Procida v Harrison
2020 NY Slip Op 35009(U)
December 8, 2020
Supreme Court, Suffolk County
Docket Number: Index No. 610658/2017
Judge: Joseph C. Pastoressa
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SHORT FORM ORDER

INDEX No. 610658/2017
CAL. No. 201902158MM

SUPREME COURT - STATE OF NEW YORK
I.A.S. PART 34 - SUFFOLK COUNTY

PRESENT:

Hon. JOSEPH C. PASTORESSA
Justice of the Supreme Court

MOTION DATE 4/8/20
ADJ. DATE 7/1/20
Mot. Seq. # 004 MOT D

ANTHONY PROCIDA, as Administrator of the Estate of BARBARA PROCIDA, DECEASED, and ANTHONY PROCIDA, Individually,

Plaintiff,

- against -

AARON R. HARRISON, M.D., LOVLEEN KAUR CAVANAGH, D.O., SOUTHSIDE HOSPITAL and NORTHWELL HEALTH, INC.,

Defendants.

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Upon the following papers read on this motion for summary judgment: Notice of Motion/Order to Show Cause and supporting papers filed by defendants Aaron R. Harrison, M.D., Lovleen Kaur Cavanagh, D.O., Southside Hospital and Northwell Health, Inc. on March 2, 2020; Notice of Cross Motion and supporting papers ___; Answering Affidavits and supporting papers filed by plaintiff Anthony Procida, individually and as Administrator of the Estate of Barbara Procida, deceased, on May 14, 2020; Replying Affidavits and supporting papers filed by defendants Aaron R. Harrison, M.D., Lovleen Kaur Cavanagh, D.O., Southside Hospital and Northwell Health, Inc., on June 24, 2020; Other ___; it is

ORDERED that the motion for summary judgment by defendants Aaron R. Harrison, M.D., Lovleen Kaur Cavanagh, D.O., Southside Hospital and Northwell Health, Inc., is determined as follows.

Barbara Procida and her husband, Anthony Procida, commenced this action to recover damages for injuries allegedly sustained as a result of medical malpractice. It is alleged that defendant Lovleen Kaur Cavanagh, D.O., and defendant Aaron Harrison, M.D., failed to detect Ms. Procida's colon cancer, which deprived her of an opportunity for early diagnosis and treatment. It is further alleged that defendants Southside Hospital and Northwell Health, Inc. are vicariously liable for the negligence of defendants Cavanagh and Harrison. Ms. Procida passed away on January 17, 2018, and the complaint was amended to substitute Anthony Procida as administrator of Ms. Procida's estate and to assert a claim

for wrongful death. In addition to the claims asserted on behalf of Ms. Procida, Anthony Procida also alleges derivative claims for loss of services, society and consortium. The plaintiff electronically filed a note of issue on November 4, 2019.

The record reveals that at 3:55 a.m. on July 7, 2015, Ms. Procida, who was 71 years old at the time, presented to the Emergency Department at Southside Hospital with lower right quadrant abdominal pain accompanied by nausea and vomiting, distention, sweats, and chills. Ms. Procida reported that her last colonoscopy had been ten years prior and had been normal. She further advised that she was on a diet because she had gained 25 pounds over the past few years. Ms. Procida did not have a fever in the Emergency Department but her white blood count was elevated at 21.09. Her abdomen was soft but tender to the touch. The emergency medicine physician ordered a CT scan of Ms. Procida's abdomen and pelvis with oral contrast only. The "Clinical Indication" for the CT scan was "evaluate appy [appendix]." The emergency medicine physician also ordered a surgical consult.

The CT scan was performed at 6:15 a.m. on July 7, 2015. Dr. Cavanagh, the defendant radiologist in this action, opened the scanned images at 6:33 a.m. and signed her final report on those images at 6:45 a.m. In the section of the final report labeled "Impression," defendant Cavanagh sets forth the following: "Focal thickening of the ventral of the proximal ascending colon with surrounding inflammatory change and reactive thickening of adjacent small bowel loops. Considerations include focal colitis or cecal diverticulitis. No extraluminal free air or pericolonic abscess. Mildly prominent appendix measuring up to 9 mm in caliber without surrounding inflammatory change." The report also states that "[t]here is no significant abdominal or pelvic lymphadenopathy."

Following the CT scan, a surgical consult was performed. The surgeon advised Ms. Procida that she had colitis but was "not certain of the etiology." IV antibiotics were started and the surgeon's plan was to continue those antibiotics and perform "serial abdominal examinations." Ms. Procida was also administered milk of magnesia for constipation. Ms. Procida's condition improved and, according to her discharge instructions, she was discharged on July 10, 2015. Ms. Procida was directed to take certain medications for colitis, hypertension, and angina pectoris syndrome.

On September 3, 2015, Ms. Procida sought the evaluation of Gastroenterologist Aaron Harrison, M.D., the second defendant physician in this action. Ms. Procida gave a history of abdominal pain, distention, bloating, constipation, as well as high cholesterol and hypertension. Ms. Procida did not report rectal bleeding. She advised defendant Harrison that she was previously hospitalized and that according to the CT scan she was found to have colitis. According to defendant Harrison's chart note, Ms. Procida advised that she was, at that time, "asymptomatic" and had "no other bowel symptoms including no diarrhea abdominal pain constipation nausea vomiting or other symptoms." She further stated that she had a colonoscopy 12 years ago which was unremarkable and that she has no family history of colon neoplasm. Included in defendant Harrison's records is a copy of the discharge documents from her July admission to Southside Hospital as well as results from blood work ordered by Ms. Procida's internist. Defendant Harrison testified that he does not recall whether he reviewed the results of the blood work. Defendant Harrison conducted an abdominal and rectal exam, both of which were normal, and recommended that Ms. Procida undergo a colonoscopy. He also advised her to follow-up with her cardiologist before the colonoscopy both to evaluate her heart and to help control her

hypertension. Ms. Procida's cardiologist cleared her for her colonoscopy and defendant Harrison performed the procedure on October 27, 2015 at Southside Hospital. Defendant Harrison set forth the following findings in his colonoscopy report: "cecum normal, ascending normal, hepatic flexure normal, transverse normal, splenic flexure normal, descending normal, sigmoid normal, rectum normal Biopsies of cecum and rectum taken." Both biopsies were negative for inflammation. A fecal occult blood test was negative. Defendant Harrison did not recommend any further colorectal surveillance. Ms. Procida testified that after the colonoscopy she felt fine.

According to Ms. Procida's deposition testimony, on July 15, 2016, she passed out at a supermarket and was brought to Brookhaven Memorial Hospital Medical Center ("Brookhaven Hospital") by ambulance. According to Brookhaven Hospital's discharge summary, Ms. Procida was admitted for generalized weakness, presyncope and feeling exhausted. During her deposition, when asked how she was feeling between the time she had the colonoscopy and when she was taken to Brookhaven Hospital, she testified to the following: "I was feeling a few weeks up to that time very tired. I had no energy. I didn't know why. Everybody said you're pale, you have no color." Ms. Procida further testified that she was feeling "weaker and weaker." Blood work revealed she was anemic, with a hemoglobin level of 5.1. An abdominal ultrasound was performed to evaluate the liver and spleen given Ms. Procida's anemia. The ultrasound revealed "multiple hepatic masses consistent with metastatic disease." Ms. Procida also underwent a CT scan, with IV contrast, of her chest, abdomen and pelvis. The scan revealed subcentimeter pulmonary nodules consistent with metastases, multiple hepatic masses, and focal thickening of the right colon adjacent to the ileocecal valve suspicious for mass and necrotic right mesenteric lymph node. An upper endoscopy and colonoscopy were attempted. A large fungating mass emanating from an ascending colon was found. At the time of the colonoscopy, the gastroenterologist could not pass the scope due to the mass. A biopsy revealed invasive well-differentiated adenocarcinoma.

On July 22, 2016, Ms. Procida underwent an obstructive colonic tumor removal with right hemicolectmoy and a small bowel resection performed by General Surgeon Sang H. Jho, M.D., at Brookhaven Hospital. Dr. Jho found a large palpable mass in the mid ascending colon which was attached to a tongue of omentum and the proximal transverse colon. A small bowel mass was also detected. Ms. Procida's liver was noted to be heavily burdened with multiple large metastatic lesions. Dr. Jho removed the cecum, ascending colon, hepatic flexure, the first one-third of the transverse colon, part of the terminal ileum, as well as fat and lymph nodes. According to Dr. Jho's final pathology report, there was a "moderately differentiated adenocarcinoma of cecum transmurally invasive through cecal wall into serosa and muscularis of adjacent benign colon (T4 lesion)." The report further notes that there is a "nearly circumferential tumor in the cecum abutting the ileocecal valve." The tumor measured 6 cm in diameter and up to 1.5 cm thick. There was a separate focus of the identical adenocarcinoma involving the submucosa, muscularis and serosa of the ascending colon consistent with regional metastasis. Three of the eight mesocolonic lymph nodes tested positive for cancer. The pathology from the portion of the proximal ileum that was removed during the segmental resection revealed "moderately differentiated adenocarcinoma histologically similar to cecal tumor and showing transmural invasion of intestine and mucosal ulcer, consistent with metastasis." The pathology from the liver biopsy was positive for necrotic metastatic adenocarcinoma. Ms. Procida was diagnosed with Stage IV colon cancer. She underwent multiple rounds of chemotherapy as well as radiation.

Ms. Procida was admitted to Brookhaven Hospital on April 6, 2017 for the treatment of a small bowel obstruction. On September 15, 2017, Ms. Procida was admitted to John T. Mather Memorial Hospital where there was an attempt to treat the liver lesions with embolization of the tumor by cutting off blood supply. Ms. Procida was admitted to Brookhaven Hospital again on September 20, 2017. She presented with sudden vision loss which, she advised, began soon after the embolization procedure conducted at John T. Mather Memorial Hospital. She also complained of abnormal flashing. An MRI examination of Ms. Procida's brain revealed "acute medial left occipital infarct." It was determined that Ms. Procida likely suffered from an embolic stroke and she was discharged with instructions to take certain medications. Ms. Procida passed away on January 27, 2018.

Defendants Cavanagh, Harrison, Southside Hospital and Northwell Health now move pursuant to CPLR 3212 for summary judgment in their favor. In support of their motion, the defendants submit, *inter alia*, copies of the pleadings, the parties' deposition transcripts, copies of certified and uncertified medical records, the affirmation of their radiology medical expert, Douglas S. Katz, M.D., F.A.C.R., the affidavit of defendant Harrison, and the affirmation of Michael L. Grossbard, M.D., the medical expert retained to opine on the staging of cancer. The plaintiff, in opposition to the motion, submits, *inter alia*, the redacted affirmation of their medical expert in radiology, the redacted affidavit of their medical expert in gastroenterology and the redacted affirmation of their medical expert in surgical oncology. The plaintiff provided unredacted copies of the affirmations and affidavit to the Court for *in camera* review.

"A defendant moving for summary judgment in a medical malpractice action must demonstrate the absence of any material issues of fact with respect to at least one of the elements of a cause of action alleging medical malpractice: (1) whether the physician deviated or departed from accepted community standards of practice, or (2) that such a departure was a proximate cause of the plaintiff's injuries" (***Rosenthal v Alexander***, 180 AD3d 826, 827, 118 NYS3d 658, 659 [2d Dept 2020]; ***Herrera v Sanroman***, 187 AD3d 863, 863, 130 NYS3d 383, 384 [2d Dept 2020]). Where a defendant physician has satisfied his or her burden of proof, "the burden shifts to the plaintiff to rebut the defendant's showing by raising a triable issue of fact as to both the departure element and the causation element" (***Simpson v Edghill***, 169 AD3d 737, 738, 93 NYS3d 399, 401 [2d Dept 2019]).

In support of the motion seeking dismissal of the claims against defendant Cavanagh, the defendants submit the affidavit of Douglas Katz, M.D., F.A.C.R., a physician duly licensed to practice medicine in the State of New York and board certified in diagnostic radiology. It is Dr. Katz's opinion that defendant Cavanagh "interpreted, and reported, the subject CT scan accurately and in accordance with accepted standards of radiological practice." At the outset, Dr. Katz explains that defendant Cavanagh's ability to assess the relevant anatomy was limited for reasons outside of her control. In this regard, Dr. Katz highlights that the CT scan was performed without IV contrast, which limits the ability of the radiologist to assess the bowel wall as well as the solid abdominal and pelvic organs. According to Dr. Katz, it would have been up to the emergency room physician who ordered the scan to request IV contrast. Dr. Katz explains that defendant Cavanagh's ability to characterize any bowel abnormalities was further limited since the oral contrast did not reach the right colon. The doctor goes on to explain that even if the oral contrast had reached the right colon, "it would be speculative to say if it would have provided more specific information, in that bowel wall thickening and enhancement can be seen in a variety of processes." Dr. Katz adds that the CT scan was done on a STAT basis and as such could not

be delayed. Morevoer, there was substantial stool in Ms. Procida's cecum, making it difficult to make a clear distinction of the bowel wall.

Dr. Katz represents that defendant Cavanagh's findings of "focal thickening of the ventral (i.e., anterior or frontal) wall of the proximal (first part of the) ascending colon with surrounding inflammatory change and reactive thickening of the adjacent small bowel" is consistent with his own findings. Dr. Katz opines that these conditions can be caused by many things, including focal colitis and diverticulitis. He also provides that focal wall thickening visible on a CT scan is a "non-specific finding" and that the two most common causes are colitis and diverticulitis. Moreover, Dr. Katz adds, the fact that Ms. Procida's symptoms improved following the administration of IV antibiotics is consistent with colitis. Dr. Katz further explains that it was appropriate for defendant Cavanagh to also include diverticulitis as a potential consideration. He explained that it is sometimes difficult to identify diverticula on a CT scan due to the associated inflammation.

Dr. Katz also addresses whether defendant Cavanagh should have included the possibility of cancer in her differential. On reviewing the subject images, Dr. Katz did not include cancer in his differential considerations. He explained that there is no discernable evidence of a mass anywhere on the CT scan, no stricturing or narrowing of the lumen, enlarged lymph nodes near the colon, or large bowel obstructions, all of which are signs of colon cancer. Moreover, Dr. Katz adds, Ms. Procida's symptoms, as provided to Dr. Cavanagh, were atypical of colon cancer, which usually presents with rectal bleeding, among other signs and symptoms. Dr. Katz explains that the standard of care for a radiologist interpreting a CT scan is to "report his/her findings and the possible diagnoses which match the radiological findings and the provided clinical history." It is not the standard of care to include each and every possible diagnosis, only the most relevant. Here, in view of the fact that the CT did not reveal any findings consistent with cancer and Ms. Procida's clinical history was not consistent with colon cancer, "it is not the standard of care to include the possibility of cancer as a potential consideration." Moreover, Dr. Katz adds, defendant Cavanagh's report is not improperly limiting in that it specifically states "considerations include focal colitis or cecal diverticulitis."

In addition to the affirmation of Dr. Katz, the defendants also rely on the affidavit of Michael L. Grossbard, M.D., a physician duly licensed to practice medicine in the State of New York and board certified in internal medicine and medical oncology. It is Dr. Grossbard's opinion that, based on the size and the description of the cancer as diagnosed in July of 2016, and the doubling time of colon cancer, Ms. Procida already had metastatic cancer in her liver in July of 2015. According to Dr. Grossbard, the CT performed with oral and IV contrast on July 17, 2016 at Brookhaven Hospital revealed that Ms. Procida had four lesions to her liver which were greater than 3 cms, the largest of which was 5 cm. Dr. Grossbard opines that "it would be unusual for a metastasis from a moderately differentiated colonic adenocarcinoma to grow from 0 cms to 3 cms in one year." He further explains that "generally, lesions can only be appreciated on a CT scan if they are larger than a few mm in size, and it would be difficult to visualize any such lesion on a CT performed without intravenous contrast." Dr. Grossbard further opines that since Ms. Procida already had liver metastasis in July of 2015, she had Stage IV colon cancer at that time, which, as a general matter, is a cancer that has most commonly spread to the liver and the lungs, or has spread to other distant organs.

While Dr. Grossbard concluded that, at the time of the 2015 CT scan, Ms. Procida's cancer was so advanced that it spread from the colon to the liver where it metastasized, Dr. Katz's found that there was no evidence of cancer on the 2015 CT scan. Although Dr. Grossbard bridges the gap between the two opinions with regard to why the lesions on Ms. Procida's liver were not visible on the CT scan, the defendants do not offer an explanation as to how one might have Stage IV colon cancer and that cancer not be visible in the colon, where the cancer originated. In any event, assuming that the defendants made a prima facie showing of their entitlement to summary judgment, the plaintiffs submit an affidavit from a radiologist who concludes that Dr. Cavanagh deviated from accepted standards of care in failing to recognize on the CT scan that the findings were consistent with a neoplasm requiring its inclusion as a possible differential diagnosis in her report.

With regard to proximate cause, Dr. Grossbard explains that "[t]he five year survival rate for a patient with Stage IV colon cancer is 14%," and that Ms. Procida's survival rate, as well as treatment, would have been the same had she been diagnosed in July 2015, October 2015 or July 2016. Dr. Grossbard therefore concludes that even if defendant Cavanagh departed from the standard of care with respect to the CT scan, no act or omission on her part contributed to Ms. Procida's death or purported injuries. However, the plaintiff's medical expert in surgical oncology offers a conflicting opinion. Based on the expert's review of the CT images, the expert opines that there is no evidence of a metastatic lesion in the liver in July or October 2015, either clinically or diagnostically. The expert goes on to explain that had Ms. Procida been diagnosed with colon cancer in July or October 2015, "she would have received adjuvant therapy (chemotherapy) which is effective in the treatment of microscopic metastatic disease." The worst case scenario for Ms. Procida would have been T3N1, which would have given her a 55% chance of five-year survival. Moreover, if the pericolonic lymph node seen on the CT scan was negative, she would have been a T3N0 (Stage II) and her survival rate would have been 66%. The expert opines that "[i]t cannot be denied that diagnoses followed by treatment given 9 or 12 months sooner would have resulted in a significant extension of Barbara Procida's survival because the tumor would have been smaller and not have metastasized both locally and distantly." Moreover, the expert adds, had Ms. Procida been diagnosed nine or twelve months earlier, she would have been "in a stable and in an optimum condition for diagnostic work and treatment." The plaintiff's expert in surgical oncology raises triable issues of fact with regard to whether defendant Cavanagh's purported deviation was the proximate cause of the plaintiff's injuries. As such, to the extent the defendant's motion seeks dismissal of the plaintiff's claims against defendant Cavanagh, the motion is denied.

The Court notes that defendant Harrison is serving as his own medical expert in gastroenterology. Defendant Harrison is duly licensed to practice medicine in the State of New York and has been board certified in internal medicine since 1977, and in gastroenterology since 1979. A defendant physician's affidavit, although self-serving, can establish his or her entitlement to judgment as a matter of law (***Colao v St. Vincent's Med. Ctr.***, 65 AD3d 660, 661, 885 NYS2d 306, 308 [2d Dept 2009]) where the affidavit is detailed, specific and factual in nature, and does not assert in simple conclusory form that the physician acted within the accepted standards of medical care (*see* ***Toomey v Adirondack Surgical Assoc.***, 280 AD2d 754, 720 NYS2d 229 [3d Dept 2001]).

Defendant Harrison explains that on September 3, 2015, Ms. Procida indicated to him that she was referred to his office by Southside Hospital. She proceeded to provide defendant Harrison with her

medical history. Ms. Procida brought with her a set of discharge instructions. No other test results, reports, or any other information regarding Ms. Procida's hospital admission were included. According to defendant Harrison, in September 2015, his office did not have the capability to review a hospital admission chart remotely. He also adds that having the chart would not have changed his evaluation and treatment of Ms. Procida since his plan was to perform a colonoscopy.

According to defendant Harrison, the standard of care when performing a colonoscopy, is to evaluate all areas of the colon. To that end, the scope is placed into the anus and travels through the rectum, sigmoid colon, descending colon, around the splenic flexure, transverse colon, around the hepatic flexure, through the ascending colon, and to the cecum, where it reaches the ileocecal valve. Here, the cecum, ascending colon, hepatic flexure, transverse colon, splenic flexure, descending colon, sigmoid colon and rectum were all normal. It is also the standard of care for gastroenterologists to take photographs of certain anatomical landmarks during a colonoscopy to ensure that he/she has reached the cecum and performed a complete colonoscopy. Defendant Harrison explains that his chart contains a photograph taken of the cecum which contains a crevice that appears to be the appendical orifice, which goes into the appendix. It is therefore defendant Harrison's opinion that he reached the cecum and fully evaluated Ms. Procida's colon. Moreover, defendant Harrison further provides that it is the standard of care, when performing a colonosocpy, that the withdrawal time be six minutes or greater and that this standard does not change when biopsies are taken. According to defendant Harrison's chart, the withdrawal time was six minutes, although defendant Harrison testified that the endoscopy record, which is completed by the nurses, provides that the withdrawal time was 7 minutes.

Defendant Harrison collected biopsies from Ms. Procida's cecum and the rectum to determine whether there were any microscopic inflammation or colitis since the cecum and the rectum are where colitis is most commonly found. Defendant Harrison explains that since the colonoscopy and biopsies were negative, there was no reason to refer Ms. Procida to a surgeon. Dr. Harrison concludes that it is his opinion that the medical and surgical treatment that he provided was appropriate, and he did not depart from accepted standards of medical and surgical care during his treatment of Ms. Procida.

In opposition, the plaintiffs submit an affidavit from a gastroenterologist who concludes that Dr. Harrison deviated from accepted standards of care in negligently performing differential diagnosis of the decedent and in negligently performing a colonoscopy during which he failed to observe a cancerous lesion in the cecum. Summary judgment is not appropriate in a medical malpractice action where the parties adduce conflicting medical expert opinions (*see* ***Rodriguez v Bursztyn***, 187 AD3d 1230, 1230, 131 NYS3d 569 [2d Dept 2020]; ***Contreras v Adeyemi***, 102 AD3d 720, 721, 958 NYS2d 430 [2d Dept 2013]; ***Bengston v Wang***, 41 AD3d 625,626, 839 NYS2d 159 [2d Dept 2007]). Such credibility issues can only be resolved by a jury (*see* ***Kovacic v Griffin***, 170 AD3d 1143, 1144, 96 NYS3d 677 [2d Dept 2019]; ***Feinberg v Feit***, 23 AD3d 517, 518-519, 806 NYS2d 661 [2d Dept 2005]).

Turning to the issue of proximate cause, as with defendant Cavanagh, Dr. Grossbard's opinion establishes, prima facie, that any purported deviation by defendant Harrison was not the proximate cause of the plaintiff's injuries. However, the plaintiff's expert in surgical oncology also raises triable issues of material fact with regard to this issue by opining, as discussed above, that had the plaintiff been diagnosed in July or October 2015, in the worst case scenario, Ms. Procida would have had a 55% five

year survival and if the pericolonic lymph node seen on the CT scan was negative, she would have been a T3N0 (Stage II) and her survival rate would have been 66%. In view of the above, to the extent the defendants' motion seeks summary judgment dismissing the plaintiff's claims against defendant Harrison, the motion is denied.

The defendants also argue that all claims regarding negligent hiring and credentialing against Southside Hospital and Northwell Health should be dismissed. As a general matter, "where an employee is acting within the scope of his or her employment, the employer is liable for the employee's negligence under a theory of respondeat superior and no claim may proceed against the employer for negligent hiring, retention, supervision or training" (***Talavera v Arbit***, 18 AD3d 738, 738, 795 NYS2d 708, 709 [2d Dept 2005]). A review of the amended complaint finds that there are no separate causes of action asserted against Southside Hospital and Northwell Health for negligent hiring or credentialing. To the extent that the plaintiffs assert a claim for negligent retention and hiring, those claims are dismissed.

With regard to Northwell Health, the defendants contend that all claims against it must be dismissed on the grounds that there is no basis for imposing liability since Northwell Health does not provide medical care or treatment to patients. In support, the defendants provide the affirmation of Abraham Z. Schwartz, Esq., who represents that he is Vice President of the Medical Malpractice Program at Northwell Health. Schwartz explains that Northwell is the corporate parent of Southside Hospital and that Northwell Health "does not provide or render patient care and has never provided or rendered patient care, and does not maintain insurance coverage for medical malpractice claims." However, both defendants testified that they were employees of Northwell Health. Schwartz did not address the employment of the defendants as between Northwell Health and Southside. Therefore, the defendants did not establish their entitlement to judgment as a matter of law on this issue. Accordingly, the motion to dismiss as against Northwell is denied.

Dated: December 8, 2020

HON. JOSEPH C. PASTORESSA J.S.C.

____FINAL DETERMINATION __X__ NON-FINAL DETERMINATION