts to the party opposing the motion "to produce evidentiary proof in admissible form sufficient to establish the existence of material issues of fact which require a trial of the action." *Alvarez v. Prospect Hospital*, 68 N.Y.2d 320, 324 [1986]. Specifically, a plaintiff "must submit evidentiary facts or materials to rebut the prima facie showing by the defendant physician that he was not negligent in treating plaintiff so as to demonstrate the existence of a triable issue of fact." *Alvarez*, 68 N.Y.2d at 324.

A plaintiff "must submit an affidavit from a physician attesting that the defendant departed from accepted medical practice and that the departure was the proximate cause of the injuries alleged." *Rogues*, 73 A.D.3d at 207. "General allegations of medical malpractice, merely conclusory and unsupported by competent evidence tending to establish the essential elements of medical malpractice, are insufficient to defeat defendant physician's summary judgment motion." *Id.* at 325. An affidavit from an expert which sets "forth general conclusions, misstatements of evidence and unsupported assertions, is insufficient to demonstrate a defendant's failure to comport with accepted medical practice, or that any such failure was the proximate cause of plaintiff's injuries." *Coronel v. New York City Health & Hosps. Corp.*, 47 A.D.3d 456, 457 [1st Dept 2008].

Pursuant to Public Health Law § 2805-d[2], "[t]he right of action to recover for medical, dental or podiatric malpractice based on a lack of informed consent is limited to those cases involving either (a) non-emergency treatment, procedure or surgery, or (b) a diagnostic procedure which involved invasion or disruption of the integrity of the body."

"To prevail on such claim, a plaintiff must establish, via expert medical evidence, that defendant failed to disclose material risks, benefits and alternatives to the medical procedure, that a reasonably prudent person in plaintiff's circumstances, having been so informed, would not have undergone such procedure, and that lack of informed consent was the proximate cause of her injuries." *Balzola v Giese*, 107 AD3d 587, 588 [1st Dept 2013]. A defendant moving for summary judgment on a lack of informed consent claim must show *inter alia* that there is no factual dispute as to whether the plaintiff was informed "of any foreseeable risks, benefits or alternatives" of the treatment rendered. *Balzola*, 107 A.D.3d at 588.

Motion Sequence 3 – Dr. Katz's Motion for Summary Judgment

In the Bill of Particulars, Plaintiff claims that the Dr. Katz was negligent in his performance of laparoscopic sigmoid resection surgery on Plaintiff on August 23, 2013. Specifically, Plaintiff claims that Dr. Katz was negligent "in causing and permitting the anastomosis to be and remain under excessive tension; in failing to take down the splenic flexure; in failing to remove diseased areas of colon; [and] in causing and permitting the anastomosis created by defendant to become and remain markedly angulated resulting in severe obstruction of the bowel." Plaintiff claims that Dr. Katz was negligent in the post-operative care he rendered "in ignoring the patient's complaints, signs and symptoms; in falsely and negligently reassuring the patient despite serious post-operative complaints, signs and symptoms; in failing to timely diagnose, treat and surgically correct angulation of the surgical anastomosis in causing prolonged pain, suffering and disability; in causing the necessity for plaintiff to undergo additional surgery to correct the errors made by the defendant; [and] in failing to properly document plaintiff's visits, signs, symptoms and conditions in the post-operative period."

Plaintiff claims that he sustained the following injuries as a result of Dr. Katz's negligence: "anastomotic stricture(s) with angulation of colon and adhesions; severe abdominal pain; constipation and obstruction of bowel; bloating, gas and abdominal distention;

aggravation, exacerbation and worsening of pre-existing diverticulosis/diverticulitis; weight loss; sleep disturbance; fevers; colonic spasm; dilatation of anastomotic stricture; laparoscopic assisted colorectal resection; additional procedures including numerous rectosigmoids; nausea & vomiting; surgical scarring; and pain, suffering, mental anguish and loss of enjoyment of life, continuing pain and the need for continuing treatment." Plaintiff alleges that these injuries "are permanent and/or have permanent sequelae."

Expert Affidavits

Dr. Katz submits the expert affidavit of Walter Longo, M.D. Dr. Longo is a physician licensed to practice medicine in the State of Connecticut and board certified in General Surgery and Colon and Rectal Surgery.

Plaintiff submits the opposing expert affidavit of Alan W. Hackford, M.D. Dr. Hackford is a physician licensed to practice in the State of Massachusetts who is Board Certified by the American Board of Surgery and the American Board of Colon and Rectal Surgery.

Dr. Longo states that he has reviewed the pleadings; the medical records; and the deposition transcripts of all parties and non-parties. Dr. Longo states that his "opinions are based upon [his] review of the above materials and upon [his] knowledge, training and experience."

Dr. Longo opines "within a reasonable degree of medical certainty that Dr. Katz did not depart from accepted standards of medical care in connection with the treatment he provided to the plaintiff" and "that there is no connection between the care the patient received from Dr. Katz and his alleged injuries."

Dr. Longo opines "within a reasonable degree of medical certainty, that Dr. Katz's performance of the patient's laparoscopic sigmoid resection on August 23, 2019 was correct, appropriate and within accepted standards of surgical care and treatment." Dr. Longo opines

that Dr. Katz did not improperly fail to take down the splenic fixture during the procedure because Dr. Katz determined it was not indicated at the time of the surgery and the medical records show that there was no tension on the anastomosis.

Dr. Longo further opines "within a reasonable degree of medical certainty" that Dr. Katz removed an adequate portion of Plaintiff's colon during the surgery and the anastomosis he created was correctly placed. Dr. Longo references Dr. Katz' testimony that he removed all areas of diverticulitis, the operative report that indicated Plaintiff's bowel was dissected to below the area of inflammation, and Dr. Longo's testimony that he had believed he had removed all of Plaintiff's sigmoid colon during the surgery. Dr. Longo opines that "the fact that 3 cm of distal sigmoid colon, which did not contain any evidence of diverticulitis, remained below Dr. Katz's anastomosis" based on Dr. Milsom's later surgery "does not constitute a departure from accepted standards of medical or surgical care and treatment." Dr. Longo states, "[T]he fact that a miniscule, non-diseased portion of the patient's distal sigmoid was later found below Dr. Katz's anastomosis, despite Dr. Katz's best efforts to remove the entire sigmoid colon, does not indicate that Dr. Katz's departed from accepted standards of medical care in connection with the surgery at issue."

Dr. Longo further opines that there is no connection between Plaintiff's alleged injuries and the care that Dr. Katz provided to Plaintiff. Dr. Longo opines that Plaintiff's post operative anastomotic bowel structure is a known risk of the laparoscopic colectomy procedure and does not indicate negligence arising from the surgery. Dr. Longo opines that "the amount of bowel removed and/or the location of a sigmoid anastomosis has no relationship to the chance of and/or occurrence of postoperative bowel stricture in the absence of diverticulitis in the remaining colon." Dr. Longo states that "a surgeon's decision as to whether or not splenic takedown is necessary during the laparoscopic sigmoid resection procedure is completely unrelated to, and has no impact on, a patient's chance of developing of a postoperative anastomotic stricture."

Dr. Longo further opines, "Given: (1) the absence of any disease process that could have caused and/or contributed to the patient's postoperative bowel angulation; and: (2) the identification of postoperative adhesions in the area distal to Dr. Katz's anastomosis, it is my opinion, within a reasonable degree of medical certainty, that the patient's postoperative bowel angulation was the result of adhesions, which are a known and accepted risk of the laparoscopic colon resection procedure, and that said bowel angulation was unrelated to any of the allegedly negligent care." Dr. Longo further opines that Plaintiff's "postsurgical complaints of abdominal pain and bowel dysfunction were primarily the result of his then undiagnosed irritable bowel syndrome, and as such, unrelated to the alleged improper surgery by Dr. Katz and/or sequelae from same."

Dr. Longo further opines that "Dr. Katz obtained proper informed consent from the patient prior to his August 23, 2013 laparoscopic colectomy procedure" in light of Dr. Katz's testimony and the informed consent form that was executed by Plaintiff on August 6, 2013.

Plaintiff's expert Dr. Hackford states that he has reviewed the medical records, depositions, radiology scans and images relating to Plaintiff's care, and the affidavit of Dr. Longo. Dr. Hackford opines "with a reasonable degree of certainty in the field of colon and rectal surgery that defendant Lester Brian Katz, M.D. departed from accepted standards of practice in performing an inadequate sigmoid colon resection on the plaintiff; in negligently failing to remove all or substantially all of the sigmoid colon; in leaving behind a significant portion of the sigmoid colon distal to the anastomosis, and that these departures, and others set forth below were a substantial factor and proximate cause of injury, pain and suffering, and necessitated additional surgery and treatment."

Dr. Hackford opines that Dr. Katz "negligently failed to remove a significant portion of the sigmoid colon distal to the anastomosis that remained symptomatic, in spasm and causing severe pain, and feeling of obstruction to the patient." Dr. Hackford opines that this "was clearly documented by Dr. Milsom during colonoscopy on 11/25/14 and surgery

on 4/7/15." Dr. Hackford opines that "[t]he standard of care in the surgical treatment of sigmoid diverticulitis is to remove all, or substantially all of the sigmoid colon" which is typically 35-40 cm in length. Dr. Hackford states that the sigmoid colon specimen that Dr. Katz removed based on the pathology report is 8.8 cm in length and "Dr. Katz clearly did not remove the entire sigmoid colon as he is 'sure' he did." Dr. Hackford states that "[t]he evidence is incontrovertible that Dr. Katz himself made this 'mistake' and left a significant portion of the sigmoid colon distal to the anastomosis that caused a continuation and indeed a worsening of the patient's symptoms, and ultimately necessitated additional surgery."

Dr. Hackford further opines that Dr. Katz "departed from accepted standards in failing to adequately mobilize the sigmoid colon, either by taking down the splenic flexure and/or otherwise sufficiently mobilizing the sigmoid colon from below so as to permit complete removal of the sigmoid colon." Dr. Hackford states that "[t]he standard of care in sigmoid resection for diverticulitis is to take down the splenic flexure of the bowel," which is what Dr. Milsom did in the subsequent surgery. Dr. Hackford states that "[w]hile there is some room for a surgeon to exercise judgment as to the splenic flexure, it is clear that Dr. Katz failed to remove the entire sigmoid colon as he was required to do, and it is more probable than not that the failure to take down the splenic flexure or otherwise sufficiently mobilize the bowel at the distal end was a substantial contributing factor to that failure." Dr. Hackford states, "Nevertheless, whether Dr. Katz did or did not specifically take down the splenic flexure, he needed to remove all or substantially all of the sigmoid colon, which he clearly failed to do."

Dr. Hackford further opines "with a reasonable degree of certainty in the field of colon and rectal surgery that the departures from accepted standards of practice set forth above were a proximate cause and substantial factor in causing prolonged and permanent pain, suffering and disability and the necessity for further medical treatment and surgery, with additional scarring, adhesions and residual bowel dysfunction." Dr. Hackford states that "the surgery performed by Dr. Milsom to remove the prior anastomosis and additional sigmoid colon

would not have been necessary if Dr. Katz had not deviated from the standard of care." Dr. Hackford states, "Dr. Katz' leaving behind residual sigmoid colon predisposed the patient to additional complications including strictures and adhesions, both from the original surgery (treated by Dr. Lewis), as well as the surgery by Dr. Milsom."

Dr. Hackford states:

> With regard to Dr. Longo's definitions of diverticulosis and diverticulitis (¶6,7), I would add that diverticulitis is in part caused by high pressure in a narrow segment of the bowel i.e. the sigmoid. There are also changes in muscular activity that results in spasm, high-pressure, and abdominal pain. Thus, even in the absence of inflammation, the involved segment, again the sigmoid, can be quite symptomatic and this is referred to as symptomatic diverticular disease.
>
> With regard to Dr. Longo's contention that splenic flexure takedown is not necessary for every patient (¶9), it should be noted that unless the sigmoid is unusually redundant (which there is no evidence of in this case), mobilization of the upstream side (splenic flexure) or downstream side (rectum) is necessary to close the gap without tension. Dr. Longo's contention that it may be difficult to tell where the sigmoid colon ends and the rectum begins is vague and inaccurate (110,11) …
>
> Further, it is postulated that there is a "sphincter" at the distal end of the sigmoid colon that tends to hold things in the sigmoid keeping the rectum empty. This area reflexively contracts with colonic motor activity preventing stool from entering the rectum. Spasm in this area can lead to

> a sense of obstruction and pain with constipation. Leaving the segment behind not only increases the risk of recurrent diverticulitis but also results in persistence of pain, a sense of obstruction, and constipation. The colonoscopy by Dr. Milsom clearly demonstrated spasm in the segment of sigmoid colon distal to the anastomosis. In this connection, Dr. Longo references the fact that there was no evidence in the pathology report of Dr. Milsom's surgery of any "diverticulitis or other process". (¶18) However whether there was pathological evidence of diverticulitis was not the issue here; as stated above, the patient's complaints were causally related to the spasm, sense of obstruction and constipation due to the segment of sigmoid colon negligently left behind by Dr. Katz. The patient had symptomatic diverticular disease that required the entire sigmoid to be removed and not just the previously inflamed part. Clearly 8 centimeters is not the entire sigmoid."

Dr. Hackford states that "[w]hile Dr. Longo alludes to the alleged absence of excessive tension on the anastomosis (¶28), this does not excuse the fact that there was an inadequate length of colon removed."

Dr. Hackord states that the "[w]ith regard to the patient's persistence of symptoms and the positive response to antispasmodics referenced by Dr. Longo, this suggests that there may have been two processes going on: symptomatic diverticular disease and irritable bowel syndrome (IBS)." Dr. Hackord opines that "the possible coexistence of an IBS diagnosis makes it all the more important that the distal sigmoid be removed [and] Dr. Katz' failure to do so was a departure from the standard of care that was a substantial factor in causing injury to this patient."

Discussion

Dr. Katz makes a prima facie showing of entitlement to summary judgment. *Alvarez*, 68 N.Y.2d at 324. Dr. Longo, on behalf of Dr. Katz, opines that Dr. Katz met the standard of care and treatment he provided to Plaintiff.

The burden now shifts to Plaintiff to demonstrate by admissible evidence the existence of a factual issue requiring a trial of the action. *Lindsay-Thompson*, 147 A.D.3d at 639.

Plaintiff's expert fails to rebut Dr. Katz's prima facie showing with the affidavit submitted in opposition to the motion. Plaintiff's opinions are speculative and not supported by the evidence in the record.

Turning to the specific claims of negligence, Dr. Hackford fails to rebut Dr. Katz's prima facie showing that Dr. Katz removed an adequate portion of Plaintiff's sigmoid colon. As Dr. Katz points out in his reply, "While plaintiff's counsel and his expert make additional broad statements that Dr. Katz departed from accepted standards of medical care and treatment did not remove the entire sigmoid colon, there are no claims of any injury stemming from any portion of the sigmoid colon that was proximal to or above the patient's anastomosis. To the contrary, the claimed injuries are all alleged to stem from Dr. Katz's failure to remove 3 cm. of colon distal to or below the anastomosis." The presence of the 3 cm. of distal colon post Dr. Katz's surgery alone is not indicative of a departure of generally accepted practices. Here, there is nothing more in the record. There was no evidence of diverticulitis or infection in the pathology for the remaining 3 cm. of distal sigmoid that Dr. Milsom later removed.

Plaintiff's expert fails to rebut Dr. Katz's prima facie showing that Dr. Katz's decision to not take down the splenic flexure during the procedure was within accepted standards of medical and surgical care. Dr. Hackford acknowledges that the decision to take down the splenic flexure is a judgment call and not necessary in every procedure. Rather, it is Dr. Hackford's opinion that Dr. Katz's failure to take down the splenic flexure in this case resulted in Dr. Katz's removal of an

inadequate amount of colon that led to additional damages. As stated above, the remaining 3 cm of distal colon post Katz's surgery is not alone evidence of negligence.

Dr. Katz states that Plaintiff's expert's claim that Dr. Katz's failure to remove the 3 cm. portion of distal colon posed a risk for "systematic diverticular disease" and contained a residual sphincter muscle that was prone to spasm should be rejected. Dr. Katz contends that these claims were not raised in the Complaint or Bills of Particulars and are new theories of liability. Nonetheless, as Dr. Katz points out in his reply papers, "[i]t cannot be disputed that (1) symptomatic diverticular disease requires the presence of diverticulosis; and (2) that none of the patient's medical records, radiology reports, or surgical pathology reports document the presence of diverticulosis in the 3 cm. of colon at issue in the case." Plaintiff's expert "postulation" concerning the residual sphincter is also not supported by the record.

Plaintiff's expert claims that Dr. Katz's allegedly negligent departures "were a proximate cause and a substantial factor in causing prolonged and permanent pain, suffering and disability and the necessity for further medical treatment with surgery, with additional scarring, adhesions and residual bowel dysfunction." Plaintiff's expert further opines that the departures led to Dr. Milsom's removal of the prior anastomosis and additional sigmoid colon. Plaintiff's expert further opines that leaving the residual sigmoid colon led to complications such as strictures and adhesions.

Plaintiff's expert fails to rebut Dr. Longo's opinion that Plaintiff's postoperative bowel stricture is a known risk of the procedure; that postoperative adhesions are a known risk of the procedure; and that the development of bowel angulation resulted from naturally occurring post operative adhesions.

Plaintiff's expert further fails to create an issue of fact that Plaintiff's post operative abdominal pains and bowel issues were a result of Dr. Katz's negligence. Plaintiff continued to have the same complaints he had prior to Dr. Katz's surgery and after Dr. Milsom's surgery and treatment until he was prescribed antispasmodic medication

used to treat IBS. Indeed, any allegedly negligent failure to take down the splenic flexure and remove colon distal to the anastomosis was without effect as demonstrated by Dr. Milsom's surgery having done those things, and still, Plaintiff continued to have the same complaints.

To be clear, there is no evidence of tension on the anastomosis as there was no leak or failure of the joinder. That adhesions were found to have attached the anastomosis to the pelvic wall, thus creating angulation, as found during Dr. Milsom's surgery, is a risk of the surgery and not evidence of negligence. Further, the distal colon removed by Dr. Milsom showed no evidence of diverticulitis on pathology, and could not have been the cause of Plaintiff's complaints. Finally, the issue of leaving behind the sphincter muscle thus causing spasm is new, not based on any facts in the record, and speculative. Again, Dr. Milsom removed this area and Plaintiff's complaints continued.

Dr. Katz also established his prima facie entitlement to judgment as a matter of law dismissing the cause of action based upon an alleged lack of informed consent through Dr. Katz's testimony and medical notes and the signed consent to surgery form that Plaintiff executed prior to the April 23, 2013 surgery. Plaintiff's expert does not address that Dr. Longo's opinion that Plaintiff understood the risks associated with the surgery and consented to go forward with the surgery.

Accordingly, Dr. Katz's motion for summary judgment is granted in its entirety and the action is dismissed as against Dr. Katz. The Clerk is directed to enter judgment accordingly.

Motion Sequence 4 – Dr. Lewis' Motion for Summary Judgment

In Plaintiff's Bill of Particulars, Plaintiff claims that Dr. Lewis was negligent on October 30, 2013 and December 30, 2013 in that Dr. Lewis negligently performed a colonoscopic evaluation, flexible sigmoidoscopy, and dilation of anastomotic stricture surgery, and that the procedures were not indicated and harmful to Plaintiff. Plaintiff also

claims that Dr. Lewis was negligent "in failing to properly evaluate and diagnose the patient both prior to and subsequent to performing invasive procedures; in causing and permitting the anastomosis to be and remain pathologic and with impaired function; [and] in causing and permitting the anastomosis created by [Dr. Katz] to remain markedly angulated resulting in severe obstruction of the bowel." Plaintiff also claims that Dr. Lewis was negligent "in ignoring the patient's complaints, signs and symptoms; in falsely and negligently reassuring the patient despite serious post-operative complaints, signs and symptoms; in failing to timely diagnose, treat and correct angulation of the surgical anastomosis; in failing to timely refer the patient for definitive surgical treatment of the problem(s) resulting from the prior surgery" performed by Dr. Katz. Plaintiff further claims that Dr. Lewis failed to properly interpret radiological studies and caused Plaintiff "prolonged pain" and the need for additional surgery.

Plaintiff claims that Dr. Lewis' departures caused Plaintiff to sustain damages including not limited to: aggravation of pre-existing diverticulosis/diverticulitis; anastomotic stricture(s) with angulation of colon and adhesions; abdominal pain; constipation; weight loss; sleep disturbance; fevers; colonic spasm; dilation of anastomotic stricture; laparoscopic assisted colorectal resection; additional procedures; nausea and vomiting; surgical scarring; and pain, suffering, mental anguish and loss of enjoyment of life.

In support of Dr. Lewis' motion for summary judgment, Dr. Lewis submits the expert affidavit of Mark S. Friedman, M.D. Dr. Friedman is a physician licensed to practice medicine in the State of New York and is Board Certified in Gastroenterology and Internal Medicine. Dr. Friedman states that he has reviewed the pleadings, Bills of Particulars, deposition testimony, and Plaintiff's medical records

Dr. Friedman opines "to a reasonable degree of medical certainty, that the care and treatment rendered by Dr. Lewis to the plaintiff on October 30, 2013 and December 30, 2013, and at all times, was timely, appropriate, and within good and accepted medical and gastroenterological standards of care, and did not proximately cause

plaintiff's claimed injuries, and that all of plaintiff's claims are meritless" Dr. Friedman contends that Dr. Lewis' October 30, 2013 colonoscopy and December 30, 2013 flexible sigmoidoscopy were indicated and appropriate treatment plans given Plaintiff's symptoms. Dr. Friedman further opines that "there is no merit to plaintiff's allegation that Dr. Lewis failed to properly interpret radiological studies;" "Dr. Lewis's post-procedure care and treatment of plaintiff was proper and appropriate;" and "there is no evidence of any abnormal bowel angulation during Dr. Lewis's treatment of plaintiff." Dr. Friedman opines that "within a reasonable degree of medical certainty there is no merit to plaintiff's allegations that Dr. Lewis permitted the anastomosis to remain markedly angulated, or failed to timely diagnose, treat and correct angulation of the surgical anastomosis, as there is no evidence that angulation of the surgical anastomosis existed during either the October 30, 2013 colonoscopy or the December 30, 2013 sigmoidoscopy" and that "Dr. Lewis did not deviate from the standard of care by failing to refer plaintiff for surgery as no surgical consultation was necessary." Lastly, Dr. Friedman opines "within a reasonable degree of medical certainty that there is no causal or proximate connection between the alleged acts or omissions on the part of Dr. Lewis and the alleged injuries of the plaintiff" and "that the angulations were a result of naturally-occurring postoperative adhesions following the surgery of Dr. Katz and not a result of any negligence on the part of Dr. Lewis."

Dr. Lewis makes a prima facie showing of entitlement to summary judgment. *Alvarez*, 68 N.Y.2d at 324. Dr. Friedman, on behalf of Dr. Lewis, opines that Dr. Lewis met the standard of care and treatment she provided to Plaintiff.

The burden now shifts to Plaintiff to demonstrate by admissible evidence the existence of a factual issue requiring a trial of the action. *Lindsay-Thompson*, 147 A.D.3d at 639. Plaintiff fails to satisfy this burden. Plaintiff does submit an opposing expert affidavit. Plaintiff does not oppose Dr. Lewis' motion for summary judgment.

Accordingly, Dr. Lewis' motion for summary judgment is granted in its entirety and the action is dismissed as against Dr. Lewis. The Clerk is directed to enter judgment accordingly.

Wherefore it is hereby

ORDERED that Defendant Lester Brian Katz, M.D.'s motion (Motion Sequence 3) for summary is granted in its entirety and the action is dismissed as against Defendant Lester Brian Katz, M.D., and the Clerk is directed to enter judgment accordingly; and it is further

ORDERED that Defendant Blair S. Lewis, M.D.'s motion (Motion Sequence 4) for summary judgment is granted in its entirety without opposition and the action is dismissed as against Defendant Blair S. Lewis, M.D., and the Clerk is directed to enter judgment accordingly.

This constitutes the Decision and Order of the Court. All other relief requested is denied.

Dated: JUNE 2, 2020

HON. EILEEN A. RAKOWER

Check one: X FINAL DISPOSITION NON-FINAL DISPOSITION