Austin v Fielding
2020 NY Slip Op 34380(U)
December 30, 2020
Supreme Court, New York County
Docket Number: 805155/16
Judge: Joan A. Madden

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NEW YORK: PART 11

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RANDOLPH AUSTIN and IDA AUSTIN, INDEX NO. 805155/16

Plaintiffs,

-against-

GEORGE A. FIELDING , M.D. and NYU HOSPITALS CENTER,

Defendants.

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JOAN A. MADDEN, J.:

In this action for medical malpractice and lack of informed consent, defendants move for summary judgment and plaintiffs oppose.

On October 16, 2013, defendant Dr. George A. Fielding performed a laparoscopic hiatal hernia repair and Nissen-fundoplication surgery on plaintiff Randolph Austin, and on July 29, 2014, he performed revision surgery.[1] Based on the affidavit of plaintiffs' expert, Dr. Howard M. Simon, plaintiffs allege that Dr. Fielding departed from the standard of care by: 1) failing to properly document Mr. Austin's symptoms prior to surgery; 2) failing to perform appropriate testing prior to the October 16, 2013 and the July 29, 2014 surgeries; and 3) performing an unnecessary Nissen fundoplication. Plaintiffs' expert further opines that Dr. Fielding failed to properly inform Mr. Austin of the potential risks and benefits of a Nissen Fundoplication, and incorrectly advised that the procedure had a 65% to 70% chance of curing his hiccups. The

[1]According to defendants' expert, a hiatal hernia is a condition where the upper stomach bulges via an opening in the diaphragm, the thin muscle separating the chest from the abdomen; and a Nissen fundoplication is a surgical procedure that treats gastroesophageal reflux disease (GERD), and involves the gastric fundus, the upper portion of the stomach, being wrapped around the lower end of the esophagus and stitched in place, thereby reinforcing the closing function of the lower esophageal sphincter.

expert opines that as a result of the departures and the lack of informed consent, Mr. Austin suffered debilitating injuries, including severe dysphagia (trouble swallowing), spasms, difficultly breathing and hearing, difficulty projecting his voice and voice changes, and more intense and frequent hiccups.

The following facts are not disputed unless otherwise noted. In December 2012, Mr. Austin began experiencing intractable hiccups, which he testified as affecting him "all day and all night" and driving him to the "point of insanity." On January 2, 2013, Mr. Austin saw his primary care physician, Dr. Angelo DeMarco, for complaints of frequent hiccups, abdominal pain, reflux, heartburn, dizziness, shortness of breath and nausea. Dr. DeMarco found that Mr. Austin had "persistent hiccups," as well as an epigastric mass, generalized malaise and fatigue, dizziness and lightheadedness, and referred him for a consultation with a gastroenterologist.

On February 1, 2013, Mr. Austin saw gastroenterologist Dr. Harry Snady for complaints of hiccups, heartburn, epigastric pain and nausea. On February 7, 2013, Dr. Snady performed an endoscopy or EGD study (esophago gastro duodenoscopy), which showed a hiatal hernia from 35 to 38 cm, chronic esophagitis and mild gastritis. Around this same time, Mr. Austin saw his cardiologist, Dr. Ahmad, who diagnosed a blocked artery and treated him with a stent.

On September 17, 2013, Mr. Austin first presented to defendant Dr. Fielding. According to Mr. Austin, he came to Dr. Fielding for one reason, "intractable hiccups" and Dr. Fielding told him that he could perform a surgery that had a "good chance of curing my hiccups" and the surgery had a likelihood of around 65% to 70% of "curing my hiccups." However, Dr. Fielding's notes of the September 17, 2013 visit state that Mr. Austin "presents to discuss repair of symptomatic hiatal hernia. [He] is in no apparent distress. Gives good history of symptomatic

reflux with heart burn, regurgitation, night cough and voice change. Tests confirm hiatal hernia with reflux. . . . Patient will undergo laparoscopic repair of hiatal hernia." Dr. Fielding ordered a barium esophagram that was performed on September 17, 2013 and showed "no evidence of a hiatal hernia or reflux." Notably, Mr. Austin disputes Dr. Fielding's notes and asserts that he never told Dr. Fielding that he had reflux with regurgitation, night cough or voice change. .

On October 16, 2013, Dr. Fielding performed a laparoscopic hiatal hernia repair and Nissen fundoplication surgery on Mr. Austin, and indicated a post-surgical diagnosis of "hiatal hernia" and "severe gastroesophageal reflux." After surgery and up until the revision surgery on July 29, 2014, Mr. Austin returned to Dr. Fielding's office for many visits, and his complaints included dysphagia, difficulty tolerating food, nausea, vomiting, difficulty breathing, trapped air and increased hiccups. During some of those visits Dr. Fielding ordered an esophagram and/or prescribed medication, including Prilosec, Norvasc and Dexilent. At Dr. Fielding's request, non-party Dr. Gurvits performed an endoscopy with balloon dilation on April 19, 2014. On May 4, 2014, Mr. Austin advised that the dilation relieved his hiccups for only several days. On June 17, 2014, Dr. Fielding discussed the option of a revision of the fundoplication due to Mr. Austin's continuing dysphagia, and on July 29, 2014, he performed revision surgery. At follow-up visits in July, August and September 2014, Mr. Austin complained of esophageal spasms and worsening hiccups, and was prescribed medications including Levsin, Zofran, Thorazine and Reglan. On October 16, 2014, Dr. Fielding noted that Mr. Austin still had hiccups, spasms and dysphagia. Dr. Fielding referred him again to Dr. Gurvits for another endoscopy with dilation. On May 15, 2015, Mr. Austin saw Dr. Fielding for the last time, complaining of severe hiccups and occasional esophageal spasms.

On August 4, 2016, plaintiffs commenced the instant action asserting claims for medical malpractice and lack of informed consent. Defendants are now moving for summary judgment and plaintiffs oppose.

A defendant moving for summary judgment in a medical malpractice action must make a prima facie showing of entitlement to judgment as a matter of law by showing that "in treating the plaintiff there was no departure from good and accepted medical practice or that any departure was not the proximate cause of the injuries alleged." Roques v. Nobel, 73 AD3d 204, 206 (1st Dept 2010). To satisfy this burden, defendant must present expert opinion testimony that is supported by the facts in the record, addresses the essential allegations in the complaint or the bill of particulars, and is detailed, specific and factual in nature. See id; see Joyner–Pack v. Sykes, 54 AD3d 727, 729 (2nd Dept 2008). Expert opinion must be based on facts in the record or those personally known to the expert, and the opinion of defendant's expert should specify "in what way" the patient's treatment was proper and "elucidate the standard of care." Ocasio-Gary v. Lawrence Hospital, 69 AD3d 403, 404 (1st Dept 2010). Defendant's expert opinion must "explain 'what defendant did and why.'" Id (quoting Wasserman v. Carella, 307 AD2d 225, 226 [1st Dept 2003]).

"[T]o avert summary judgment, plaintiff must demonstrate that the defendant did in fact commit malpractice and that the malpractice was the proximate cause of the plaintiff's injuries." Roques v. Nobel, supra at 207. To meet this burden, "plaintiff must submit an affidavit from a medical doctor attesting that the defendant departed from accepted medical practice and that the departure was the proximate cause of the injuries alleged." Id. If the parties' conflicting expert opinions are adequately supported by the record, summary judgment must be denied. See Frye v.

Montefiore Medical Center, 70 AD3d 15 (1st Dept 2009); Cruz v. St Barnabas Hospital, 50 AD3d 382 (1st Dept 2008).

Applying the foregoing standards, the Court concludes that defendants are not entitled to summary judgment, as the parties' experts offer conflicting opinions that are adequately supported by the record, as to the alleged departures and the lack of informed consent claim.

In support of the motion, defendants submit an expert affidavit from Dr. Saber Ghiassi, a board certified surgeon, who reviewed the pleadings, the bills of particulars, party and non-party depositions, the opinion of plaintiffs' expert Dr. Howard Simon, and Mr. Austin's medical records, radiological studies and diagnostic tests, including those from the offices of Dr. Angelo DeMarco, Dr. Harry Snady, Dr. Grigory Gurvits, Dr. Fielding, Ambulatory Care for Endoscopy, the NYU Program for Surgical Weight Loss and NYU Hospitals Center. In opposition, plaintiffs submit the expert affidavit of Dr. Howard M. Simon, a board certified surgeon who reviewed Mr. Austin's medical records, the deposition testimony of Mr. Austin and Dr. Fielding, the pleadings, the bills of particulars, and the affidavit of defendants' expert, Dr. Ghiassi.

First, as to the departures that the October 16, 2013 surgery was unnecessary, defendants' expert, Dr. Ghiassi opines that Mr. Austin was an appropriate candidate for laparoscopic Nissen fundoplication and hiatal hernia repair, as fundoplication is a standard, widely accepted and effective treatment for gastroesophageal reflux disease (GERD) and it is "indisputable" Mr. Austin was suffering from GERD when he presented to Dr. Fielding on September 17, 2013, and no contraindications were present preventing Mr. Austin from undergoing such surgery. Dr. Ghiassi opines that before considering Nissen fundoplication or any other type of anti-reflux surgery, an objective finding of gastroesophageal reflux is "mandatory per the prevailing

standard of care," and can be achieved by several tests, including EGD, which Mr. Austin underwent on February 7, 2013; and the biopsy from the EGD found that Mr. Austin had "Esophageal squamous/esophagogastic type mucosa showing mild nonspecific reactive changes." Dr. Ghiassi opines that these "reactive changes" in Mr. Austin's esophagus are reliable and objective evidence that he was "indeed suffering from GERD," and once such evidence is found, the standard of care does not require any further testing to confirm the diagnosis. Disputing plaintiffs' allegation that Dr. Fielding failed to appropriately and adequately test Mr. Austin's esophagus and peristalsis prior to surgery and failed to obtain objective proof of GERD prior to surgery, Dr. Ghiassi opines that Mr. Austin's diagnosis of GERD was objectively confirmed by the esophageal squamous/esophagogastric type mucosa showing mild nonspecific reactive changes on his EGD pathology and his exhibiting typical GERD symptoms, such as his long history of well-documented heartburn.

Dr. Ghiassi states that once a diagnosis of reflux is objectively confirmed, a Nissen fundoplication is indicated if the patient has: 1) inadequate reflux symptom control with medication, or 2) the patient wishes to have surgery despite successful management of symptoms with medication, or 3) the patient suffers from GERD complications, such as Barrett's esophagus or peptic stricture, or 4) the patient suffers from extra-esophageal manifestations, such as asthma, hoarseness, cough, chest pain or aspiration. He opines that the standard of care requires that only 1 of these 4 categories be satisfied, and it is indisputable that Mr. Austin had a long history of taking the medication Dexilant (treats heartburn caused by GERD, prescribed by his gastroenterologist) and he continued to have symptoms of GERD, including extra-esophageal manifestations such as voice changes, cough and aspiration. He opines that Mr. Austin presented

to Dr. Fielding for the purpose of a surgical consultation for relief of his GERD symptoms and that Mr. Austin's clinical symptoms, coupled with the result of the February 7, 2011 EGD biopsy, made him an appropriate candidate for a Nissen fundoplication.

Disagreeing with the opinion of plaintiffs' expert that a manometry was required to assess esophageal motility prior to surgery, Dr. Ghiassi points to the Guidelines for Surgical Treatment of Gastroesophageal Reflux Disease promulgated by the Society of American Gastrointestinal and Endoscopic Surgeons in 2010, which were in effect at the time of Mr. Austin's treatment and are currently in effect. He opines that such guidelines "specifically rebuff" the contention of plaintiffs' expert by stating that "there is no support in the literature for mandatory preoperative manometry, and there are numerous studies refuting the need for a tailored approach for fundoplication." Dr. Ghiassi opines this statement comports with the standard of care, and as such there were no additional or different tests, diagnostic, radiological, or otherwise, that were necessary or required by the standard of care, prior to Dr. Fielding's performance of the laparoscopic Nissen fundoplication with hiatal hernia repair.

Dr. Ghiassi further disagrees with the opinion of plaintiffs' expert that Dr. Fielding misdiagnosed Mr. Austin as having a hiatal hernia. He opines that contrary to plaintiffs' contention, Dr. Fielding was aware of and appreciated Mr. Austin's September 17, 2013 esophagram which did not show a hiatal hernia, but he was also aware of the February 7, 2013 EGD which did show a hiatal hernia from 35 to 38cm, chronic esophagitis and mild chronic gastritis. Dr. Ghiassi opines that a hiatal hernia does not resolve without surgical intervention, so based on the objective findings of the EGD, Dr. Fielding correctly assessed that Mr. Austin still had a hiatal hernia and it was consistent with the standard of care for Dr. Fielding to proceed with

the fundoplication with hiatal hernia repair despite the esophagram findings and a history of medical management.

Dr. Ghiassi also opines that plaintiffs' contention that Dr. Fielding inappropriately performed a Nissen fundoplication with hiatal hernia repair for Mr. Austin's complaints of hiccups is "misguided" and not based on the objective medical facts of the case, since the Nissen fundoplication was indicated for Mr. Austin's documented GERD with symptoms as evidenced by the EGD and medical history/complaints, and the hiatal hernia repair was indicated by both the preoperative finding of a hiatal hernia from 35 to 38 cm and Dr. Fielding's intraoperative diagnoses of a "large hiatal hernia" and "severe gastroesophageal reflux." He opines that whether or not Mr. Austin complained of hiccups to Dr. Fielding is "inconsequential" to Dr. Fielding's decision to proceed with the laparoscopic Nissen fundoplication with hernia repair, as a patient having hiccups is not a contraindication to such procedure and "indeed hiccups, could be an 'extra-esophageal manifestation' of Mr. Austin's documented GERD and thus providing further support for his indication for surgery."

Addressing the lack of informed consent claim, Dr. Ghiassi opines that the medical records and deposition testimony show that Mr. Austin's consent to the laparoscopic Nissen fundoplication with hiatal hernia repair was appropriately and adequately obtained. He points to Dr. Fielding's September 17, 2013 office note that he and Mr. Austin discussed the operation and the "risks of surgery, especially leak, sepsis and death. Also, discussed risk of failure of the operation, and late recurrence. Also, discussed eating strategy after surgery, chance of dysphagia, and sever flatus. Patient had the opportunity to ask pertinent questions which were answered." He states that the foregoing was "confirmed" by Mr. Austin at his deposition, and that the NYU

hospital records contain a "Consent for Surgery and/or Interventional Procedures and Medical Treatment" for "Laparoscopic Nissen Fundoplication, possible open," signed by Mr. Austin and two witnesses on the day of the surgery, October 16, 2013. He opines that contrary to the opinion of plaintiffs' expert, the consent form signed by Mr. Austin confirms that no guarantees were made that the procedure would cure his hiccups, and the medical records confirm that prior to surgery, Dr. Fielding specifically documented his discussion with Mr. Austin as to the "risk of failure of the operation and late recurrence."

Turning to plaintiffs' expert, Dr. Howard Simon opines that Dr. Fielding departed from the standard of care by recommending Nissen fundoplication surgery based on a single endoscopy showing "mild esophagitis," and by failing to order additional testing, such as a repeat endoscopy or a manometry. Dr. Simon also opines that before recommending surgery, Dr. Fielding should have recommended "lifestyle changes (i.e. dietary, etc) and/or continued to monitor Mr. Austin with medication for reflux." He states that a manometry measures the functioning of the esophagus, and would have shown whether there was some issue in Mr. Austin's esophagus itself, rather than a failure of the sphincter between the esophagus and stomach to keep stomach acid out of the esophagus; and a repeat endoscopy would have shown if the esophagitis was mild or more severe, as mild esophagitis normally does not warrant surgical intervention and the risks inherent in surgery, but more severe esophagitis may warrant such treatment.

Dr. Simon further opines that it was "particularly unwise" to immediately recommend reflux surgery when the September 17, 2013 esophagram ordered by Dr. Fielding showed no reflux or hiatal hernia. He opines that given the conflicting results of the February 2013 EGD

which showed a hiatal hernia, chronic esophagitis and mild gastritis, and the September 2013 esophagram which showed no evidence of a hiatal hernia or reflux, additional testing was warranted prior to surgery to reconcile the inconsistent test results, and in the absence of additional testing, Dr. Fielding's recommendation of a Nissen fundoplication departed from the standard of care.

Dr. Simon opines that assuming, as Mr. Austin asserts, that Dr. Fielding told him that a Nissen Fundoplication had a 65% to 70% chance of curing his hiccups, this statement was "false when made," as a Nissen fundoplication is not a treatment for hiccups and did not have any reasonable chance of curing Mr. Austin's hiccups. Dr. Simon notes that at his deposition, Dr. Fielding agreed that a Nissen fundoplication is not a treatment for hiccups.

Addressing Dr. Ghiassi's reliance on the Guidelines for the Treatment of GERD, Dr. Simon opines that the Guidelines do not indicate that a Nissen fundoplication was a proper treatment for Mr. Austin, as the Guidelines are an "insufficient basis" for determining the appropriate treatment for a patient. He states that while the Guidelines are a useful tool to assist in analyzing symptoms and whether a given procedure might be appropriate, since each patient's situation is specific, the Guidelines do not provide the answer to whether a procedure is right for a particular patient. He opines that the determination of whether a doctor has adhered to the standard of care cannot be made simply by matching the doctor's actions to the Guidelines.

Dr. Simon points out that the Guidelines for GERD only recommend reflux surgery in four situations that were not present in Mr. Austin's case. First, Dr. Fielding did not wait to see if medical management of Mr. Austin's symptoms could have resolved Mr. Austin's symptoms, even though he was diagnosed with reflux in February 2013. Second, Dr. Fielding did not offer

Mr. Austin an alternative of medical management, which he rejected in favor of surgery. Third, Mr. Austin did not have the complications of reflux noted in the Guidelines, and fourth, Mr. Austin denies "extra-esophageal manifestations, such as asthma, aspiration, hoarseness and cough," that coincide with reflux. Further noting that the Guidelines state that atypical symptoms "are known to respond less well to fundoplication," Dr. Simon opines that hiccups are "certainly an atypical symptom," and as such, Dr. Fielding should not "rushed" to recommending and performing a Nissen fundoplication without further testing.

Dr. Simon opines that Dr. Fielding further departed from the standard of care by recommending and performing the July 29, 2014 revision surgery without the additional testing of a manometry to measure Mr. Austin's esophageal functions. Dr. Fielding "revised" the fundoplication from a 360 degree wrap to an 180 degree "half wrap," which was intended to relieve symptoms such as dysphagia. Dr. Simon opines if Dr. Fielding had performed a manometry and found that Mr. Austin's esophagus was severely dysfunctional, the appropriate surgery would have involved the total removal of the wrap to at least make it easier for food to traverse the esophagus and enter the stomach, and the half-wrap of the revision surgery would not have been necessary, so Mr. Austin would have avoided the suffering caused by the recovery from the second surgery and the additional scarring of his esophagus. On the other hand, had the manometry shown mild or no dysfunction of the esophagus, for a patient with no reflux, a half-wrap may have been warranted to alleviate symptoms of dysphagia while maintaining some of the benefits of a fundoplication. Dr. Simon opines that even though it was never shown that Mr. Austin had severe reflux necessitating a fundoplication to begin with, which makes it difficult to say that the half-wrap was never warranted, he states that he can opine with a reasonable degree

of medical certainty, that it was inappropriate to perform the revision surgery without a manometry.

Finally, as to the lack of informed consent, Dr. Simon opines that since a Nissen fundoplication is not a treatment for hiccups and did not have a 65% to 70% chance of curing Mr. Austin's hiccups, if he consented to the surgery based on such information, he did not and could not have given his informed consent. Mr. Austin also submits his own affidavit that he "came to Dr. Fielding for one reason . . . intractable hiccups"; he was never told that the Nissen fundoplication could actually make his hiccups worse; he would never had agreed to the Nissen fundoplication if he had known it was not a treatment for hiccups, and had he not been told by Dr. Fielding that it had "great chance of curing my intractable hiccups." Mr. Austin states that as a result of being misled by Dr. Fielding about the potential benefits of the procedure, he consented to the procedure and therefore suffered the resulting injuries, including worsened hiccups, dysphagia, choking, spasms, difficulty breathing, slow movement of food through his esophagus, difficulty projecting his voice and speaking, scarring of his abdomen, damage to his esophagus, and the pain and suffering of two surgeries. He also states that his relationship with his wife has been affected, as well as his ability to work over-time, and he anticipates an early retirement due to his deteriorating health.

Based on the foregoing, defendants are not entitled to summary judgment. The parties conflicting testimony and documentation as to what Mr. Austin told Dr. Fielding about his purpose for seeing Dr. Fielding, and what Dr. Fielding told Mr. Austin about the purpose of the Nissen fundoplication surgery, raise issues of credibility that cannot be resolved as a matter of law. Notably, Mr. Austin provides a sworn affidavit clearly and definitively stating that he never

would have consented to the surgery if he had known it was not a treatment for hiccups. Moreover, the parties' experts offering sharply conflicting opinions as to whether a Nissen fundoplication was at all necessary given plaintiffs' complaints and the inconsistent findings of the February 2013 EGD and the September 2013 esophagram; whether additional testing, such as another endoscopy or a manometry, was necessary to resolve those inconsistent findings before Dr. Fielding recommended and performed the Nissen fundoplication surgery; and whether a manometry was necessary before Dr. Fielding recommended and performed the revision surgery. Thus, in view of these credibility issues, as well as the experts' conflicting opinions that are adequately supported by the record, summary judgment is not warranted. See Frye v. Montefiore Medical Center, supra; Cruz v. St Barnabas Hospital, supra.

Accordingly, it is

ORDERED that defendants' motion for summary judgment is denied.

DATED: December 30, 2020

ENTER:

J.S.C.

HON. JOAN A. MADDEN
J.S.C.