Tejada v Kairam
2022 NY Slip Op 33586(U)
October 18, 2022
Supreme Court, New York County
Docket Number: Index No. 805074/2020
Judge: Judith N. McMahon
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SUPREME COURT OF THE STATE OF NEW YORK
NEW YORK COUNTY

PRESENT: HON. JUDITH MCMAHON, *Justice* — PART 30M

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ABEL TEJADA,

Plaintiff,

- v -

INDIRA KAIRAM,

Defendant.

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INDEX NO. 805074/2020

MOTION DATE 10/18/22

MOTION SEQ. NO. 001

DECISION + ORDER ON MOTION

The following e-filed documents, listed by NYSCEF document number (Motion 001) 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 49, 50

were read on this motion to/for SUMMARY JUDGMENT (AFTER JOINDER).

Upon the foregoing documents, it is ordered that defendant's motion for summary judgment is denied.

This matter arises out of alleged medical malpractice rendered to the 71-year-old plaintiff, Abel Tejada, on October 22, 2019, during a colonoscopy that was performed by defendant, Indira Kairam, M.D. Plaintiff alleges that Dr. Kairam perforated his colon during the procedure, which necessitated surgical transection of plaintiff's bowel and placement of a colostomy performed by New York Presbyterian Hospital. A second surgery to reverse the colostomy was performed on or about January 20, 2020 (*see* NYSCEF Doc. No. 32, para 6/Plaintiff's Bill of Particulars). Plaintiff was hospitalized from October 23, 2019 to October 31, 2019 and was thereafter confined to Isabella Center for Nursing and Rehabilitation from November 1, 2019 to December 5, 2019.

FACTUAL BACKGROUND

Plaintiff underwent a colonoscopy performed by Dr. Kairam on August 27, 2015, in which a nonmalignant tubular adenoma was discovered and removed from his sigmoid colon.

In October of 2019, plaintiff returned to Dr. Kairam for a follow-up surveillance colonoscopy. Since plaintiff was now taking the blood thinner Ranexa, the defendant instructed him to obtain clearance from his cardiologist to discontinue Ranexa for five days immediately preceding the colonoscopy. As part of obtaining plaintiff's informed consent Dr. Kairam purportedly explained, through a Spanish speaking member of her staff, that the upcoming colonoscopy had a risk of bleeding and perforation, and that plaintiff's history of having a polyp removed four years earlier presented a further concern for bleeding and perforation.

Plaintiff presented to defendant's office on October 22, 2019. Written informed consent was executed by both plaintiff and defendant (*see* NYSCEF Doc. No. 36). The procedure began at 8:55 a.m. and the defendant's records indicate that at 9:00 a.m. the colonoscope reached the area of the colon known as the cecum. Defendant obtained a detailed view of plaintiff's colon, both as she advanced the scope to the cecum and as she withdrew it. Dr. Kairam's notes reflect that no difficulties were encountered during the procedure, and no polyps, angiodysplasia or strictures were observed or treated. No specimens were collected.

Prior to discharge, defendant examined plaintiff's abdomen to make sure it was not distended, and plaintiff left the facility at 9:46 a.m. without any symptoms, tenderness, or abdominal pain.

At 11:00 p.m. the next evening, October 23, 2019, plaintiff called an ambulance and was transported to New York Presbyterian Hospital for complaints of lower abdominal pain that had been gradually increasing in intensity. His last meal was at 1:30 p.m. The ambulance crew noted plaintiff's elevated heart rate and a slight distension of the abdomen. Plaintiff was brought to NYPH's emergency department by 11:44 p.m., where he complained of abdominal discomfort following a colonoscopy. Plaintiff was noted to have tachycardia and hypertension with a rigid

diffusely tender abdomen. The ER resident noted "acute 10/10 diffuse abdominal pain that began today associated with vomiting and rigid abdomen" (*see* NYSCEF Doc. No. 39).

An abdominal x-ray performed on October 24, 2019 at 1:11 a.m. showed free air under plaintiff's diaphragm. A surgical consult conducted at 1:15 a.m. noted that plaintiff "presents to the ED with 6-hour history of worsening abdominal pain and distension. Pain started suddenly and patient has no previous history of similar episodes…history is notable for outpatient colonoscopy performed 1 day ago at outpatient facility." Plaintiff was assessed with "peritonitis and abdominal distension concerning for perforation after colonoscopy," and the plan was to "open ex lap possible bowel resection possible ostomy creation" (*see* NYSCEF Doc. No. 39, pp. 75-77).

Plaintiff underwent an emergent three- hour exploratory laparotomy at 2:37 a.m. on October 24, 2019. The surgeon noted a 1 cm perforation in the distal sigmoid colon which he repaired, and a colostomy bag was placed to collect fecal contents to allow the repaired perforation to heal. It was also determined that plaintiff had septic shock and an acute kidney injury. On January 30, 2020, plaintiff returned to New York Presbyterial Hospital to have the colostomy reversed.

MOTION FOR SUMMARY JUDGMENT AND EXPERT OPINIONS

In support of her motion, defendant attaches the affirmation of gastroenterologist Scott Tenner M.D. (*see* NYSCEF Doc. No. 29) who opines within a reasonable degree of medical certainty that defendant's performance of the October 22, 2019 colonoscopy met the applicable standards of care, and that the perforated colon which plaintiff was diagnosed with approximately one and a half days after the colonoscopy was not caused by defendant's

negligence, but rather was a known statistical risk of colonoscopy that occurred despite Dr. Kairam's properly performed procedure.

Specifically, defendant's expert sets forth that: (1) defendant performed the procedure using the appropriate technique; (2) if defendant had caused a frank perforation of the colon during the colonoscopy (*i.e.*, an actual hole in the wall of the colon) then plaintiff would have emerged from anesthesia in excruciating abdominal pain; (3) the 1 cm perforation found in the distal sigmoid colon is large, and had it occurred during the colonoscopy plaintiff would not have been able to leave the facility in good health after the procedure, as is reflected in plaintiff's medical records; (4) Dr. Kairam's ability to use retroflexion of the colonoscope (*i.e.*, pulling the colonoscope back from the cecum and eventually out of the rectum) proves that there was no hole in the bowel during the procedure; (5) defendant properly visualized, illuminated and insufflated the colon, as evidenced by her description that it was performed "without difficulty;" (6) the colonoscope was wholly within the lumen of the colonic wall, and if it was not, then plaintiff would have been in great pain once the anesthesia wore off ; (7) there is no evidence that defendant used excessive or unnecessary force either during the insertion or the removal of the colonoscope; (8) there is no evidence that defendant failed to promptly detect a perforated, traumatized or torn colon, and (9) there is no evidence from the medical records or testimony suggesting that perforation of plaintiff's bowel occurred because of a negligently performed colonoscopy. Rather, according to Dr. Tenner, the perforation may have occurred because of plaintiff's age, the declining mechanical strength of the colonic wall, or a tiny intraoperative perforation that only let out minimal fluid and air--not diagnosable at the time of the colonoscopy.

In opposition to the motion plaintiff attaches the redacted expert affirmation of his gastroenterologist (*see* NYSCEF Doc. No. 44) who opines with a reasonable degree of medical certainty that defendant deviated from accepted practice by failing to properly and fully visualize the lumen of the colon during the October 22, 2019 colonoscopy, and/or by applying excess pressure in the insertion and/or withdrawal of the colonoscope, causing the instrument to traumatize and/or perforate the mucosa layer of the distal sigmoid colon. Plaintiff's expert is emphatic that these deviations were a proximate cause of plaintiff's injuries and damages.

Specifically, plaintiff's expert sets forth that the defendant used an improper technique to visualize the lumen and used excessive pressure during the insertion and/or withdrawal of the colonoscope, causing the tip of the instrument to perforate the mucosa layer (if not more) of the distal sigmoid colon[1]. The expert opines that (1) perforation of the colon was iatrogenic in causation, avoidable, and was not an acceptable risk of the procedure since plaintiff's medical history, colonoscopy report, operative report and hospital records eliminate all known causes of perforation (*i.e.,* tumor, ulcerative colitis, diverticulitis, etc.) except for doctor error; (2) plaintiff's polypectomy four years prior could not be the cause of the perforation because it would have been completely healed by 2019, and defendant did not note any abnormalities in her October 22nd colonoscopy report; (here, plaintiff's expert emphasizes that the polypectomy was in the proximal sigmoid colon, while the October 2019 perforation was in the distal sigmoid colon, closer to the rectum); (3) defendant did not properly visualize the lumen as she advanced the colonoscope through the "S" shaped sigmoid colon, typically a challenging section to

[1] In this regard plaintiff's expert explains that "over the next day and a half, due to the inflammation and irritation at the traumatized area, the area of the colon gradually deteriorated until the serosa burst, which then became a frank perforation (i.e., a perforation through the whole colonic wall) which permitted air, feces, and possibly contaminated liquid to enter plaintiff's abdomen…requiring emergent surgical intervention, the creation of a colostomy bag, an abdominal washout, extensive hospitalization and rehabilitation, and then a second surgery approximately two months later to reverse the colostomy" (*see* NYSCEF Doc. No. 44, paras 25, 26).

traverse due to the angulation of the curves in that area; (4) this perforation was concededly not a "frank" perforation going completely through the colon wall, but rather a "delayed perforation"--with the tip of the colonoscope pressing against the mucosa, damaging the mucosa layer, symptoms of which typically progress slowly and grow gradually worse over time; (5) trauma to the protective mucosa layer created weakness, inflammation and irritation caused by the bowel contents coming in contact with the normally sterile layers of the colon, which if left untreated eventually break through the serosa and create a frank perforation; (6) if defendant reexamined plaintiff's whole colon in retroflexion as she withdrew the colonoscope, as suggested by Dr. Tenner, then that would constitute a "*severe deviation*" of the standard of care because the lumen is too narrow to safely perform such a maneuver.

Plaintiff's expert further points to references in the hospital records where plaintiff's treating physicians characterized the perforation as iatrogenic in nature (*i.e.*, "s/p Hartmann's for sigmoid perforation during colonoscopy [*see* NYSCEF Doc. No. 39, p.90]; "c scope-related sigmoid perforation"[*id.*, p. 95] and "iatrogenic colon perforation during colonoscopy resulting in peritonitis" with the assessment "71M s/p colectomy with end colostomy for iatrogenic perf during colonoscopy" [*id.*, p. 206]).

Plaintiff's expert "completely disagrees" with Dr. Tenner's opinion that the mechanism of perforation may have been a weakened colonic wall that perforated post procedure, while plaintiff was at home. Nowhere in defendant's records or colonoscopy report is there any mention of weakness or abnormality, nor does the October 24th operative report indicate that the colon walls were weak at the perforation site. While plaintiff's expert concedes that Mr. Tejeda did not suffer a frank perforation *during the procedure*, he is emphatic that defendant applied too much pressure in advancing the scope and damaged the mucosa layer during the colonoscopy,

which became inflamed, irritated, and weakened over time as the bowel contents came into contact with the traumatized area.

APPLICABLE LAW

The standards for summary judgment are well settled. The proponent "must make a *prima facie* showing of entitlement to judgment as a matter of law, tendering sufficient evidence to eliminate any material issues of fact from the case" (*Winegrad v. New York Univ. Med. Ctr.*, 64 NY2d 851, 853 [1985]; [*internal citations omitted*]). The motion must be supported by evidence in admissible form (*see Zuckerman v. City of New York*, 49 NY2d 557, 562 [1980]), and the facts must be viewed in the light most favorable to the nonmoving party (*see Vega v. Restani Constr. Corp.*, 18 NY3d 499, 503 [2012]). "In determining whether summary judgment is appropriate, the motion court should draw all reasonable inferences in favor of the nonmoving party and should not pass on the issues of credibility" (*Garcia v. J.D. Duggan, Inc.*, 180 AD2d 579, 580 [1st Dept. 1992]).

Once the movant has met his or her burden on the motion, the nonmoving party must establish the existence of a material issue of fact (*see Vega v. Restani Constr. Corp.*, 18 NY3d 499, 503 [2012]). A movant's failure to make a *prima facie* showing requires denial of the motion, regardless of the sufficiency of the opposing papers (*Winegrad v. New York Univ. Med. Ctr.*, 64 NY2d 851 [1985]; [*internal citations omitted*]). It has been held that merely "pointing to gaps in an opponent's evidence is insufficient to demonstrate a movant's entitlement to summary judgment" (*Koulermos v. A.O. Smith Water Prods.*, 137 AD3d 575, 576 [1st Dept. 2016]).

"The drastic remedy of summary judgment, which deprives a party of his day in court, should not be granted where there is any doubt as to the existence of triable issues or the issue is

even 'arguable'" (*DeParis v. Women's Natl. Republican Club, Inc.*, 148 AD3d 401 [1st Dept. 2017]; [*internal citations omitted*]).

To sustain a cause of action for medical malpractice, the plaintiff must prove two essential elements: (1) a deviation or departure from accepted practice, and (2) evidence that such departure was a proximate cause of the claimed injury. A medical provider moving for summary judgment, therefore, must make a *prima facie* showing of entitlement to judgment as a matter of law by establishing the absence of a triable issue of fact as to his or her alleged departure from accepted standards of medical practice (*Frye v. Montefiore Med. Ctr.*, 70 AD3d 15 [1st Dept. 2009]; [*internal citations omitted*]), or by establishing that the plaintiff was not injured by such treatment (*see* generally *Stukas v. Streiter*, 83 AD3d 18 [2d Dept. 2011]).

To satisfy the burden on the motion, a 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 Roques v. Noble*, 73 AD3d204, 206 [1st Dept. 2010]). If the expert's opinion is not based on facts in the record, the facts must be personally known to the expert and the opinion should specify "in what way" the plaintiff's treatment was proper and "elucidate the standard of care" (*Ocasio-Gary v. Lawrence Hospital*, 69 AD3d 403, 404 [1st Dept. 2010]). Once a defendant has made such a showing, the burden shifts to the plaintiff to "submit evidentiary facts or materials to rebut the *prima facie* showing by the defendant" (*Alvarez v. Prospect Hosp.*, 68 NY2d 320, 324 [1986]), but only as to those elements on which the defendant met the burden (*see Gillespie v. New York Hosp. Queens,* 96 AD3d 901 [2d Dept. 2012]). Accordingly, a plaintiff must produce expert testimony regarding the specific acts of malpractice, and not just testimony that alleges "[g]eneral allegations of medical malpractice, merely conclusory and unsupported by competent evidence" (*Alvarez v.*

Prospect Hosp., 68 NY2d at 325). In most instances, the opinion of a qualified expert that the plaintiff's injuries resulted from a deviation from relevant industry or medical standards is sufficient to defeat summary judgment (*Frye v. Montefiore Med. Ctr.*, 70 AD3d 15, 24). Where the expert's "ultimate assertions are speculative or unsupported by any evidentiary foundation, however, the opinion should be given no probative force and is insufficient to withstand summary judgment" (*Diaz v. New York Downtown Hosp.*, 99 NY2d 542, 544 [2002]). The plaintiff's expert must address the specific assertions of the defendant's expert with respect to negligence and causation (*see Foster-Sturrup v. Long*, 95 AD3d 726, 728-729 [1st Dept. 2012]).

Where the parties' conflicting expert opinions are adequately supported by the record, summary judgment must be denied. "Resolution of issues of credibility of expert witnesses and the accuracy of their testimony are matters within the province of the jury" (*Frye v. Montefiore Med. Ctr.*, 70 AD3d 15, 25; *see also Cruz v. St. Barnabas Hospital*, 50 AD3d 382 [1st Dept. 2008]).

ANALYSIS

The defendant has established entitlement to summary judgment dismissing plaintiff's complaint through, *inter alia*, the factionally based affirmation of Dr. Tanner, who opines that defendant adhered to the standard of care during performance of the colonoscopy, and that, as reflected in the medical records generated during and after the colonoscopy, nothing defendant did or failed to do was a proximate cause of plaintiff's subsequent bowel perforation and resulting damages.

In opposition, however, plaintiff has met his burden in rebutting defendant's *prima facie* showing by submitting, *inter alia*, the affirmation of his expert who specifically addresses the assertions made by Dr. Tanner. Relevant here, *inter alia*, is plaintiff's expert's explanation that retroflexion (in which the operator turns the colonoscope tip and cameral 180 degrees backward

to improve visualization) should be limited to the rectum, as that is one of the few regions of the large intestine with sufficient space to safely perform this maneuver, and that if defendant reexamined plaintiff's whole colon in retroflexion as she withdrew the colonoscope, as suggested by Dr. Tenner, then that particular technique constitutes a "severe deviation in the standard of care."

While the evidence of injury alone does not mean that defendant was negligent (see Landau v. Rappaport, 306 AD2d 446 [1st Dept. 2003]), the facts in this record together with plaintiff's expert's opinion as to defendant's departures from good and accepted medical practice mandate a trial on whether Dr. Kairam caused a perforation of plaintiff's bowel during the colonoscopy of October 22, 2019 and whether that perforation was a proximate cause of plaintiff's injuries and damages.

Accordingly, it is

ORDERED that defendant's motion for summary judgment is denied in its entirety; and it is further

ORDERED that the parties appear for a virtual pre-trial conference by Microsoft Teams on **January 10, 2023 at 2:45 p.m.**